CHUBB®

Chubb Life Insurance New Zealand Limited (Chubb Life)
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Mental Health Questionnaire

Policy holder details

Name Surname First name(s)

Policy number

Date of signed application DD / MM / YYYY

1. Please tick the condition(s) you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa or bulimia
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post-traumatic stress disorder
- ☐ Other
- ☐ Manic depressive illness or bi-polar disorder
- ☐ Depression including major depression or dysthymia
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness

2. Please complete the table below for all described condition(s)

Condition	Describe your symptoms	Date diagnosed	Date ceased (if applicable)
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

3. Have you ever had any recurrence of the symptoms? Yes ☐ No ☐

If **yes**, please provide details

Date DD / MM / YYYY Details

Date DD / MM / YYYY Details

4. Are you currently symptom free? Yes ☐ No ☐

5. Date of last symptoms DD / MM / YYYY

6. Have you ever attempted suicide or self-harm? Yes ☐ No ☐

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital Date DD / MM / YYYY

Treating doctor, clinic or hospital

No. and street

Suburb/Town Postcode

7. Are you aware of the cause or reason for your condition(s)? Yes ☐ No ☐

If **yes**, please provide details

8. Have you ever had any time off work due to your condition(s)? Yes ☐ No ☐

If **yes**, please provide the dates and duration

Date DD / MM / YYYY Duration

Date DD / MM / YYYY Duration

9. Are you currently or have you ever been on treatment, including medication? Yes ☐ No ☐

If **yes**, please provide details

Treatment (e.g. anti-depressants, sedatives, ECT, counselling)	**Date commenced**	**Date ceased** (if applicable)	**Reason ceased**
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? Yes ☐ No ☐

If **yes**, please provide details

11. Have you been referred for consultation with a psychiatrist or psychologist? Yes ☐ No ☐

If **yes**, please provide details — Date of last consulted DD / MM / YYYY

Name of consultant

No. and street

Suburb/Town — Postcode

12. Have you been admitted to hospital or any other care facility? Yes ☐ No ☐

If **yes**, please provide details — Date of last admitted DD / MM / YYYY

Name of institution

No. and street

Suburb/Town — Postcode

Doctor(s) consulted

13. Does your usual doctor, as advised in your completed Application Form have details of this condition(s)? Yes ☐ No ☐

14. Is the treating doctor different to your usual doctor? Yes ☐ No ☐

If **yes**, please provide details — Date of last consulted DD / MM / YYYY

Doctor/Medical centre

Phone number — Fax

No. and street

Suburb/Town — Postcode

15. I hereby declare that all statements made in this questionnaire are true and complete and that I have not withheld or misstated any material information.

Signature of Life Assured ✗ — Date DD / MM / YYYY

Returning your form:

Please return completed form to Chubb Life Insurance New Zealand Limited by post or scan and email to NewBusiness.NZ@chubb.com.