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: D D / M M / Y Y Y Y

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 Insuarnce 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: D D / M M / Y Y Y Y

_____ _____

Signature of Insured Signature of Witness