SSQ insurance

QUESTIONNAIRE – ARTHRITIS

SSQ, Life Insurance Company Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

GENERAL INFORMATION

NAME	DATE OF BIRTH	CONTRACT NUMBER

I – MEDICAL HISTORY

1. Symptoms: ☐ Pain ☐ Swelling ☐ Stiffness ☐ Redness ☐ Other (specify): ______
2. Date of first symptom: ______ Date of last attack/episode: ______
3. Frequency of attack/episode: ______ Duration: ______
4. Joints affected: ☐ Knee ☐ Hand ☐ Hip ☐ Spine ☐ Other (specify): ______
5. Investigation/exam performed: ☐ X-Ray ☐ Other (specify): ______
   Date: ______ Results: ______
6. Medical diagnosis: ☐ Osteoarthrosis ☐ Gout ☐ Psoriasic Arthrosis ☐ Rhumatoïd ☐ Infectious ☐ Other (specify): ______

II – TREATMENTS

1. Medication prescribed (dosage): ______
2. Currently under medication: ☐ No ☐ Yes (specify): ______
3. Treatments required: ☐ Chiropractor ☐ Physiotherapist ☐ Massage therapy ☐ Other (specify): ______
4. Frequency of treatments: ______
5. Surgery: ☐ No ☐ Yes (specify): ______ Date: ______
6. Surgery to be scheduled: ☐ No ☐ Yes (specify): ______ Date: ______

III – DISABILITY

1. Leave of absence: ☐ No ☐ Yes Date: ______ Duration: ______
2. Disability period: ☐ No ☐ Yes Date: ______ Duration: ______
3. Limitation/after-effects: ☐ No ☐ Yes (specify): ______
4. Current condition: ______

IV – ATTENDING PHYSICIAN

1. Name and address of physician who has your complete file: ______
   ______
2. Date of last visit: ______ Results: ______

V – ADDITIONAL INFORMATION CONCERNING YOUR CONDITION

______
______

I acknowledge having read and understood all the questions above and having given the correct answers. In addition, I consent to having them serve as the basis of the insurance contract requested.

______ Signature of witness

______ Date

______ Signature of the person to be insured or to be co-insured. If under age 18, signature of father or mother required.