

ANXIETY, DEPRESSION AND MENTAL ILLNESS QUESTIONNAIRE

1. YOUR DETAILS

Full Name (Mr/Mrs/Miss/Ms/Other)

Date of birth (DD MM YYYY)

Policy Number

2. YOUR HEALTH DETAILS

Please confirm the name of your condition.

When did you first suffer with your condition?

 (DD MM YYYY)

Please confirm the date of your last symptoms.

 (DD MM YYYY) / Ongoing

Please give details of your current treatment e.g. –
type of medication, counselling, psychiatry etc.

Have you received inpatient/outpatient care?
If so please provide full details including dates.

Please confirm the number of episodes and the
length of symptoms you have had in the last 5 years.

Episodes

Length of symptoms

Please confirm the length of any time off work or when
you have been unable to do your normal activities
in the last 5 years.

☐ 0 days ☐ 1-14 days ☐ 15-28 days ☐ More than 28 days

Have you had ever attempted suicide, self harm or
had suicidal thoughts? If yes please provide brief
details including dates.

3. DECLARATION

- I declare that the above information is true and complete to the best of my knowledge and belief.
- I understand that this shall form part of my application with my Scottish Widows plan as stated in Section 1 of this questionnaire.

Signature

Date (DD MM YYYY)

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