beneva

Questionnaire
Mental health, behavioral and/or developmental disorders

Please complete block 1 and or 2 depending on your situation and block 3 at all times

First and last names of insured _____

Y Y Y Y M M D D
Date of birth

_____
Policy/application number

Mental health or behavioral disorders – Block 1

1. What is the nature of the mental health or behavioral disorders?

Please check the appropriate boxes:

- ☐ Depression
- ☐ Adjustment disorder
- ☐ Personality disorder
- ☐ Psychosis
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Anxiety/Panic disorder
- ☐ Burn-out (related to work/school)
- ☐ Post traumatic stress disorder
- ☐ Schizophrenia
- ☐ Eating disorder (anorexia/bulimia/hyperphagia)
- ☐ Insomnia
- ☐ Obsessive-compulsive disorder
- ☐ Bipolar disorder
- ☐ Other mental health or behavioral disorder, specify: _____

2. For each condition diagnosed, please complete the table below for each episode.

Condition	Start date	End date
	Y Y Y Y M M	Y Y Y Y M M
	Y Y Y Y M M	Y Y Y Y M M
	Y Y Y Y M M	Y Y Y Y M M
	Y Y Y Y M M	Y Y Y Y M M
	Y Y Y Y M M	Y Y Y Y M M

3. Have you consulted doctors or therapists for any of the conditions mentionned above? ☐ Yes ☐ No

If yes, complete the information below:

Condition:

Profession:

Name:

Address:

Date of first consultation:

Date of last consultation and result:

Date of the next consultation:

Frequency of the consultations:

Condition:

Profession:

Name:

Address:

Date of first consultation:

Date of last consultation and result:

Date of the next consultation:

Frequency of the consultations:

3. Have you consulted doctors or therapists for any of the conditions mentionned above? (continued)

Condition:

Profession:

Name:

Address:

Date of first consultation:

Date of last consultation and result:

Date of the next consultation:

Frequency of the consultations:

4. Are you taking or have you taken medication(s) for any of the conditions mentioned above? ☐ Yes ☐ No

If yes, please complete the table below:

Condition	Medication / Dosage	Start date	End date
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M

5. Has your medication changed in the last 12 months? ☐ Yes ☐ No

If yes please specify the changes:

6. Have you been hospitalized for one of the conditions mentionned above? ☐ Yes ☐ No

If yes, complete the table below:

Hospital's name	Reason	Start date	End date
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M

7. Have you ever had suicidal thoughts and / or suicide attempts? ☐ Yes ☐ No

If yes, please complete the table below:

	Dates or periods
Suicidal thoughts	
Suicide attempts	

8. Have you had to take time off work / school or were there any limitations in your work schedule or in your daily occupations? ☐ Yes ☐ No

If yes, complete the table below:

Condition	Absences or limitations	Start date	End date
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M

9. What is your current state?

Specify:

Condition	Current state
	☐ Completely recovered, date of last symptoms: Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered, date of last symptoms: Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered, date of last symptoms: Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered, date of last symptoms: Y Y Y Y M M ☐ Sequelae, specify:

10. Additional information

Developmental disorders – Block 2

1. What is the nature of the developmental disorders?

Please check the appropriate boxes:

☐ Intellectual impairment ☐ Down Syndrome ☐ Autism spectrum disorder

☐ Any other developmental disorder: specify: _____

2. Date of diagnosis: Y Y Y Y M M

3. Have you consulted doctors or therapists for any of the conditions mentionned above? ☐ Yes ☐ No

If yes, complete the information below:

Condition:

Profession:

Name:

Address:

Date of first consultation:

Date of last consultation and result:

Date of the next consultation:

Frequency of the consultations:

Condition:

Profession:

Name:

Address:

Date of first consultation:

Date of last consultation and result:

Date of the next consultation:

Frequency of the consultations:

4. Are you taking or have you taken medication(s) for any of the conditions mentioned above? ☐ Yes ☐ No

If yes, please complete the table below:

Condition	Medication / Dosage	Start date	End date
		Y Y Y Y M M	Y Y Y Y M M
		Y Y Y Y M M	Y Y Y Y M M

5. Compared to someone the same age as you, are you able to perform the activities of daily life and the activities of domestic life without assistance? ☐ Yes ☐ No

If no, specify: _____

6. Do you need special accomodation or support to do a gainful work or to attend a school? ☐ Yes ☐ No

If yes, specify: _____

7. Additional information

Declaration and signature (must be filled at all times) – Block 3

1. 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

Protection of personal information

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