HERMANN SONS LIFE

Mental/Nervous Disorder Questionnaire

Circle answer and provide details for any positive responses.

Name _____ **Date of Birth** _____

1. Do you, or have you ever, suffered from: (Check all that apply)

   ☐ **Bipolar** ☐ **Depression** ☐ **Insomnia** ☐ **Stress**
   ☐ **Fatigue** ☐ **Suicidal Thoughts** ☐ **Anxiety** ☐ **Nerves**
   ☐ **ADD/ADHD** (attention deficit/hyperactivity) ☐ **PTSD** (post-traumatic stress disorder)

2. When was this diagnosed? _____

3. What was the cause?

   _____

   _____

   _____

4. Please list all physicians that have treated you for your condition: (Provide names and addresses)

   _____

   _____

   _____

5. Date you last consulted above physician? _____ How often do you see? _____

6. Have you ever been hospitalized or seen in the emergency room due to your condition? ☐ **Yes** ☐ **No**
   (If yes, provide dates, names and addresses for all treatment locations)

   _____

   _____

   _____

7. Have you ever received any treatment or medications for any of the above conditions? ☐ **Yes** ☐ **No**
   (If yes, provide details, including medications being taken and when last used)

   _____

   _____

   _____

8. Are you receiving psychotherapy, counseling or behavior modification? ☐ **Yes** ☐ **No**
   (If yes, provide details, including medications being taken and when last used)

   _____

   _____

   _____

Mental/Nervous Disorder Questionnaire continued

Name_____ **Date of Birth**_____

9. Symptoms are currently: ☐ **Improved** ☐ **Same** ☐ **More Severe**

10. Have you ever had time off from work due to the above condition? ☐ **Yes** ☐ **No**
(If yes, provide details, dates and length of time off)

_____

_____

_____

11. Do you drink alcoholic beverages? ☐ **Yes** ☐ **No**
Type_____ How often? _____ How much per occasion? _____

a. Have you ever received treatment or counseling for excessive use of alcohol? ☐ **Yes** ☐ **No**
(If yes, please complete Alcohol Use Questionnaire)

12. Are you currently using or have you ever used or abused illegal drugs, prescriptions or controlled substances?
☐ **Yes** ☐ **No** (If yes, please complete Drug Use Questionnaire)

13. Please provide any additional information you feel is important concerning your mental/nervous condition:

_____

_____

_____

I understand that this declaration will be relied upon by the Company in determining my insurability. I understand that any material misstatement in this declaration, or elsewhere could render the policy, if issued, voidable. I declare that the above answers are true and complete to the best of my knowledge.

_____ _____
Signature of Proposed Insured or Parent/Guardian Date