



**Viva Health Inc. Health Questionnaire—
Circulatory Disorder**

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

1. When were you first diagnosed with circulatory problems?
2. What diagnosis did your doctor give you?
3. Have you ever been hospitalized for this disorder or had any surgery? *If yes, please indicate the name of the hospital and all inpatient dates.*
4. Are you currently taking any medication? *If yes, please indicate the name of the drug, and the dosage taken.*
5. Please indicate which of the following symptoms you have experienced:

<input type="checkbox"/> Hand numbness or pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Foot numbness or pain	<input type="checkbox"/> Pain when walking short distances
<input type="checkbox"/> Finger ulcers	<input type="checkbox"/> Chest Pain
6. Has your doctor advised you to seek any treatment or have any surgery performed not mentioned above?
7. Do you smoke? If yes, please indicate the number of packs per day and the number of years smoked. Has your doctor advised you to seek medical treatment to stop smoking?

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 and that any incorrect answers may operate to void this insurance.

Date: _____ **Signature of proposed insured:** _____