



**FUTURE  
GENERALI**

**TOTAL INSURANCE SOLUTIONS**

## MENTAL HEALTH QUESTIONNAIRE - APPLICANT

### TO BE FILLED BY LIFE INSURED

Name of the Life Insured \_\_\_\_\_  
 Application Number \_\_\_\_\_

### PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED

1. What mental health condition(s) do/did you suffer from? Where possible, please mention the medical term as diagnosed by your treating health professional: \_\_\_\_\_
2. If you have not been given a precise diagnosis/diagnoses, what are/were your symptoms? \_\_\_\_\_
3. When did you first consult a doctor about your condition/s or symptom/s? \_\_\_\_\_
4. When did you last consult a doctor about your condition/s or symptom/s? \_\_\_\_\_
5. How many times have you seen a doctor, for any reason, in the last 12 months? \_\_\_\_\_
6. Have you fully recovered now?  Yes  No
  - i. If 'Yes', please advise, since when: \_\_\_\_\_
  - ii. If 'No', please provide full details of any residual symptoms: \_\_\_\_\_
7. Has there been more than one episode?  Yes  No
  - i. If 'Yes', please comment on the date and duration of each episode: \_\_\_\_\_
8. Are you aware of any factor or situation, which triggers or exacerbates your symptoms?  Yes  No
  - i. If 'Yes', please provide details: \_\_\_\_\_
9. Please provide details of your treatment. Include names of medication, dosage and frequency. Please share copies of all the reports:
 

\_\_\_\_\_

Current: \_\_\_\_\_

In the Past: \_\_\_\_\_
10. Have you ever required electroconvulsive therapy (ECT)?  Yes  No
  - i. If 'Yes', please provide the date(s) and details, along with copies of the reports: \_\_\_\_\_
11. Have you ever seen a psychiatrist/specialist or had any treatment as a hospital outpatient?  Yes  No
  - i. If 'Yes', please provide full details including date(s) and name of the psychiatrist/hospital: \_\_\_\_\_
12. Have you ever been an in-patient at a hospital or clinic?  Yes  No
  - i. If 'Yes', please provide full details including date(s) and name of the hospital/clinic: \_\_\_\_\_
13. Please provide details of any time taken off-work due to your condition(s). Include the date and duration of each absence:
 

\_\_\_\_\_
14. Have you ever had any suicidal thoughts or attempted suicide?  Yes  No
  - i. If 'Yes', please provide full details including the date/s when this occurred and follow-up treatment, if any: \_\_\_\_\_
15. Please provide any additional information on your condition that you feel will be helpful in processing your application (i.e. history of alcohol or drug abuse, co-existing physical illness, current weight, and/or behavioural issues):
 

\_\_\_\_\_

Please share copies of doctor's prescriptions, investigation reports, etc.

I declare, that the answers I have given here are true to the best of my knowledge, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree, that this form will constitute a part of my application for insurance; and that failure to disclose any material fact known to me, may invalidate the contract.

Place: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of the Life Insured

**VERNACULAR DECLARATION**

I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: \_\_\_\_\_

Address of the Declarant: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of the Declarant

Place: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Signature of the Life Insured