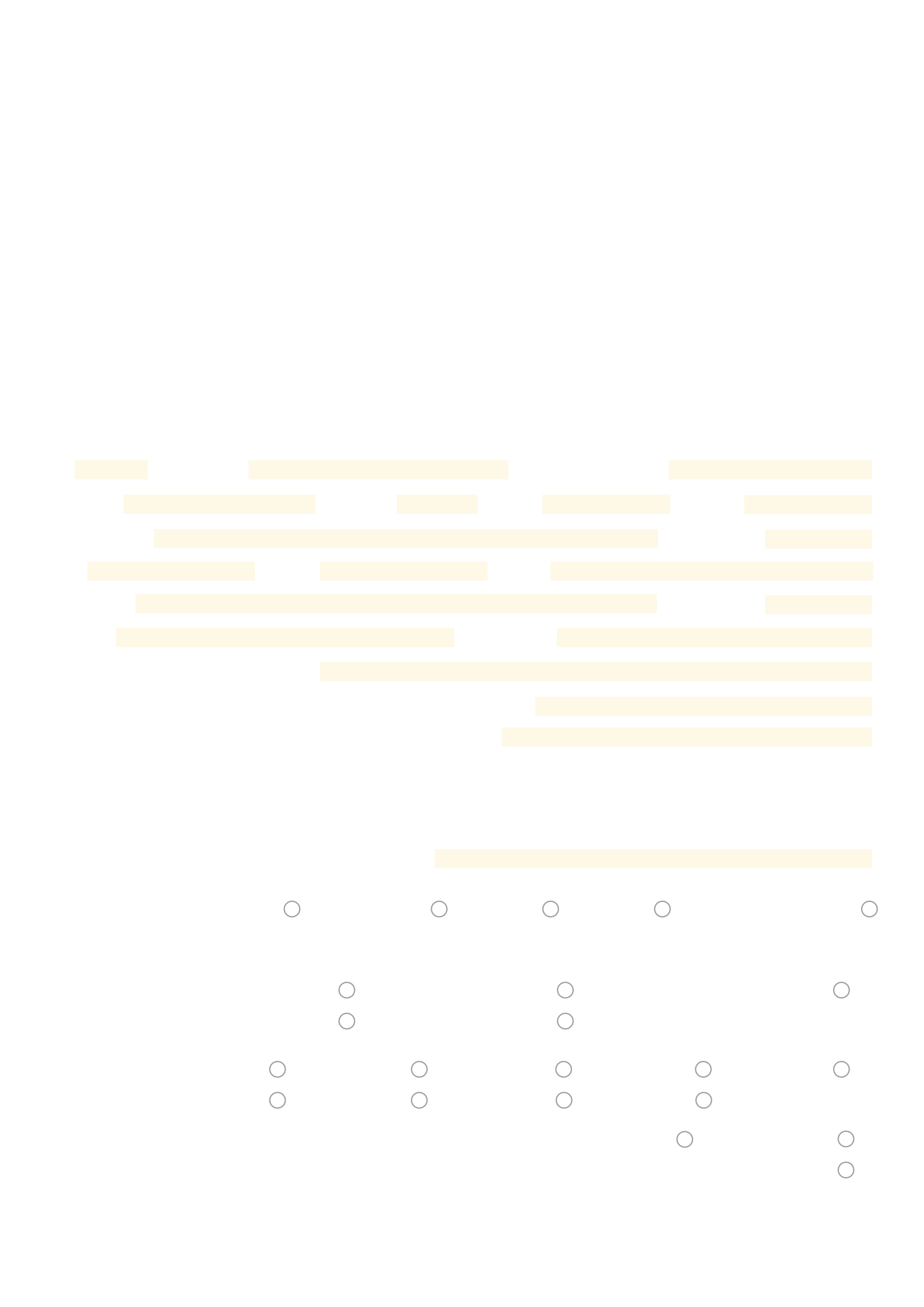

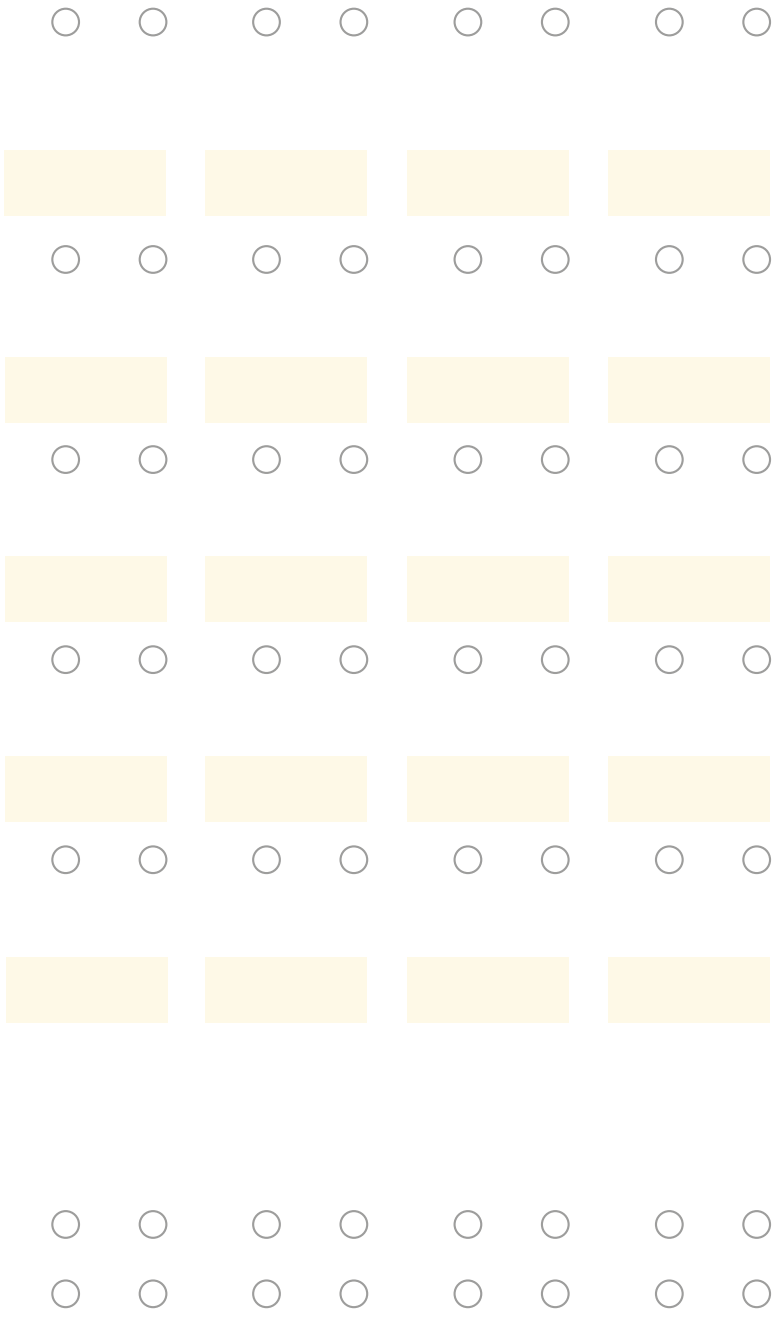

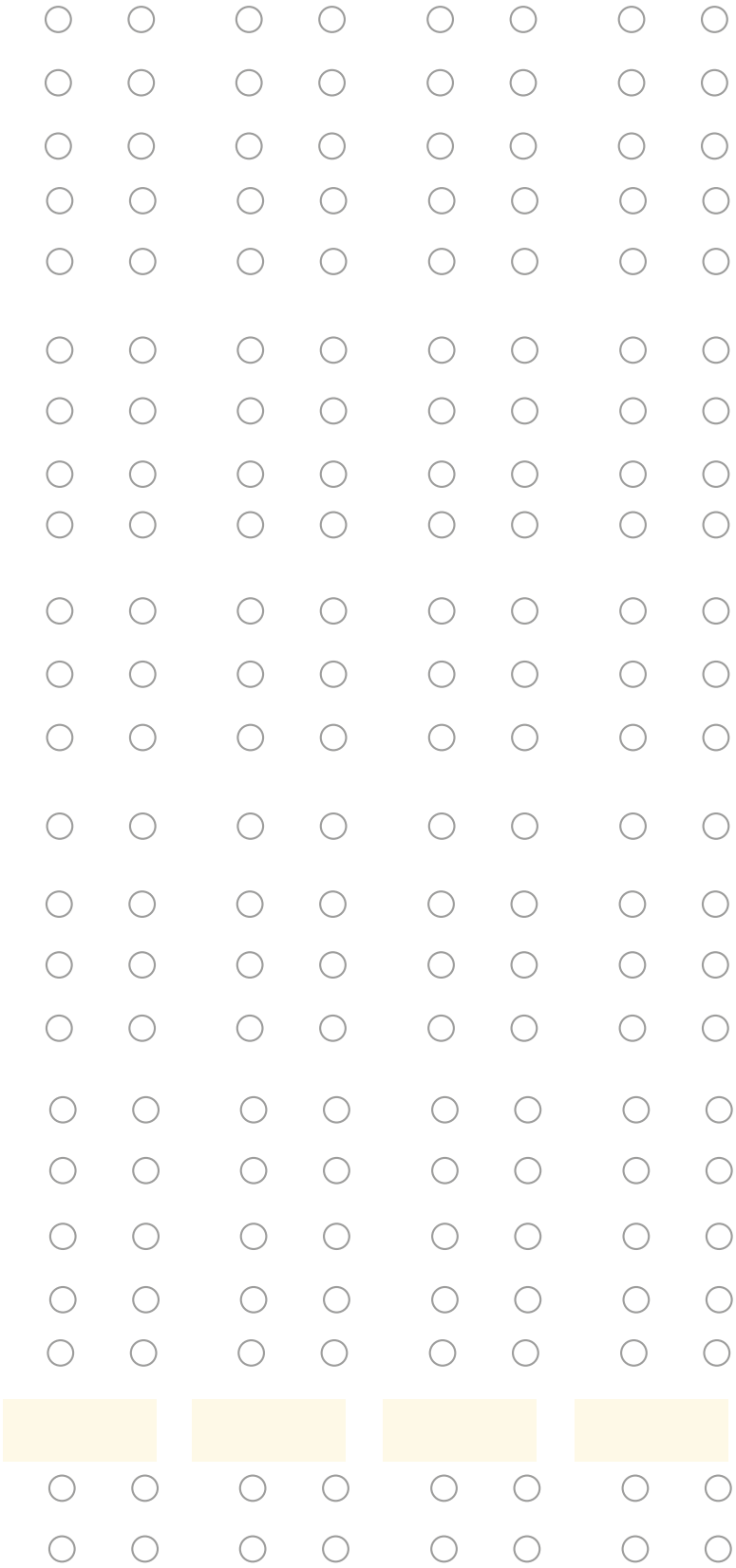

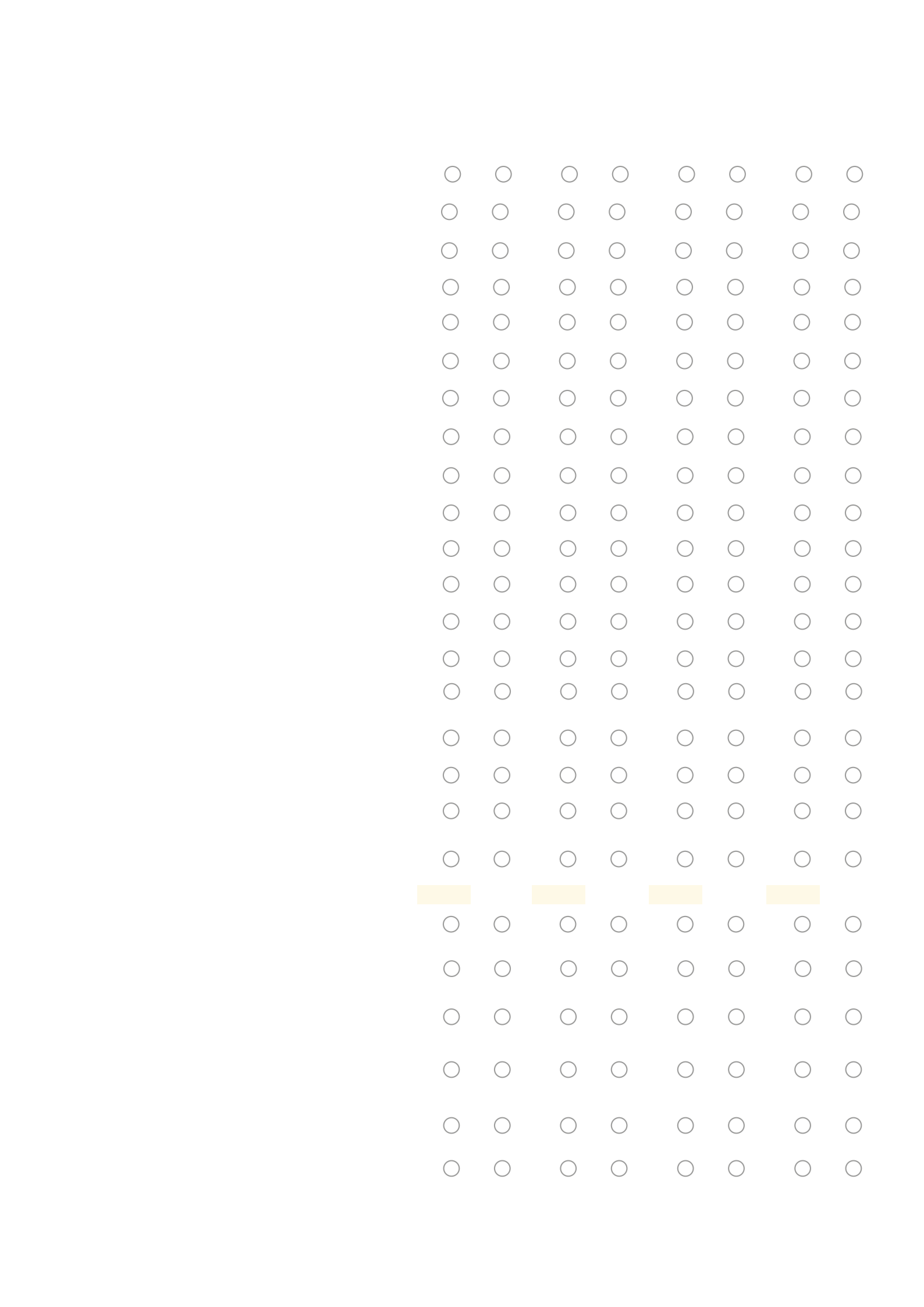

Additional information

If you answered "Yes" to any of the questions in Section 7, you MUST complete the additional information below. If you require additional space, please continue on a separate sheet.

	Question no.	Name of illness/medical condition*	Dates (to and from)	What medical treatment was provided?	Current medication name and daily dose	Have you had any hospital stay in relation to this condition?	What is the current status of the condition?**
Policyholder							
Spouse							
Dep. 1							
Dep. 2							

*Where applicable, please state the area of the body affected (e.g. left or right arm)
**Please enter either Complete Recovery, Ongoing or Recurrent (or likely to recur)