HUMANIA ASSURANCE MD®

Concussion, skull fracture head injury questionnaire

Identification

Policy number:

Name of person to be insured:

First Name of person to be insured:

Date of birth: year / month / day

Section Concussion, Skull fracture, Head injury

1. Date of accident? year / month / day

2. Did you have a skull fracture? ☐ Yes ☐ No

3. How long were you unconscious after the accident? Hours? Days?

4. Since the accident, have you suffered from:

☐ Loss of consciouness ☐ Epilepsy ☐ Fainting spell ☐ Dizziness ☐ Convulsions ☐ Paralysis ☐ Headaches

☐ Neurasthenia ☐ Mental confusion ☐ Memory loss ☐ Other similar events?

If yes, indicate number of episodes or attacks, dates, average duration in each case.

Do you currently have any symptoms? ☐ Yes ☐ No

If not, since when are you free of any symptom?

5. Did you undergo surgery for this condition ☐ Yes ☐ No

If yes, specify date, nature of surgery and results:

Name and address of hospital:

6. Did you bleed from the ears, nose or mouth? ☐ Yes ☐ No

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Concussion, Skull fracture, Head injury (...continued)

7. Have you had a lumbar puncture? ☐ Yes ☐ No

If yes, specify results: _____

8. Did you have X-ray studies or other diagnostic tests of your skull? ☐ Yes ☐ No

If yes, specify date and results: _____

9. Have you lost any time from work due to this condition? ☐ Yes ☐ No

If yes, provide details includings dates and duration of time off work: _____

I, the undersigned, declare that the above answers are true and complete and shall form part of my application for insurance with Humania Assurance.

Signed at: _____ Date: ____ year / ____ month / ____ day

Signature of witness: _____

Signature of person to be insured: _____

Humania Assurance Inc., 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8

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