

## **Activities Questionnaire**

Pol	licy Number:	Insured /Annuitant Name:
	order to continue our asses ur ability. Your cooperation	sment of your claim, we require that the following questions be answered completely and to the best of is appreciated.
1	What do you understand	your medical condition to be?
2	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
2	What are your current da	ly activities?
3	What activities are you n	o longer able to perform as a result of your medical condition?
4	Do you require assistance	to complete the activities you can no longer perform? Who provides this assistance?
5	What symptoms are you	currently experiencing and how frequent are they?
6	Are you currently working	g? Yes No
7	If "yes", please provide d	etails (e.g., number of hours worked per day, duties, etc.)
8	If you are not working, w	hat is specifically preventing you from working?

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9	What is your current treatment program, including names and dosages of current medications?		
10	Please list the names of all your current treatment providers, with their address and phone number, and how often you see each one.		
11	Are you receiving benefits from other sources? Yes No If "yes", please provide details.		
l co	nfirm that the above information is complete and accurate to the best of my knowledge.		
Nan	ne Signature Date Signed (DD/MM/YYYY)		



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