

IdentificationPolicy number: Name of person to be insured: First Name of person to be insured: Date of birth: / /
year / month / day**Section Concussion, Skull fracture, Head injury**1. Date of accident? / /
year / month / day2. Did you have a skull fracture? Yes No

3. How long were you unconscious after the accident? Hours? _____ Days? _____

4. Since the accident, have you suffered from:

- Loss of consciousness Epilepsy Fainting spell Dizziness Convulsions Paralysis Headaches
- Neurasthenia Mental confusion Memory loss Other similar events?

If yes, indicate number of episodes or attacks, dates, average duration in each case. _____
_____Do you currently have any symptoms? Yes No

If not, since when are you free of any symptom? _____

5. Did you undergo surgery for this condition Yes No

If yes, specify date, nature of surgery and results: _____

Name and address of hospital: _____
_____6. Did you bleed from the ears, nose or mouth? Yes No

Concussion, Skull fracture, Head injury (...continued)

7. Have you had a lumbar puncture? Yes No

If yes, specify results: _____

8. Did you have X-ray studies or other diagnostic tests of your skull? Yes No

If yes, specify date and results: _____

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

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

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:

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year / month / day

Signature of witness: _____

Signature of person to be insured: _____

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