

NAME: _____ **FILE** _____

1. Have you ever suffered from: anxiety depression stress other nervous disorder? Yes No

Details _____

2. When did your symptoms start?
(yr/mo/day) _____

Number of episodes: _____ Dates: _____

3. Was there any cause and/or diagnosis given to you by a doctor? Yes No

If **Yes**, what was the diagnosis: _____

4. Have you ever required any time off work, hospitalization or been on disability due to the above? Yes No

Details - include dates and duration: _____

5. Have you required medication, counselling or other treatment in the past? Yes No

If **Yes**, include type, dosage, date and duration:

Type	Dosage	Date	Duration

6. Were you referred to a psychiatrist? Yes No

If **Yes**, Name: _____

Frequency of consults: _____ Date of last consult: _____

Which doctor or hospital would have all records? _____

7. Are you currently followed by a psychiatrist, psychologist or other therapist/social worker? Yes No

Which doctor would have all records? _____

8. Have you had any suicidal thoughts or attempts because of this condition? Yes No

Please provide details and dates: _____

9. What is your current status? Stable Resolved Still under treatment

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 on my life.

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, TEL: 1-888-997-9965, FAX: 1-888-985-3872