



**VIVA Health Inc. Health Questionnaire--
Follow-up: Polio**

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

1. What age were you at onset of disease?
2. Describe how it affected you.
3. What are were you at recovery?
4. Describe any symptoms of polio which have remained since recovery (e.g. limp, shortness of breath, muscle weakness).
5. Do any of the symptoms described in question #4 restrict your activities of daily living (e.g. work responsibilities, housework, family responsibilities, driving a vehicle)? If so, please give details.
6. Are you undergoing any treatment for symptoms at this time? If so, please give details.
7. Has your physician ever treated you for or diagnosed you with post polio progressive muscular atrophy (PPMA) or post polio syndrome? If so, describe treatment.
8. If you have symptoms of PPMA, please describe. Are those becoming more frequent or prolonged?
9. 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 and that any incorrect answers may operate to void this insurance.

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