

THYROID HEALTH DISCLOSURE FORM

Please provide details of your thyroid condition for assessment of your application.

This questionnaire forms part of your insurance application and is required for further assessment. Please provide complete and accurate health information. Suppressing medical history or providing incorrect information may impact policy issuance or claim assessment.

Application No.:

Age:

Applicant Name:

Life Assured:

1. Date of Diagnosis

Date or year of diagnosis of thyroid disease

2. Type of Thyroid Condition

Which type of thyroid disease are you affected by?

☐ Hypothyroidism ☐ Hyperthyroidism ☐ Thyroiditis ☐ Goitre ☐ Others

If Others, please specify: _____

3. Symptoms

What are the symptoms you have and how frequently do you suffer from these symptoms?

4. Onset of Symptoms

When did you first experience the symptoms of thyroid? (Date/Year/Specific event)

5. Treatment Details

Have you undergone or are you currently under treatment for thyroid disease? Yes ☐ No ☐

If Yes, specify the name and dosage of medication: _____

6. Complications

Has there been any complication related to your condition (e.g. enlargement of thyroid gland, lump/nodules)? Yes ☐ No ☐

If Yes, please specify: _____

7. Surgical History

Have you undergone any thyroid surgery (e.g. biopsy, lobectomy, thyroidectomy)? Yes ☐ No ☐

If Yes, specify type of surgery and findings:

8. Recent Thyroid Function Test

Have you undergone a thyroid function test within the last 3–6 months? Yes ☐ No ☐

☐ Report Attached

9. Changes in Treatment

Has there been any change in your treatment within the last 6–12 months? Yes ☐ No ☐

If Yes, specify details: _____

10. Weight Changes

Have you lost or gained weight in the last 6 months? Yes ☐ No ☐

If Yes, specify details: _____

Supporting Documents

Please attach reports of all tests, consultations and prescriptions from the treating doctor(s).

☐ Reports Attached

Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge. I understand that the above answers shall form part of my proposal for insurance.

Date:

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Signature of Life Assured: