beneva

# Questionnaire
# Cannabis and other drugs usage

First and last names of insured ______________________

Y Y Y Y M M D D
Date of birth

______________________
Policy / application number

**1. Do you consume cannabis products for recreational or medicinal purposes?** ☐ **Yes** ☐ **No**

Please include all forms of cannabis, marijuana, and hashish. If yes, please complete the table below:

| Forms | Quantity | Frequency | Use date | Type of usage |
|---|---|---|---|---|
| Joint | Number of joints: ______ | ☐ Day<br>☐ Week<br>☐ Month<br>☐ Year | from Y Y Y Y M M<br>to Y Y Y Y M M | ☐ Recreational<br>☐ Medicinal* |
| ☐ Edible products<br>☐ Oil<br>☐ Other | | ☐ Day<br>☐ Week<br>☐ Month<br>☐ Year | from Y Y Y Y M M<br>to Y Y Y Y M M | ☐ Recreational<br>☐ Medicinal* |

* If you were using it for medicinal purposes, please complete the table below:

| For what condition | Prescribed | Prescribing physician (name and address) |
|---|---|---|
| | ☐ Yes ☐ No | |
| | ☐ Yes ☐ No | |

**2. Has your consumption been higher in the last two (2) years?** ☐ **Yes** ☐ **No**

If so, please indicate the details:

Form, quantity, frequency, type of usage: ______________________

The reason of the change in the habits: ______________________ Date: Y Y Y Y M M

**3. In the last ten (10) years, have you used drugs or narcotics that were not prescribed by a physician?** ☐ **Yes** ☐ **No**

☐ Cocaïne / Crack ☐ Anabolic steroids ☐ Heroin, Morphine, Methadone, Fentanyl

☐ LSD, Magic mushrooms, Mescaline ☐ Amphetamines ☐ Sedatives or tranquilizers

☐ Others: ______________________

| Type of drugs or narcotics | Quantity per occasion | Frequency | Date of use |
|---|---|---|---|
| | | | from Y Y Y Y M M to Y Y Y Y M M |
| | | | from Y Y Y Y M M to Y Y Y Y M M |
| | | | from Y Y Y Y M M to Y Y Y Y M M |

**4. With regard to your consumption of cannabis or other drugs, have you ever:**

**a) been advised to reduce or cease your consumption or consulted a healthcare professional?** ☐ **Yes** ☐ **No**

If yes, please complete:

For what product: ☐ Marijuana ☐ Other drug

Date: Y Y Y Y M M

Name and contact details of the professional consulted: ______________________

**b) had therapy or treatment?** ☐ **Yes** ☐ **No**

If yes, please complete:

For what product: ☐ Marijuana ☐ Other drug

Kind of treatment: ______________________________

When: Start date: Y Y Y Y M M End date: Y Y Y Y M M

Name and contact details of the doctor or establishment consulted: ______________________________

______________________________

Is this your only treatment or therapy period? ☐ Yes ☐ No

If no, please specify the number of time and dates: ______________________________

______________________________

**c) attended support group meetings?** ☐ **Yes** ☐ **No**

If yes, please complete:

For what product: ☐ Marijuana ☐ Other drug

When: Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ still attending

## 5. Additionnal information: ______________________________

______________________________

______________________________

## 6. Declaration

**I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.**

**X** ______________________________ Y Y Y Y M M D D

Signature of insured (signature of the father, mother or legal guardian if the insured is a minor) | Date of signature