

Supplemental Health Questionnaire



You are being asked to complete this Questionnaire because either a question on the Group Insurance Application was answered 'Yes', or the amount of Life Insurance for which you have applied exceeds the maximum amount of insurance indicated on your application. Industrial Alliance Pacific Life Insurance Company requests this additional information for further consideration of your Application.

Is the Insurance Application attached?

 Y

 N

If 'No', give date Insurance Application was completed:

M		D		Y
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TELL US ABOUT YOURSELF

(Please Print)

APPLICANT 1			APPLICANT 2		
SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	DATE OF BIRTH M D Y	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	DATE OF BIRTH M D Y
HEIGHT	WEIGHT	PLACE OF BIRTH**	HEIGHT	WEIGHT	PLACE OF BIRTH**
TELEPHONE NUMBER		OCCUPATION	TELEPHONE NUMBER		OCCUPATION
APPLICATION NO.		H.O. USE ONLY	APPLICATION NO.		H.O. USE ONLY
NAME AND ADDRESS OF PERSONAL PHYSICIAN			NAME AND ADDRESS OF PERSONAL PHYSICIAN		
DATE AND REASON LAST CONSULTED ANY DOCTOR			DATE AND REASON LAST CONSULTED ANY DOCTOR		
DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED			DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED		

** Province, State or Country

Initials: _____ Date: _____

Initials: _____ Date: _____