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Description automatically generated with medium confidence**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) | | | |
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| 1. Has any reason for your condition been identified? | | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | | |
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| 1. When was the condition diagnosed or when did you first experience symptoms? | | | | | | | | | | |
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| 1. Have you had any suicide attempt? | | | | | | Yes (Please provide details.)  No | | | | |
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| 1. Have you had any recurrence of this condition? | | | | | | Yes (Please provide details.)  No | | | | |
| Diagnosis | | | Date From (Month/Year) | | | | Date To (Month/Year) | | | |
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| 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 |
|  |  | | |  | |  | | | |  |
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| 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 | |
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| 1. Has further treatment or investigation been discussed or contemplated? | | | | | | Yes (Please provide details.)  No | | | | |
| Type of Treatment/Investigation | | | | | Proposed Date (Month/Year) | | | | | |
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| 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 | | | | |
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| 1. Please provide any additional information that you feel is important. | | | | | | | | | | |
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| 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.** |

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| **Name:** |  |

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| **Signature:** |  |

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

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