


**DRUG USE QUESTIONNAIRE**

Proposed Insured:	Date of Birth:	Application/Policy #:
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**Are you now using or have you ever used:**

Marijuana (Hash, Cannabis, Weed, Pot, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cocaine (Coke, Crack, Snow, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hallucinogens (Acid, Angel dust, Haze, LSD, Mushrooms, Microdots, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Opiates (Codeine, Heroin, Methadone, Morphine, Opium, Smack, Fentanyl, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Barbiturates (Depressants, Downers, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sedatives (Tranquilizers, Tranks, Valium, Downers, Diazepam, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Amphetamines (Crystal Meth, Ecstasy, MDMA, Ice, Speed, Uppers, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anticholinergics (Belladonna, Bromide, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Inhalants (Aerosols, Glue, Ether, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Others (Anabolic Steroids, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" provide details: \_\_\_\_\_

Type	Usual quantity	Frequency of use	Duration	Date last used
		<input type="checkbox"/> Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Per year <input type="checkbox"/> Single time	<input type="checkbox"/> ___ Weeks <input type="checkbox"/> ___ Months <input type="checkbox"/> ___ Years	
		<input type="checkbox"/> Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Per year <input type="checkbox"/> Single time	<input type="checkbox"/> ___ Weeks <input type="checkbox"/> ___ Months <input type="checkbox"/> ___ Years	
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Have you ever been treated or counselled for drug consumption or abuse, or has someone ever recommended that you seek treatment or counselling for drug consumption or abuse or to reduce your drug consumption?

YES  NO If "YES" provide dates, names and addresses of doctors, hospitals and treatment centres:

Have you ever been arrested, charged or lost your job in connection with your drug use?

YES  NO If "YES" provide dates:

I declare that the above answers and statements are true, complete and correctly recorded and shall form part of my Application for Insurance with The Equitable Life Insurance Company of Canada.

\_\_\_\_\_

Date

\_\_\_\_\_

Proposed Life Insured

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