HUMANIA ASSURANCE MD®

Loss of consciousness questionnaire

Identification

Policy number:

Name of person to be insured:

First Name of person to be insured:

Date of birth: year / month / day

Section Loss of consciousness

1. Have you ever been told that you had a ☐ Convulsion ☐ Epilepsy ☐ Syncope ☐ Fainting spell

☐ Other types of loss of consciousness, specify:

If yes, please answer the following:

a) Date of first episode: year / month / day

b) How many episodes since?

c) Have you lost counsciouness? ☐ Yes ☐ No

If yes, for how long?

d) Did you have precusor signs or symptoms before the episode? ☐ Yes ☐ No

e) Date of most recent episode: year / month / day

f) What is the length of time between episodes?

2. Indicate name and addresse of all physicians and clinics consulted as well as dates of consultations for this condition:

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Loss of consciousness (...continued)

3. Have any diagnostic tests been completed or recommended? ☐ Yes ☐ No

   Did you have: ☐ Skull X-Ray ☐ Magnetic resonance imaging (MRI) ☐ Electroencephalogram ☐ Other tests:

   If yes, specify date(s) and results of each test:

4. What medications or treatments were you prescribed for this condition?

5. Are you presently receiving any treatment or taking medication? ☐ Yes ☐ No

   If yes, name of medication or type of treatment:

6. What is your doctor's diagnosis or explanation of the cause of your condition?

7. Have you ever been hospitalized for this condition? ☐ Yes ☐ No

   If yes, provide dates and duration of time off work:

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Loss of consciousness (...continued)

8. Have you lost any time from work due to this condition? ☐ Yes ☐ No

If yes, provide dates and duration of time off work:

9. Are your job duties or daily activities restricted in any way because of this condition? ☐ Yes ☐ No

If yes, describe restrictions and limitations:

I, the undersigned, declare that the above answers are true and complete and shall form part of my application for insurance with Humania Assurance.

Signed at: _____ Date: _____ / _____ / _____
year / month / day

Signature of witness: _____

Signature of person to be insured: _____

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

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