



NAME		
FIRST NAME		
DATE OF BIRTH		APPLICATION OR POLICY NUMBER
D	M	

ATTENTION DEFICIT DISORDER WITH OR WITHOUT HYPERACTIVITY

1. **What condition was diagnosed :**

<input type="checkbox"/> Attention Deficit Disorder (ADD)	<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Aggressive/violent behavior
<input type="checkbox"/> Oppositional Defiant Disorder (ODD)	<input type="checkbox"/> Impulsive behavior
<input type="checkbox"/> Other : _____	

2. **Date of diagnostic :** ____/____/____

3. **Was medication prescribed :** Yes No
 If yes:
 Name of medication : _____
 Dosage : _____
 Frequency : _____

4. **Was a psychologist or psychiatrist consulted :** Yes No
 If yes:
 Date of the appointment(s): _____
 Name and address of the specialist: _____

5. **Are there any nervous or neurological conditions associated with the condition:** Yes No
 If yes Details : _____

6. **Education level:** _____

7. **Was there a need of an absence from school or work related to the condition:** Yes No
 If yes From: _____ To: _____

8. **Are the symptoms under control:** Yes No
 If not, specify : _____

9. **Name and address of the physician seen for this/these condition(s):** _____

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