Viva Health Inc. Health Questionnaire—Headache

Employee Name:_____ Group Name:_____
Proposed Insured:_____ D.O.B._____

1. Have you ever had any type of headache? *If so, list the type of headache and any medical diagnosis.*

2. What was the approximate date these headaches first occurred?

3. How often do these headaches occur?

4. Could these headaches be the result of an injury?

5. What type of treatment has your physician prescribed for the headaches?

6. Have you ever been hospitalized because of these headaches? *If so, when?*

7. Have you ever undergone any diagnostic testing (e.g. CAT Scan, MRI) for headaches? If so, please describe this testing in detail, including type of test, date administered, and follow-up treatment.

8. When was the last time you had a headache?

9. Give the name, address, and phone number of you attending physician.

10. Do you smoke? If yes, how many cigarettes per day?

I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued ant that any incorrect answers may operate to void this insurance.

Date:_____ Signature of proposed insured:_____

Use reverse side for additional comments or if further space is needed