

# Generali Worldwide

## Health Plan – Medical Questionnaire

### Urinary Tract Infection



Please complete all sections in **BLOCK CAPITALS** or tick the boxes, where appropriate.

Group Number:

Employer Name:

Employee Name:

Employee ID Number:

Applicant Name:

Applicant Date of Birth:

**ALL QUESTIONS MUST BE COMPLETED**

1. Diagnosis: (i.e. cystitis, urethritis)

2. When did urinary tract infection(s) or problems first occur?

3. How frequent are the symptoms? (State average number per month/ per year)

4. When was the latest episode?

5. Has any underlying cause been established?

Yes  No

If Yes, give full details.

6. Were medications prescribed?

Yes  No

If Yes, list name, dosage, frequency, still taking?

7. Have any investigations or tests been carried out or are any planned? Yes  No   
If Yes, give details, dates and results.

Name of Test:	Date:	Results:

8. Are any future tests or treatments planned? Yes  No   
If Yes, please provide details.

Additional Comments

**CERTIFICATION:** I certify that these answers and statements are true to the best of my knowledge and belief. I will inform Generali Worldwide of any material changes to the information provided which take place between the time the form is completed and the time coverage become effective. I agree that this document shall form a part of my request for coverage.

Applicant signature:

Date:

**This completed and signed form may be mailed to:**  
**Generali Worldwide,**  
**P.O. Box AP-59217, Slot 2052, Nassau, Bahamas**  
**or faxed to +1 242 328 5972 or scanned and e-mailed to: [underwriting@generalibahamas.com](mailto:underwriting@generalibahamas.com)**

**PLEASE RETAIN A COPY FOR YOUR RECORDS**

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