Assumption Life

Gastro-Intestinal Questionnaire

First Name : ______________________ Last Name : ______________________

Policy Number : ______________________ Date of Birth : ______________________

1. Medical diagnosis : ______________________

2. Please indicate which of the following apply to your condition, and provide us with further details :

Symptoms	**Details**
☐ Weight loss (10 pounds or more)	______________________
☐ Frequent diarrhea (4 episodes or more per day)	______________________
☐ Severe abdominal pain	______________________
☐ Anal fistula	______________________
☐ Intestinal obstruction	______________________
☐ Anemia	______________________
☐ Bleeding	______________________
☐ Any associated illness (arthritis, cirrhosis, etc.)	______________________

Tests	**Details**
☐ Barium enema or swallow	______________________
☐ Abdominal ultrasound	______________________
☐ Laparoscopy	______________________
☐ Endoscopy / sigmoidoscopy / colonoscopy / ERCP	______________________
☐ Other ______________________	______________________

Treatment / Surgery	**Details**
☐ Diet	______________________
☐ Medication	______________________
☐ Total colectomy	______________________
☐ Partial colectomy	______________________
☐ Colostomy	______________________
☐ Bowel resection	______________________
☐ Fistula repair	______________________

3. Date you first experienced symptoms : ______________________

4. Frequency of symptoms : ______________________

5. Date of your last symptoms : ______________________

6. Was any hospitalization required for any of these conditions? ☐ Yes ☐ No
   If yes, dates and duration: ______________________

7. Was any time required off work for any of these conditions? ☐ Yes ☐ No
   If yes, dates and duration: ______________________

8. Do you have any pending consultation, treatment or surgery? ☐ Yes ☐ No
   If yes, please provide details (date, treatment, name of physician). ______________________
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I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

______________________ ______________________

Signature of the person to be insured (parent or legal guardian if a minor) Date

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 855-230-2500