UV INSURANCE

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

GASTROINTESTINAL DISORDER QUESTIONNAIRE

1. **Date of the first symptoms:** _____
2. **Frequency of attacks (or pain):** _____
3. **Date of the last symptoms:** _____
4. **Did the symptoms have anything to do with your diet?** _____
5. **Symptoms:**
   - ☐ Vomiting
   - ☐ Black stools
   - ☐ Others: _____
   - ☐ Pain decreased after eating
   - ☐ Pain after eating
6. **Have you lost weight in the last 6 months?** Yes ☐ No ☐ **If yes**, how much: _____
7. **What was your physician's diagnosis?** _____

   _____
8. **Have you ever had any special examination undertaken?** Yes ☐ No ☐

   If yes, provide date, location and results: _____
9. **Have you ever undergone surgery as a result of a gastrointestinal disorder?** Yes ☐ No ☐

   If yes, provide complete details: _____
10. **If you have had a surgery, do you still feel any symptoms?** Yes ☐ No ☐

    If yes, provide complete details: _____
11. **Do you currently follow a diet?** Yes ☐ No ☐
12. **Are you currently under treatment?** Yes ☐ No ☐

    If yes, provide complete details: _____
13. **Name and address of the attending physician:** _____

    _____
14. **Date of the last consultation:** _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X _____ X _____

SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X _____ _____

WITNESS **DATE**

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819 478-1315 ■ Toll free: 1 800 567-0988 ■ Fax: 819 474-1990