



Supplemental Health Questionnaire for the Insurance Application

INSURED ("Insured" refers to the Proposed Insured when applying for new insurance coverage)

Policy no. _____

Name _____

Date of birth: (DD/MM/YYYY) _____

Complete a separate additional **Supplement Health Questionnaire** for each condition declared in the **Insurance Application form (LP257)**, Health history section for questions **16 C)-D)-H)-I)-J)-L)-M)-N)-O)-P) and Q)**.

- i. Question number: _____
- ii. Your condition: _____
- iii. Date of diagnosis: (MM/YYYY) _____
- iv. Provide details regarding your symptoms: _____
- v. Have you had any treatments, medications, surgery or investigation for your condition? Yes No
If **yes**, provide details such as surgery, medication, dosage, duration, frequency, follow-up or other investigation:

- vi. Have you had any exams or tests for you condition? Yes No
If **yes**, provide details, such as type of exams/test, results, dates, follow-up and other investigations:

- vii. Have you been off work or disabled because of this condition? Yes No
If **yes**, provide the start and end date of your disability period
Start date: (MM/YYYY) _____ End date: (MM/YYYY) _____ Ongoing
- viii. Have you been hospitalized because of this condition? Yes No
If **yes**, when were you last hospitalized? (MM/YYYY) _____
If **yes**, provide duration: _____
- ix. Are you fully recovered from this condition? Yes No
If **yes**, since when? (MM/YYYY) _____
If **no**, provide details about your condition: _____
- x. Do you have symptoms or complication due to your condition? Yes No
If **yes**, provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

I understand that my answers to the above questions will be relied on by ivari in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire (being part of the Application for Insurance) may be rendered void on the grounds of misrepresentation or fraud. I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to ivari.

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

Signature of **INSURED** _____

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