Underwriting Maternity Questionnaire

(TO BE COMPLETED BY THE FEMALE APPLICANT)

1. FEMALE APPLICANT'S GENERAL INFORMATION

Last Name: ______________________________

First Name: ______________________________

Date of Birth (mm/dd/yyyy): ____ ____ ______ GBG ID (if applicable): ______________

Current Height: ☐meters ☐feet Current Weight: ________ ☐kilograms ☐ pounds

2. POLICYHOLDER INFORMATION (IF DIFFERENT THAN THE FEMALE APPLICANT)

Last Name: ______________________ First Name: ______________________

Date of Birth (mm/dd/yyyy): ____ ____ ______

3. GYNECOLOGICAL AND OBSTETRIC HISTORY

NUMBER OF PREGNANCIES: ______________ NUMBER OF VAGINAL DELIVERIES: ______________

NUMBER OF C-SECTIONS: ______________ NUMBER OF PREMATURE BIRTHS: ______________

NUMBER OF MISCARRIAGES: ______________ NUMBER OF THERAPEUTIC INTERRUPTIONS OF PREGANANCY: ____

ARE YOU CURRENTLY PREGNANT OR SUSPECT TO BE PREGNANT? ☐YES ☐NO

3.1 IN CASE OF C-SECTIONS, PLEASE INFORM THE REASON FOR THE PROCEDURE:

____

3.2 IN CASE OF PREMATURE BIRTH, PLEASE REFER THE FOLLOWING:

a. Cause: ______________________________

b. Weeks of pregnancy: ______________________________

c. How Many days in the hospital (Mom and Child): ______________________________

3.3 IN CASE OF MISCARRIAGE OR THERAPEUTIC INTERRUPTION OF PREGNANCY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

a) Reason: ______________________________

b) Weeks of pregnancy: ______________________________

3.4 PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE DETAILS FOR ANY AFFIRMATIVE ANSWER:

a. Have you ever had an ectopic pregnancy, pre-eclampsia, eclampsia, gestational diabetes, placenta previa, placental abruption or blood incompatibility? ☐Yes ☐NO If yes, please provide details.

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b. Have you or a family member had a child with congenital or hereditary disorders, or a stillborn child, multiple pregnancy or any complication of the pregnancy or delivery? ☐YES ☐NO If yes, please provide details.

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3. GYNECOLOGICAL AND OBSTETRIC HISTORY (CONTINUED)

c. Have you ever had a history of any gynecological disorder, i.e., menstrual disorders, abnormal PAP, fibroids, endometriosis, etc? ☐ YES ☐ NO If yes, please provide details.

d. Have you ever had surgery of the reproductive system (uterus, ovaries, tubes, vagina, breasts), conization of the cervix or any other pelvic invasive procedure? ☐ YES ☐ NO If yes, please provide details.

e. Have you ever been diagnosed or treated for arterial hypertension, diabetes, cardiovascular disorders, anemia, renal or hormonal disorders? ☐ YES ☐ NO If yes, please provide details.

f. Do you smoke cigarrettes? ☐ YES ☐ NO Amount per day: ____________

g. Have you ever been submitted to any fertility/infertility treatment? ☐ YES ☐ NO If yes, please provide details.

h. Have you ever been diagnosed, treated or had any gynecological symptoms not mentioned above?
☐ YES ☐ NO If yes, please provide details.

AUTHORIZATION

I hereby certify that I have read and reviewed all the answers and statements in this Questionnaire and that they are complete and true to the best of my knowledge. Any omission or incomplete or incorrect statement may lead to denial of claims or cancellation of coverage.

Applicant's signature:

____

Date (mm/dd/yyyy): ____ ____ ______

Please send the completed questionnaire to our Underwriting Department

Email: underwriting@gbg.com
Mail: 7600 Corporate Center Drive, Suite 500
Miami, FL 33126 USA

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