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 ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M to Y Y Y Y M M	☐ Recreational ☐ Medicinal*
☐ Edible products ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M to Y Y Y Y M M	☐ Recreational ☐ 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

---

Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the *Personal Information Protection Statement* located at beneva.ca.