Viva Health Inc. Health Questionnaire—Glaucoma

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

1. When were you diagnosed with glaucoma?

2. When was your last doctor visit? Please provide the doctor name and address.

3. Have you ever been hospitalized? If so, when and for how long?

4. Are you taking any medication? Yes___ No___ If yes, please list the name and dosage.

5. What percentage of your vision is remaining? Is your vision getting better, worse, or no change?

6. Has the physician recommended any surgery or further treatment not yet performed?

7. Do you smoke? If yes, how much? (include packs per day and number of years)

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