Assumption Life

Reset

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). _____
   _____

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