Viva Health Inc. Health Questionnaire
Motor Vehicle Accident

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

1. When did the motor vehicle accident occur?

2. Was the accident someone else's fault? *If yes, please provide the name of the other person's insurance.*

3. What bodily injuries did you incur?

4. Were you hospitalized as a result of the accident? *If yes, please list the name of all hospitals involved, and the dates hospitalized.*

5. Were you unable to work as a result of your injuries? How long were you disabled?

6. Has your doctor advised you to seek any further treatment or are you scheduled to have any surgery? *If yes, please describe.*

7. Are you currently on any medication as a result of the accident? Please list any medications and dosage taken.

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:_____