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## GASTRO-INTESTINAL QUESTIONNAIRE (to be completed by proposed insured)

Name: \_\_\_\_\_ Application No.: \_\_\_\_\_

1. Date you first experienced symptoms? \_\_\_\_\_
2. Date of last attack and how often do they occur? \_\_\_\_\_
3. Are attacks becoming more frequent? \_\_\_\_\_
4. Do you experience:     Vomiting             Passing of Black Stools             Symptoms Relieved by Eating Food  
Do attacks occur at about the same time after eating?     Yes             No  
Other (explain): \_\_\_\_\_
5. Have you lost weight within the last six months?     Yes             No    If so, how much and reason if known:  
\_\_\_\_\_
6. When and why did you last consult your attending physician?  
\_\_\_\_\_
7. Name and address of Doctor:  
\_\_\_\_\_
8. What was your understanding of the diagnosis of the complaint? \_\_\_\_\_  
If it was an ulcer, were you told it was:     Duodenal             Gastric             Other: \_\_\_\_\_
9. Have you been advised to go on a diet, or to take medication?     Yes             No
10. Have you had, or been advised to have:     X-Rays             Tests             Surgery             Further Consultations  
If yes, please give doctor or hospital names, dates and results:  
\_\_\_\_\_
11. If operation performed, have there been any subsequent recurrences?     Yes             No  
If yes, describe frequency, symptoms, last recurrence, name of doctor or hospital is involved:  
\_\_\_\_\_
12. Are you still under treatment?     Yes             No            If yes, give type, quantity and frequency:  
\_\_\_\_\_

I hereby agree that the foregoing questions and answers shall form part of the application for insurance made by me to BMO Life Assurance Company on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ ; and they shall be of the same effect as if contained in the original application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Proposed Insured