

# Health History Questionnaire

## INSTRUCTIONS

Please follow these instructions closely. The information obtained is important for underwriting your insurance submission. Please review the Field Underwriting Guide with your Broker if you have any questions on completing this questionnaire. We sincerely appreciate your business.

- Please print clearly
- Print in black ink
- All recorded answers must be in English
- Answer every question
- Use the additional space to provide full details of your health history
- Any answer changes must be initialed by the Proposed Insured
- Please sign and date this form once completed

Did you require a third-party translator to complete these questions? .....  Yes  No  
If "Yes," complete and attach an Interpreter Services Declaration form.

## PROPOSED INSURED INFORMATION

Family Name/Last Name	Given Name/First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy)
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Passport or government identity document:

Type of Identification	Passport Number or Government ID Number
Country of Issue	Date of Expiration (dd/mm/yyyy)

## CURRENT HEALTH STATUS

Height \_\_\_\_\_m \_\_\_\_\_cm      Weight \_\_\_\_\_kg

Has your weight changed over the last 12 months? Loss/Gain (circle one): \_\_\_\_\_kg Reason: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

Please circle the specific condition for which any "Yes" answer is given.

A. Have you ever been treated for or had any symptoms or indication of:

1. High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels? .....  Yes  No
2. Anemia, hemophilia, or any other blood or bleeding disease or disorder? .....  Yes  No
3. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder? .....  Yes  No

Provide details to "Yes" answers in Section Q on page 5.

**PERSONAL HEALTH HISTORY (continued)**

- 4. Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder? .....  Yes  No
  - 5. Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn’s disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver? .....  Yes  No
  - 6. Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder? .....  Yes  No
  - 7. Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones? .....  Yes  No
  - 8. Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy? .....  Yes  No
  - 9. Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder? .....  Yes  No
  - 10. Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson’s disease, tremor, Alzheimer’s disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system? .....  Yes  No
  - 11. Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth? .....  Yes  No
  - B. Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus? .....  Yes  No
  - C. Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system? .....  Yes  No
  - D. Have you ever had a blood transfusion? .....  Yes  No
  - E. Other than for conditions already disclosed, in the last 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests? .....  Yes  No
  - F. Have you been hospitalized or had any surgery in the last 10 years? .....  Yes  No
  - G. Do you have any symptoms for which you have not yet consulted a physician or received treatment? .....  Yes  No
  - H. Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results? .....  Yes  No
  - I. Do you have a deformity or an amputation? .....  Yes  No
  - J. Are you taking any prescribed or non-prescribed medications? .....  Yes  No
  - K. Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vapour products, marijuana, nicotine patches, nicotine gum, hookah, e-cigarettes or shisha)? .....  Yes  No
- If “Yes,” provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

**PERSONAL HEALTH HISTORY (continued)**

L. In the last 10 years have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics?.....  Yes  No  
 If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

M. Do you currently drink alcohol? .....  Yes  No

If "Yes," which of the following best describes the average frequency of your alcohol consumption?

Daily  Weekly  Monthly  Less than once per month

On those days when you drink alcohol, how many drinks do you typically have? \_\_\_\_\_

N. Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counseling or medical advice due to your use of drugs or alcohol? .....  Yes  No

If "Yes," indicate the type of counseling or treatments, and dates started and ended (include any participation in organizations/support groups) in Section Q on page 5.

**O. Family History**

1. Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder?.....  Yes  No

If "Yes," complete the following chart:

Your relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

2. Please provide current age or age at death and cause of death of remaining family members not recorded above:

Family Member	Current Age	or Age at Death and Cause of Death
Mother		
Father		
Brothers		
Sisters		

**PERSONAL HEALTH HISTORY (continued)**

**P. Medical Advisor/Clinic/Hospital Information**

Do you have a personal care physician? .....  Yes  No  
If "Yes," provide details below:

Name of personal physician, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

**If you have no personal physician or health care advisor, please provide details of why you last consulted any medical clinic, health care advisor or hospital. This includes details of any health screening exams.**

Name of medical doctor, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			



## SIGNATURE

I declare and represent to the life insurance company that my answers provided in this Health History Questionnaire are complete, correct, and true to the best of my knowledge and belief. I understand and acknowledge that my answers, as recorded in this Health History Questionnaire, together with all ancillary forms and information as may be required by the insurance company, will form the basis for life insurance coverage and that all such documents may be incorporated as part of any policy or certificate issued which provides life insurance coverage on my life. I understand that if I misrepresent any of my answers or statements or fail to provide all relevant information in complete detail, that may result in benefits being contested by any company which provides me with life insurance coverage and the policy may be voided.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Broker.

*NOTE: If the proposed insured is under age 18 then the signature of a parent or legal guardian is required in the space provided below.*

Signature of Proposed Insured X	Date (dd/mm/yyyy)
Signature of Parent/Legal Guardian (please circle which applies) X	Date (dd/mm/yyyy)