**MENTAL HEALTH QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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| **First Name:** |       | **Last Name:** |       |
| **Date of Birth** (mm/dd/yyyy): |       | **Policy/Application No.:** |       |

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| 1. Please state the precise diagnosis, or nature of the condition. Attach a copy of any medical report if available.
 |
| [ ]  Anxiety | [ ]  Post-traumatic stress | [ ]  Others:       |
| [ ]  Eating Disorder | [ ]  Schizophrenia |
| [ ]  Depression | [ ]  Dementia |
| [ ]  Bipolar Disorder | [ ]  Neurodevelopmental Disorder |
| [ ]  Substance Related | [ ]  Sleep Disorder |
| 1. Please describe your symptoms.
 |
| Symptoms | Date From (Month/Year) | Date To (Month/Year) |
|       |       |       |
|       |       |       |
| 1. Has any reason for your condition been identified?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. When was the condition diagnosed or when did you first experience symptoms?
 |
|       |
| 1. Have you had any suicide attempt?
 | [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. Have you had any recurrence of this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Diagnosis | Date From (Month/Year) | Date To (Month/Year) |
|       |       |       |
|       |       |       |
|       |       |       |
| 1. Were you prescribed medication for this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Name of Medication | Date Prescribed (Month/Year) | Dosage | Date Medication Stopped (Month/Year) | Reason |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| 1. Have you ever had any other treatment for this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Name of Test or Investigation | Date Started (Month/Year) | Date Stopped (Month/Year) |
| [ ]  Counseling |       |       |
| [ ]  Cognitive Behavioral Therapy |       |       |
| [ ]  Electroconvulsive Treatment |       |       |
| [ ]  Others:       |       |       |
| 1. Have you been admitted to a hospital/facility due to this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Date Admitted (Month/Year) | Date Discharged (Month/Year) | Name of Hospital/Facility | Reason for Confinement |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| 1. Has further treatment or investigation been discussed or contemplated?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Type of Treatment/Investigation | Proposed Date (Month/Year) |
|       |       |
|       |       |
| 1. Have you taken time-off work due to this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. Have your working duties been affected or restricted in any way?
 | [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. Please provide any additional information that you feel is important.
 |
|       |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition:
 |
| Name of Doctor, Hospital or Clinic | Address | Date of Last Consultation (Month/Year) |
|       |       |       |
|       |       |       |

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| **DECLARATION** |
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| **I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.** **I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.**  |

|  |  |
| --- | --- |
| **Name:** |       |

|  |  |
| --- | --- |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Date of Signing:** |       |

