



Nervous Disorder Questionnaire

500-5000 Yonge Street
Toronto, ON M2N 7J8
Fax: 1-877-767-0477

Policy Number: _____

PLEASE PRINT

Name of Proposed Insured: _____ Date of birth: DD / MM / YYYY

Do you or have you suffered from or received treatment for:

- Anxiety
- Eating disorder
- Burn out
- Suicidal thoughts or attempt(s)
- Panic / Phobias
- Post-traumatic stress disorder
- Insomnia / Sleep problems
- Bipolar or manic-depressive illness
- Depression
- Schizophrenia or other psychotic illness
- Alcohol or substance abuse / addiction
- Other _____

When did the first symptom occur, what were your symptoms and what appeared to be cause for your symptoms?

Are you currently experiencing any symptoms? Yes No

If **"Yes,"** describe current symptoms: _____

If **"No,"** how long have you been symptom free? _____

Name, address & phone number of Professional(s) consulted: _____

Please specify if the Professional(s) consulted is your Family Physician, Psychiatrist, Psychologist, Counsellor or Addiction Specialist?

Provide details: _____

Was a diagnosis made? If so advise date, diagnosis and treatment: _____

Details of any medication (type, dose, frequency): _____

Are you still taking medication? Yes No If **"No,"** provide date medication was stopped and reason: _____

Have you ever been hospitalized for the condition(s) mentioned above? Yes No If **"Yes,"** provide details below.

Do you or have you ever-received inpatient/outpatient psychotherapy/counselling? Yes No If **"Yes,"** provide details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition?

Yes No If **"Yes,"** provide details below:

I understand that my answers to the above questions will be relied on by *ivari* in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire (being part of the Insurance Application) may be rendered void on the grounds of misrepresentation or fraud. I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to *ivari*.

Date: DD / MM / YYYY

Signature of Insured

Signature of Witness