NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

QUESTIONNAIRE FOR MENTAL ILLNESS OR EMOTIONAL DISORDERS

1. **Please provide the date symptoms of the condition first appeared:** _____/_____/_____ (D / M / Y)

2. **Please indicate the associated disorders felt with the condition:**

   ❑ Fatigue ❑ Insomnia ❑ Depression ❑ Nervousness ❑ Weight Loss ❑ Suicidal Ideas
   ❑ Suicide Attempt ❑ Palpitations ❑ Tremors ❑ Others Details:_____

3. **Which are the factors that aggravate your symptoms?** _____

4. **Please indicate the activities which are affected by the condition and provide the complete details:**
   ❑ Work _____
   ❑ School _____
   ❑ Activity of daily living _____
   ❑ Sports Activities _____

5. **Please provide time off work or total disability:** From:_____/_____/_____ (D / M / Y) to: _____/_____/_____ (D / M / Y)

   If more than once: From:_____/_____/_____ (D / M / Y) to: _____/_____/_____ (D / M / Y)

6. **Medical Diagnosis:** _____

7. **Name(s) and address(es) of the physician(s) consulted:** _____

   _____

8. **Are you taking any medication(s)?** ❑ Yes ❑ No

   If yes, provide the type and dosage? _____

9. **In the last 6 months, was your medication modified?** ❑ Yes ❑ No

   If yes, provide the complete details: _____

10. **Have you ever been hospitalized because of your condition?** ❑ Yes ❑ No

    If yes, provide the date, duration and location: _____

11. **Have you or do you follow any additional therapy with a physician, psychiatrist or psychologist?** ❑ Yes ❑ No

    If yes, provide complete details: _____

12. **Have you fully recovered?** ❑ Yes ❑ No **If yes**, since when? _____

13. **Weekly consumption:** Wine _____ Beer _____ Spirituous _____

14. **Have you ever used drugs? (Marijuana, hash, cocaine, etc.) give details:** _____

    _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ **SIGNATURE OF THE PROPOSED INSURED**

X_____ **SIGNATURE OF THE POLICY OWNER**

X_____ **WITNESS**

_____ **DATE**