QUÉBEC BLUE CROSS®

Questionnaire

Cardiovascular Conditions

IDENTIFICATION

Last name:	First name:
Contract N°:	Date of birth: M M D D Y Y Y Y

INFORMATION

1. Have you ever been diagnosed with any of the following? ☐ Yes ☐ No
   ☐ Chest pain ☐ Hypertension ☐ High cholesterol ☐ Diabetes
   ☐ Heart murmur ☐ Arrhythmia ☐ Other _____

2. Do you have a family history of cardiovascular disease? ☐ Yes ☐ No

3. Have you ever consulted a cardiologist? ☐ Yes ☐ No If yes, please specify the date: M M D D Y Y Y Y

4. Have you ever had to undergo the following tests/exams? ☐ Yes ☐ No If yes, specify the date: M M D D Y Y Y Y
   ☐ ECG ☐ Blood test including lipids ☐ Echocardiogram ☐ MRI ☐ Other_____
   Please specify the reason and the results:_____

5. Did you require any treatment? ☐ Yes ☐ No
   If yes, please specify (type, duration and results): _____

6. Do you still require treatment?
   If yes, please specify (medication and dosage):_____

7. Did you require time off work? ☐ Yes ☐ No
   If yes, please provide: Date of beginning: M M D D Y Y Y Y Date of return to work: M M D D Y Y Y Y

8. Are you fully recovered? ☐ Yes ☐ No
   If yes, since when: M M D D Y Y Y Y

9. Provide any information relevant to the evaluation of the risk. _____
   _____

DECLARATION

I hereby declare that the above information is complete, accurate and current. I agree that this information will be used as the basis of the assessment carried out in order to establish my eligibility for Canassurance Hospital Service Association and/or Canassurance Insurance Company coverage. I also understand that, once my application has been assessed and approved, the information contained in this form will be an integral part of the insurance policy that will be issued. Any false statements in this form will lead to legal measures, including policy cancellation.

_____ M M D D Y Y Y Y
Signature of the Insured Date

_____ M M D D Y Y Y Y
Signature of policy holder (if different from Insured) Date

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