Equitable™

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NERVOUS DISORDER QUESTIONNAIRE

Proposed Insured:	Date of Birth:	Policy Number:

1. Have you ever had any indication of the following: **(complete All boxes)**

Fatigue	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Insomnia	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
Nervousness	☐ Yes ☐ No	Suicidal thoughts	☐ Yes ☐ No
Eating Disorder	☐ Yes ☐ No	Suicide attempts	☐ Yes ☐ No

2. What do you think the cause was?

3. Name and addresses of doctor(s) and therapist(s) consulted for the above conditions:

4. When did you first consult a doctor/therapist for the above and what was the diagnosis:

4a. When did you last consult a doctor/therapist for the above and how often do you see them?

5. Are you under treatment and/or taking any prescription or non-prescription medication? ☐ Yes ☐ No

   If Yes, please advise the medication, dosage and frequency: _____

   If No, please indicate the date it was discontinued: _____

6. Have you ever been hospitalized, been recommended to be hospitalized or had any tests? ☐ Yes ☐ No
   If Yes, give names, dates, addresses and recommendations:

7. Are your symptoms: ☐ Resolved ☐ Unchanged ☐ More Severe

8. Have you ever had any time off work due to the above problems? ☐ Yes ☐ No
   If Yes, length of time and dates:

9. What is your average alcohol, wine, or beer consumption per week?

10. Do you use marijuana, cocaine or any illegal or addictive drugs? ☐ Yes ☐ No
    If Yes, specify type and frequency of use:

I declare that the above answers and statements are full, complete and true and shall form part of my application for insurance with Equitable®.

Date	Witness	Proposed Insured

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