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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