

NAME			
FIRST NAME			
DATE OF BIRTH			APPLICATION OR POLICY NUMBER
D	M	Y	

DRUG QUESTIONNAIRE

1. When did you start using drugs? _____

2. Please provide the reason that motivated you to use drugs: _____

3. Please indicate below the drugs you currently use or have used in the past:

	YES	NO
a) OPIATES; HEROIN (came, junk, horse, H, smack) MORPHINE, CODEINE, DEMEROL, METHADONE	<input type="checkbox"/>	<input type="checkbox"/>
b) BARBITURITES (goof balls, downers, barbs, reds, yellow, jackets, candy, etc.) AMYLOBARBITONE, PHENOBARBITONE, SECONAL, NEMBUTAL, PENTOBARBITONE	<input type="checkbox"/>	<input type="checkbox"/>
c) CANNABIS (marijuana, pot, grass, weed, joint, hashish, hemp, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
d) AMPHETAMINES (speeds, ups, pep pill, wake-up, etc.) BENZEDREX, DEXEDRINE, METHEDRINE	<input type="checkbox"/>	<input type="checkbox"/>
e) COCAINE	<input type="checkbox"/>	<input type="checkbox"/>
f) HALLUCINOGENS Mescaline, LSD (acid) DMT, ANGEL DUST, PSILOCYBIN	<input type="checkbox"/>	<input type="checkbox"/>
g) ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>
h) ANABOLIC STEROIDS	<input type="checkbox"/>	<input type="checkbox"/>
i) ECSTASY	<input type="checkbox"/>	<input type="checkbox"/>
j) OTHERS	<input type="checkbox"/>	<input type="checkbox"/>

4. Please provide complete details to all affirmative answers:

TYPE	QUANTITY	FREQUENCY	FROM	TO

5. Have you ever received treatment because of your drug use? Yes No

If yes, provide the name(s), address(es) of the physician(s) or institution(s) consulted and the date(s) of the consultations:

6. If you no longer use any drugs, what motivated your decision to quit? _____

7. Have you any intent to use any drugs in the future? Yes No

8. Are you a member of NA (Narcotic Anonymous) or any other organisation? Yes No

9. Have you ever been tested for hepatitis B or C? Yes No

If yes, details: _____

10. Please provide any additional important information that you may deem useful: _____

I declare the information above is true and complete and that it will form part of my insurance application with **UL Mutual**.

X _____ X _____
SIGNATURE OF THE PROPOSED INSURED SIGNATURE OF THE POLICY OWNER

X _____
WITNESS DATE