1891 financial life
A Fraternal Benefit Society

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MENTAL/NERVOUS DISORDER QUESTIONNAIRE

TO BE COMPLETED BY THE PROPOSED INSURED

Name of Proposed Insured: _____ DOB: _____
MM/DD/YYYY

1) In the past 5 years, have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: Check all that apply

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

2) What date was this diagnosed? _____

3) What was the cause?

_____
_____
_____

4) Please list all physicians that have treated you for your condition(s), provide names and addresses:

_____
_____
_____

5) Date you last consulted current physician? _____

6) How often do you see current physician? _____

7) In the last 5 years, have you been hospitalized or seen in the Emergency Room due to your condition(s)?

☐ No ☐ Yes If yes, provide dates, names, and addresses for all treatment locations:

_____
_____
_____

8) In the last 5 years, have you received any treatment or medications from a member of the medical profession for any of the above conditions? ☐ No ☐ Yes If yes, provide details, including medications being taken and when last used:

_____
_____
_____

9) Are you receiving psychotherapy, counseling or behavior modification?

☐ No ☐ Yes If yes, provide details:

_____
_____
_____

10) Symptoms are currently: ☐ Improved ☐ Same ☐ More Severe

11) In the last 5 years, have you had time off from work due to the above condition?

☐ No ☐ Yes If yes, provide details, dates, and length of time off:

_____

_____

_____

12) Do you drink alcoholic beverages?

☐ No ☐ Yes If yes: Type? _____. How often? _____. How much per occasion? _____.

13) In the last 5 years, have you received medical treatment or counseling for excessive use of alcohol?

☐ No ☐ Yes If yes, please complete Alcohol Use Questionnaire.

14) Are you currently using or have you ever used or abused illegal drugs, prescriptions, or controlled substances?

☐ No ☐ Yes If yes, please complete Drug Use Questionnaire.

15) 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 1891 Financial Life in determining my insurability. A false statement on this application will not prevent the right to receive the benefit unless the false statement was made with the actual intent to deceive and unless it materially affected the acceptance of the risk assumed by the insurer. I declare that the above answers are true and complete to the best of my knowledge and belief.

_____ _____

Signature of Proposed Insured Date

If age 16 or over, or Parent or Guardian if under age 16 or the age of majority required by the state where the policy is issued for delivery