

**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 if involved:  
 \_\_\_\_\_  
 \_\_\_\_\_
12. Are you still under treatment?       Yes       No      If yes, give type, quantity and frequency:  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that all answers to the questions in this questionnaire and statements made are true and complete and will form part of my application for insurance with BMO Life Assurance Company. I understand that if I do not completely and truthfully answer all of the questions, the company may void the policy.

| Province Signed | Date (DD/MMM/YYYY) | Signature        |
|-----------------|--------------------|------------------|
|                 |                    | Proposed Insured |
|                 |                    | X                |