VIVA Health Inc. Health Questionnaire--
Follow-up: Varicose vein/Phlebitis

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

1. Do you now have varicose veins or phlebitis or any other vein disorder?

2. If not, have you ever had them? If so, when and for how long? *Please give date of full recovery.*

3. Have you had blood clots?

4. What parts of your body did they affect?

5. Has it ever extended above the knee?

6. Has it ever produced open sores or ulcers?

7. What treatment was prescribed? *Please list dates.*

8. Was surgery and ligation, or injection included in your treatment? *If so, give details.*

9. Are you presently taking any anti-coagulant medication? *If so, please indicate type, dosage, and frequency.*

10. Please list the name and address of your attending physician.

11. Were you hospitalized? *If yes, where, when, and for how long?*

12. Please give the date of your last checkup. List the name and address of the physician who would have those records.

13. 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:_____

Use reverse side for additional comments or if further space is needed.