HUMANIA ASSURANCE MD®

Identification

Policy/Application No.: ⬜⬜⬜⬜⬜⬜⬜

Last name of person to be insured: ⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

First name of person to be insured: ⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

Date of birth: ⬜⬜⬜⬜ / ⬜⬜ / ⬜⬜
year / month / day

Section Nervous disorder

1. Type: ☐ Anxiety ☐ Depression ☐ Fatigue ☐ Major Depression ☐ Insomnia ☐ Burn-out ☐ Adjustment Disorder

☐ Stress ☐ Bipolar Disorder ☐ Suicidal Thoughts ☐ Suicide Attempt ☐ ADD/ADHD

☐ Other (Please indicate): _____

2. Date(s) of each type selected above: _____

3. Cause(s) of symptoms: _____

4. Duration of lost time from work or school:

   Within last 12 months (Dates): _____

   Within last 12 months to 24 months (Dates): _____

   Within last 24 months to 5 years (Dates): _____

5. Treatments:

   ☐ Medication – Type, Dose, Dates, Frequency: _____

   ☐ Psychotherapy – Dates and frequency: _____

   ☐ Hospitalizations - Dates: _____

   ☐ Electroshock: _____

   ☐ Other (Please specify): _____

Nervous disorder (suite)

6. Family History of nervous disorders or suicide: ☐ Yes ☐ No

   If yes, please specify type and family relationship: _____

7. Alcohol use: ☐ Yes ☐ No

   If yes, please specify the dates, quantity and frequency: _____

8. Drug use: ☐ Yes ☐ No

   If yes, please specify the type, dates, quantity and frequency: _____

9. Have you ever been treated for drug or alcohol abuse: ☐ Yes ☐ No

   If yes, please specify the dates: _____

10. Do you current have any symptoms? ☐ Yes ☐ No

    If not, since when are you free of any symptoms? _____

11. Are you currently taking any medication or under the care of a physician (including a psychologist or psychiatrist)? ☐ Yes ☐ No

12. Do you continue to be followed by a physician? ☐ Yes ☐ No

13. Date of last consultation: ☐☐☐☐ / ☐☐ / ☐☐
                                 year   / month / day

14. Name and address of all physicians and health care professionals consulted for this condition: _____

    _____

    _____

    _____

15. Name and address of last physician consulted: _____

    _____

    Date: ☐☐☐☐ / ☐☐ / ☐☐
                 year   / month / day

    Reason: _____

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

Signed at _____   Date ☐☐☐☐ / ☐☐ / ☐☐
                                                      year / month / day

Signature of person to be insured _____

Signature of witness _____

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6