QUESTIONNAIRE:
Mental Nervous Health Prequalification

Please complete the following questions with as many details as possible:

Name of Proposed Insured: _____ DOB _____

Gender: ☐ M ☐ F Do you use Tobacco? ☐ Yes ☐ No

1. Describe your symptoms occurring within the last 10 years, and reasons for your consultations or use of medications: _____

_____

2. Date of first appointment/consultation: _____ Date of last appointment/consultation: _____

3. Specific diagnosis: _____ Date diagnosed: _____

4. Name, address and phone number of physician or therapist:

_____

_____

5. Describe type or treatment: _____

_____

6. Has treatment included the use of prescription medications? □Yes □No If yes, list medications including first and last dates each medication was taken and dosages (indicate any change in dosages):

_____

_____

7. Name and address of prescribing physician, if other than as named in Item 4 above:

_____

_____

8. Have you missed work for more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No
If yes, give dates and details:

_____

9. Have you been an in-patient for any of the above conditions? ☐ Yes ☐ No If yes, give dates, reasons including name and address of hospital or facility:_____

_____

Use the space below for any additional information which may be helpful for the underwriting of you application:

_____

_____

_____