

- Life Investors Insurance Company of America     Stonebridge Life Insurance Company  
 Monumental Life Insurance Company     Transamerica Life Insurance Company  
 Peoples Benefit Life Insurance Company     Western Reserve Life Assurance Co. of Ohio

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

Supplement to Application dated \_\_\_\_\_

### Mental Health / Depression / Anxiety Questionnaire

|  |               |              |  |
|--|---------------|--------------|--|
| Name of Proposed Insured   | Date of Birth |              |  |
| Specific diagnosis? (i.e. depression, anxiety, bipolar, schizophrenia, other)  |               |              |  |
| Date of diagnosis?   |               |              |  |
| What medication(s) are you currently taking and the dosage(s)?   |               |              |  |
| Have you been treated for this condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give dates, duration and treatment.  |               |              |  |
| Have you ever been referred for or received outpatient psychotherapy or counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name, address and telephone number of doctor and dates of treatment. |               |              |  |
| Have you ever been hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give the date and reason for your hospitalization and the name, address and telephone number of the hospital.       |               |              |  |
| Have you lost time from work due to your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give frequency, duration and dates:  |               |              |  |
| Have you ever attempted suicide or have you had suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details:  |               |              |  |
| Physician's Name   | Address       | Phone Number | Area of Specialty<br>(i.e. family physician, psychiatrist, etc.) |
|  |               |              |  |
|  |               |              |  |
|  |               |              |  |
| How often do you see each doctor and date last seen?   |               |              |  |

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Agent