



Name of Proposed Insured: _____ **Application/Policy No:** _____

1. Please specify/describe all **current** and **past** symptoms, history or diagnosis of (tick off appropriate boxes):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Fatigue, exhaustion | <input type="checkbox"/> Marriage/family counselling | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Suicidal thoughts or attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Major Depression | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Psychosis/hallucinations |
| <input type="checkbox"/> Burn out | <input type="checkbox"/> Panic Attack(s) | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Anger management problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Dysthymia | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Post Traumatic Stress | <input type="checkbox"/> Generalized Anxiety Disorder |
| <input type="checkbox"/> Phobia(s) | <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Counselling for (specify): _____ | |
| <input type="checkbox"/> Other (describe): _____ | | | |

2. Have you experienced any symptoms within the last 12 months? Yes No

If yes: Describe all symptoms: _____

If no: How long have you been completely symptom-free? _____

3. a) Date of onset of your initial symptoms: _____

b) Cause(s) of symptoms: _____

c) How many separate occurrences or episodes of symptoms have you had? _____

d) What was the duration of each occurrence or episode? _____

4. Has your physician given you a diagnosis? Yes No **If yes,** provide full details, including the date a diagnosis was given: _____

5. Have you taken medication, prescribed or non-prescribed, or received treatment in the past 12 months?
 Yes No **If yes,** provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment and the date treatment was first recommended: _____

6. What other medication(s) or treatment has been prescribed in the past? Provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment, the date treatment was first recommended, and the date and reason medication(s) or treatment was discontinued: _____

(continued on following page)



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7. Have you been referred to a psychiatrist or psychologist for this condition? Yes No **If yes**, provide full name(s) and address(es) of those consulted, date of first consultation, frequency of follow-up visits and date of the last consultation: _____

8. Have you ever consulted an emergency room or been hospitalized for this condition? Yes No **If yes**, advise date(s), reason(s) and name and address of hospital(s): _____

9. Have you ever had any suicidal thoughts or attempts? Yes No **If yes**, provide dates and details: _____

10. Have you ever lost any time from work due to this condition? Yes No **If yes**, provide details including dates and duration of time off work: _____

11. Have your job duties or daily activities ever been restricted or modified in any way because of this condition? Yes No **If yes**, describe restrictions, modifications or limitations: _____

12. Other than those already declared, please provide the names and addresses of all physicians, psychiatrists, psychologists, counsellors, mental health care providers, other health care practitioners, hospitals or facilities consulted for this condition and include details and duration of treatment: _____

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: _____ **Date:** _____

(Day/Month/Year)