PT Great Eastern Life Indonesia
Menara Karya Lt. 5
Jl. H. R. Rasuna Said Blok X-5 Kav. 1-2
Jakarta Selatan 12950 – Indonesia

Customer Contact Centre
(+62) 21 2554 3800 (Senin - Jumat, 09.00-17.00 WIB)
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Great Eastern
An OCBC Company

Stomach Disorder Questionnaire

Last Name: _____ First Name: _____
Please Print

Date of Birth: _____ Policy/Application Number: _____

1. Please state the precise diagnosis, or nature of the condition you are suffering from (e.g. Barrett's esophagus, duodenal ulcer, gastro-esophageal reflux, indigestion, irritable bowel syndrome, hiatus hernia etc.) and attach a copy of any medical reports if available.

2. When was the condition diagnosed or when did you first experience symptoms? / /

3. Please describe your symptoms:

4. How often do you typically experience symptoms:

5. Are the symptoms becoming: ☐ more frequent ☐ less frequent ☐ unchanged

6. Are your aware of anything that precipitates your symptoms? ☐ Yes ☐ No
If yes, please provide details:

7. When did you last experience symptoms? / /

8. Do you currently take any medication for this condition? ☐ Yes ☐ No
If yes, please provide details:

Name of medication	Dose	Frequency

9. Other than already stated above, have you taken any other medication or had any other treatment in the past for this condition? ☐ Yes ☐ No
If yes, please provide details:

Name of medication or treatment	Dose	Frequency	Date last taken

10. Have you ever had any tests or investigations for this condition e.g. barium meal, colonoscopy, endoscopy, gastroscopy, ultrasound etc.? ☐ Yes ☐ No
If yes, please provide details:

Name of test or investigation	Location	Date	Result

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11. Have you ever been admitted to hospital for this condition? ☐ Yes ☐ No
If yes, please provide details:

Name of doctor, hospital or clinic	Address	Dates

12. Has any further treatment or investigation been discussed or contemplated? ☐ Yes ☐ No
If yes, please provide details:

13. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Date of last consult

14. Have you ever taken time off work with this condition? ☐ Yes ☐ No
If yes, please provide dates and durations:

15. Have your working duties ever been affected or restricted in any way? ☐ Yes ☐ No
If yes, please provide details including dates and durations:

16. Please provide any additional information that you feel is important:

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

	x	/ /
Name	Signature	Date