AMERICAN INCOME LIFE INSURANCE COMPANY
Executive Office: P. O. Box 2608, Waco, Texas 76797 (254) 761-6400
www.ailife.com

DEPRESSION QUESTIONNAIRE

PROPOSED INSURED'S NAME _____ APPLICATION NUMBER _____

1. HAVE YOU EVER BEEN MEDICALLY DIAGNOSED OR TREATED FOR ANY TYPE OF DEPRESSION, ANXIETY OR NERVOUS DISORDER? ☐ YES ☐ NO

2. GIVE DATE OF DIAGNOSIS. _____

3. DO YOU CURRENTLY TAKE MEDICATION? ☐ YES ☐ NO
   IF YES, MEDICATION: _____ DOSAGE: _____
   MEDICATION: _____ DOSAGE: _____
   MEDICATION: _____ DOSAGE: _____

4. WERE YOU HOSPITALIZED? ☐ YES ☐ NO IF YES, DATE(S) _____
   HOW LONG WERE YOU IN THE HOSPITAL? _____
   NAME/ADDRESS OF HOSPITAL: _____
   _____

5. HAVE YOU MISSED TIME FROM WORK? ☐ YES ☐ NO
   IF YES, LENGTH OF TIME MISSED _____ DATES _____

6. ARE YOU CURRENTLY DISABLED DUE TO THIS CONDITION? ☐ YES ☐ NO

7. PHYSICIAN NAME/ADDRESS WHO HAS TREATED THE CONDITION: _____
   _____ DATE LAST SEEN: _____
   _____

8. HAVE YOU EVER RECEIVED TREATMENT FROM A PSYCHOLOGIST OR PSYCHIATRIST? ☐ YES ☐ NO
   NAME/ADDRESS _____
   _____
   DATE FIRST SEEN: _____ DATE LAST SEEN: _____

X _____ DATE _____
(PROPOSED INSURED'S SIGNATURE)