Print Reset

ARTHRITIS QUESTIONNAIRE

NAME _____ **FILE** _____

1. At what age did you first experience symptoms of joint pain or arthritis? _____

2. What kind of arthritis do you have? ❒ Rheumatoid ❒ Osteoarthritis ❒ Other _____

3. Do you use medication to treat or to control symptoms? ❒ Yes ❒ No
   If **Yes**, state medication used, dosages and frequency of use _____
   _____

4. Have you ever had any other type of treatment? ❒ Yes ❒ No
   If **Yes**, please provide details including dates and name of physician. _____
   _____

5. Which joints are affected? _____

6. Do you require the use of cane, crutches or a wheelchair? ❒ Yes ❒ No
   If **Yes**, please provide details. _____

7. Does your condition limit you in any way? At work? At home? ❒ Yes ❒ No
   Have you ever been off work? ❒ Yes ❒ No
   If **Yes**, dates and duration of time off work. _____

8. Date last consult for this illness and result: _____
   _____

9. Are there any pending consultations, diagnostic tests or medical procedures for this condition? ❒ Yes ❒ No
   If **Yes**, please provide details. _____
   Name of physician: _____
   Dates: _____

DECLARATION:
I declare that the answers and statements to the above questions are complete and true to the best of my knowledge and belief. I understand they will form part of my application for insurance.

I understand that if I do not fully, completely and truthfully answer the above questions (if I misrepresent my answers or statements) the Company may void this policy.

Date _____ Signature of Proposed Insured _____

PLEASE RETURN FORM TO:
The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8
TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com

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