BMO Insurance

BMO Life Assurance Company
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1-877-742-5244 • 416-596-4143 Fax

Mood Disorder Questionnaire

Name:	Application No.:

1. Indicate all symptoms you have (or have had). (Check all that apply)
   ☐ Fatigue ☐ Insomnia ☐ Nervousness ☐ Eating disorder ☐ Weight loss ☐ Anxiety ☐ Panic attack
   ☐ Phobias ☐ Depression ☐ Other (including details) ______
2. Describe the event(s) that lead to your symptoms noted above:

   (a) Date of your first episode: ______
   (b) Date of your most recent episode ______ (c) frequency of your episodes: ______
3. Are your symptoms: ☐ Resolved ☐ Less severe ☐ Unchanged ☐ More severe
4. What was the diagnosis given for your symptoms? (Check all that apply)
   ☐ Depression ☐ Adjustment disorder ☐ Anxiety ☐ Post-Traumatic stress disorder ☐ Obsessive compulsive disorder
   ☐ Personality disorder ☐ Seasonal affective disorder ☐ Bipolar disorder ☐ Schizophrenia
   ☐ Other ______

   Please provide details for all yes answers including dates, diagnosis, duration of the medical condition and name/address/phone number of the physician(s) consulted:
5. Have you ever had any suicidal ideations, suicide attempts, been hospitalized or recommended to be hospitalized?
   ☐ Yes ☐ No If "Yes", please provide full details including dates:
6. Have your job duties and/or leisure activities been affected in any way? ☐ Yes ☐ No
   Have you taken any time off work? ☐ Yes ☐ No If "Yes", please provide full details including dates, durations etc:
7. List all medications you have been prescribed by a physician in the last 5 years: If none check box ☐

Medications (name and dosage)	From (dd/mmm/yyyy)	To (dd/mmm/yyyy)	Frequency

8. Have you ever had any of the following treatments? If none check box ☐ or check all that apply.

☐ Psychotherapy ☐ Counselling ☐ Cognitive Behavioural Therapy ☐ Electroconvulsive Treatment

☐ Other (including details) ______

9. In the last 10 years, have you ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug including cannabis, cocaine, amphetamines, barbiturates etc not prescribed by a physician? ☐ Yes ☐ No

If "Yes", please complete Form# 144E Drug Questionnaire.

10. Do you presently drink alcoholic beverages? ☐ Yes ☐ No

If Yes, indicate your average weekly quantity and type of beverage consumed (ie beer, wine, spirits) If "No", indicate reason why and date last used.

11. Please provide the names, addresses and phone numbers for all physicians consulted for the medical conditions noted above:

Comments: If you require additional space for answers please include question#

I declare that all answers to the questions in this questionnaire and statements made are true and complete and will form part of my application for insurance with BMO Life Assurance Company. I understand that if I do not completely and truthfully answer all of the questions, the company may void the policy.

Province Signed	Date (DD/MMM/YYYY)	Signature
		Proposed Insured X