QUESTIONNAIRE REGARDING ADAPCI HYBRID OPTION

NAME :	FIRST NAME :
DATE OF BIRTH : _____/_____/_____ D M A	APPLICATION OR POLICY NUMBER :

1. Within the past 5 years, have you undergone surgery? ☐ Yes ☐ No

2. Have you ever received care, consulted, been diagnosed or experienced symptoms relating to the following disorders : **(to encircle if it is necessary)**

a) Cystic fibrosis, dementia, senility, muscular dystrophy, transverse myelitis or other brain disorder ☐ Yes ☐ No

b) Transient ischemic attack (TIA), arrhythmia, hemophelia, hemochromatosis, platelet disorder, Epstein-Barr virus ☐ Yes ☐ No

c) Schizophrenia, psychosis, eating disorder (bulimia, anorexia) ☐ Yes ☐ No

d) Joint disorder (hip, knee, shoulder), amputation, osteo-arthritis, myasthenia gravis, post-polio syndrome, degenerative disc disease, scleroderma ☐ Yes ☐ No

3. Have you ever used any mechanical or medical devices such as: wheelchair, walker, cane, motorised cart, stair lift or have you ever suffered of a condition causing limited motion or an imbalance? ☐ Yes ☐ No

4. Have you ever consulted or been advised to seek care of : physiotherapist, chiropractor, ergotherapist, osteopath, nurse or other professional or received care in a nursing home, long term care facility, rehabilitation facility, convalescence facility, psychiatric facility or any other health care facility? ☐ Yes ☐ No

5. Do you need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, maintaining continence, taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No

For all affirmative answers, please complete the following table:

Quest. no	Date	Reason	Details: tests, results, treatment, duration, recovering date, side-effect, doctor's names and hospitals consulted

6. Any of your family members (father, mother, brother or sister) have ever suffered one of the following illnesses: cystic fibrosis, hemophelia, muscular dystrophy or dementia? ☐ Yes ☐ No

If yes, details (family member, illness, age at diagnosis, current age or age at death, cause of death)

_____

7. Within the past 24 months, did you take medications? If yes, please complete the following table: ☐ Yes ☐ No

Name of medication	Dose and frequency	Reason	Date started	Date stopped

A telephone interview can be ordered by Head Office to verify the insurability of the life insured. When is the best time to contact you? Day: _____ Time: _____ Phone number:_____

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**_____ **X**_____ **X**_____

DATE | SIGNATURE OF THE PROPOSED INSURED | POLICY OWNER SIGNATURE | WITNESS