

Health Questionnaire – Dependant Group Benefits

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

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		No	Yes
2 a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	5 Do you have an annual checkup If “Yes” provide results: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
b) asthma, chronic cough, shortness of breath, or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	If “No” provide date and results of last check up. Date: _____ Results: _____		
c) high blood pressure? If yes provide BP Readings for the past 12-months	<input type="checkbox"/>	<input type="checkbox"/>			
d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems?	<input type="checkbox"/>	<input type="checkbox"/>	In the past 5 years have you:		
e) ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	b) received or applied for disability benefits for 3 months or longer?	<input type="checkbox"/>	<input type="checkbox"/>
g) cancer, tumor, leukemia, enlarged glands or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	c) had a urinary tract infection or any sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
h) diabetes, sugar in urine or thyroid disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Within the past 12 months, have:		
i) urine, kidney or bladder disorder?	<input type="checkbox"/>	<input type="checkbox"/>	7 a) your duties been modified due to health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
j) anemia, bleeding or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	b) you been off work for more than 5 consecutive days due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
k) difficulty with eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>	c) you used tobacco products? If “Yes”, indicate the number per day _____	<input type="checkbox"/>	<input type="checkbox"/>
l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)	<input type="checkbox"/>	<input type="checkbox"/>	8 Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
m) a positive HIV (Human Immune Deficiency Syndrome) test?	<input type="checkbox"/>	<input type="checkbox"/>	9 Are you presently under medical treatment by diet, Medicine, or other means?	<input type="checkbox"/>	<input type="checkbox"/>
3 a) Indicate your average weekly consumption of alcohol Beer _____ oz. Wine _____ oz. Liquor _____ oz.	<input type="checkbox"/>	<input type="checkbox"/>	10 Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you ever been advised to stop drinking alcohol or to drink less?	<input type="checkbox"/>	<input type="checkbox"/>	11 a) For women: are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4 a) Have you ever been refused life or health insurance or been offered it on special terms?	<input type="checkbox"/>	<input type="checkbox"/>	b) Have you ever had any complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
b) If you have recently applied for another insurance Policy, please provide: Date: _____ Policy No. _____ Name of Insurance Company:	<input type="checkbox"/>	<input type="checkbox"/>	12 In the past 12-months have you experienced any symptoms that you have not yet sought medical attention for ?	<input type="checkbox"/>	<input type="checkbox"/>

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 Norfolk Mobility Benefits Inc., 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 Norfolk Mobility Benefits Inc., to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy of 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.