



**BACKACHE QUESTIONNAIRE (For completion by the Participant)**

**Note: This questionnaire forms part of your application for Takaful proposal. You are required to disclose in this questionnaire, fully and faithfully all the facts that you know or ought to know. Failure to take reasonable care in answering the questions may result in voidance of your contract of Takaful, refusal or reduction of your claim(s), change of the terms or termination of your contract of Takaful.**

Full name of the Participant: \_\_\_\_\_

NRIC No. : \_\_\_\_\_ Certificate No. : \_\_\_\_\_

1. When did you first have backache?

2. a. How many attacks have you had in the past 2 years?

<u>Year</u>	<u>No of attacks</u>
_____	_____
_____	_____

b. When was the last attack? \_\_\_\_\_

3. Did you consult any doctor concerning it? If Yes, please state name and address of the doctor and the last consultation date.

[        ] No

[        ] Yes; please provide details:

a. Name & address of doctor

\_\_\_\_\_  
\_\_\_\_\_

b. Date of last consultation

\_\_\_/\_\_\_/\_\_\_\_\_

c. What was the doctor's advice?

\_\_\_\_\_

d. Any follow-up required?

[        ] No    [        ] Yes

Date of last follow up: \_\_\_\_\_



4. Has any investigation been done eg: X-ray, CT scan, MRI, etc?

No

Yes; please provide details and copy of the results.

Type of Investigation	Results	Date
_____	_____	___/___/_____
_____	_____	___/___/_____

5. What was the cause of the backache?

- Muscle pain                       Osteoporosis  
 Prolapsed disc                       Paget's disease of the bone  
 Scoliosis                               Others: \_\_\_\_\_

6. How has the backache been treated?

- Bed rest                               Pain killer  
 Surgery                                 Injection  
 Massage or ointment                 Physiotherapy  
 Others: \_\_\_\_\_

Date of treatment: \_\_\_/\_\_\_/\_\_\_\_\_

7. Have you been advised to undergo any surgery or has any surgery been done?

No

Yes; please provide details:

Type of surgery	Hospital	Date
_____	_____	___/___/_____
_____	_____	___/___/_____

8. Are your activities restricted in any way?

No                       Yes, please provide details:-

\_\_\_\_\_

\_\_\_\_\_



9. Has any future treatment been discussed or contemplated such as changes in medication, surgery or other therapy?  
[        ] No        [        ] Yes

If Yes, please provide details.

- [ ] Surgery  
[ ] Physiotherapy  
[ ] Medication  
[ ] Others: \_\_\_\_\_

10. Have you taken any time off in the last 2 years? If so, please state when and duration.  
[        ] No        [        ] Yes

Year \_\_\_\_\_ Number of days \_\_\_\_\_

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#### DECLARATION AND AUTHORIZATIONS

I declare that the above answers are true and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this supplementary questionnaire shall form part of my application for Takaful coverage with FWD Takaful Berhad and that failure to disclose any material fact known to me may invalidate the contract of takaful.

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Signature of Participant

I/C No:

Date: