Health Questionnaire – Dependant Group Benefits

Name of Employee Surname First Name Middle Initial	Telephone ( )	Occupation
Address of Employee (number, street) Street Apt. City/town Province Postal Code		Date of Birth (dd./mm/yy)

Name of Dependent (Last Name / First Name)	Relationship	Date of Birth	Height	Weight

INCOMPLETE FORMS WILL BE RETURNED

To be completed by the Dependent– Statement of Health – Answer Every Question – Give Details

Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:

			No	Yes
2	a)	dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder?	☐	☐
	b)	asthma, chronic cough, shortness of breath, or convulsions	☐	☐
	c)	high blood pressure? If yes, provide BP Readings	☐	☐
	d)	pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems?	☐	☐
	e)	ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder?	☐	☐
	f)	arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia	☐	☐
	g)	cancer, tumor, leukemia, enlarged glands or lymph nodes?	☐	☐
	h)	diabetes, sugar in urine or thyroid disorder?	☐	☐
	i)	urine, kidney or bladder disorder?	☐	☐
	j)	anemia, bleeding or blood disorder?	☐	☐
	k)	difficulty with eyes or ears?	☐	☐
	l)	acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)	☐	☐
	m)	a positive HIV (Human Immune Deficiency Syndrome) test?	☐	☐
3	a)	Indicate your average weekly consumption of alcohol Beer _____ oz. Wine _____ oz. Liquor _____ oz.	☐	☐
	b)	Have you ever been advised to stop drinking alcohol or to drink less?	☐	☐
4	a)	Have you ever been refused life or health insurance or been offered it on special terms?	☐	☐
	b)	If you have recently applied for another insurance Policy, please provide: Date: _____ Policy No. _____ Name of Insurance Company:	☐	☐

		No	Yes
5	Do you have an annual checkup If "Yes" provide results: _____ _____ If "No" provide date and results of last check up. Date:_____ Results: _____ _____	☐	☐
	In the past 5 years have you:		
6	a) except for an annual check up, consulted a Doctor or other health practitioner, submitted to an ECG, blood tests, X – rays or other tests, had surgery or been treated in a hospital?	☐	☐
	b) received or applied for disability benefits for 3 months or longer?	☐	☐
	c) had a urinary tract infection or any sexually transmitted disease?	☐	☐
	Within the past 12 months, have:		
7	a) your duties been modified due to health reasons?	☐	☐
	b) you been off work for more than 5 consecutive days due to illness or injury?	☐	☐
	c) you used tobacco products? If "Yes", indicate the number per day _____	☐	☐
8	Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician?	☐	☐
9	Are you presently under medical treatment by diet, Medicine, or other means?	☐	☐
10	Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger?	☐	☐
11	a) For women: are you pregnant?	☐	☐
	b) Have you ever had any complications of pregnancy?	☐	☐
12	In the past 12-months have you experienced any symptoms that you have not yet sought medical attention for ?	☐	☐

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Name of Applicant: _____

For each "Yes" answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

Authorization

I certify that the above statements and those on any attached sheet are true and complete. I authorize SC International and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for The Norfolk Group, to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy or this authorization is as valid as the original.

Date: _____ Signature of Applicant or Legal Guardian _____
(Required in all instances)

You should keep a copy of this Health Questionnaire for your records.