UV INSURANCE

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

ATTENTION DEFICIT DISORDER WITH OR WITHOUT HYPERACTIVITY

1. What condition was diagnosed :

- ❒ Attention Deficit Disorder (ADD)
- ❒ Attention Deficit Hyperactivity Disorder (ADHD)
- ❒ Oppositional Defiant Disorder (ODD)
- ❒ Other : _____
- ❒ Behavioral Problems
- ❒ Aggressive/violent behavior
- ❒ Impulsive behavior

2. Date of diagnostic : _____/_____/_____

3. Was medication prescribed : Yes ❒ No ❒

If yes:

Name of medication : _____

Dosage : _____

Frequency : _____

4. Was a psychologist or psychiatrist consulted : Yes ❒ No ❒

If yes:

Date of the appointment(s): _____

Name and address of the specialist: _____

5. Are there any nervous or neurological conditions associated with the condition: Yes ❒ No ❒

If yes Details : _____

6. Education level: _____

7. Was there a need of an absence from school or work related to the condition: Yes ❒ No ❒

If yes From**:** _____ To**:** _____

8. Are the symptoms under control: Yes ❒ No ❒

If not, specify : _____

9. Name and address of the physician seen for this/these condition(s):_____

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_____
SIGNATURE OF THE PROPOSED INSURED

X_____
SIGNATURE OF THE POLICY OWNER

X_____
WITNESS

_____
DATE

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