beneva
by LaCapitale

Evidence of Insurability
Group Insurance

Beneva
625 Jacques-Parizeau St, PO Box 1500 Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856 • Fax: 418 646-1313 • adm.collectif@beneva.ca

Group No. | Employer No.

Identification No.

1 INFORMATION ABOUT PROPOSED INSUREDS

PARTICIPANT (you)

Last name and first name	Name at birth (if different)	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)
No. Street Apt.		City	
Province	Postal code	Main telephone No. Ext.	Telephone (other) Ext.

IMPORTANT: If you are a retired participant who has left the workforce, please skip the next question and proceed to the following one, which asks you to provide identifying information concerning your spouse.

Are you currently employed? ☐ Yes ☐ No	If not, as of when? Year Month Day	Reason for absence from work:

SPOUSE (if coverage is desired)

Last name and first name	Name at birth (if different)	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)

CHILDREN (if coverage is desired) I **IMPORTANT:** *Please use a second form if you have more than two children.*

	Last name and first name	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)
Child 1			
Child 2			

2 HEIGHT AND WEIGHT OF PROPOSED INSUREDS

Proposed insured	Height ☐ cm ☐ ft/in	Current weight ☐ kg ☐ lb.	Weight one year ago ☐ kg ☐ lb.	Reason for any variation
Participant				
Spouse				
Child 1				
Child 2				

3 INSURANCE HISTORY

Have you ever had a travel, a life, critical illness or disability insurance application declined, postponed, modified or subject to a rating or exclusion?

Proposed insured	No	Yes	Date YYYY/MM	Name of insurer	Type of insurance	Reason for decision
Participant						
Spouse						
Child 1						
Child 2						

4 FAMILY HISTORY (Complete this section only if applying for critical illness insurance)

Has one of your biological parents or siblings, living or deceased, ever suffered from or been diagnosed with one of the following: cerebrovascular accident (stroke), cancer, multiple sclerosis, diabetes or blood pressure problem, heart or kidney disease, polycystic kidney disease, Alzheimer's disease, Huntington's disease, motor neuron disease or any type of hereditary disease?

Family member	PARTICIPANT ☐ Yes ☐ No					SPOUSE ☐ Yes ☐ No				
	Condition	Age at onset of condition	Current age	Age at death	Cause of death	Condition	Age at onset of condition	Current age	Age at death	Cause of death
Father										
Mother										
Sister(s)										
Brother(s)										

5 DRUG, ALCOHOL OR TOBACCO USE

	Participant	Spouse	Child 1	Child 2
1. During the last 12 months, have you smoked cigarettes, cigarillos or a pipe, or used any form of tobacco or tobacco substitute, such as a nicotine patch or gum, or marijuana containing any tobacco product or nicotine? **If you quit in the last 12 months, please indicate the date that you quit.**	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month
2. Have you ever taken medication or drugs for other than medical reasons? **Name of substance:** **Date last used:**	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month	☐ Yes ☐ No Year Month
3. Do you consume alcoholic beverages? **If so, please indicate the amount you currently consume weekly and the amount you consumed weekly one year ago.**	☐ Yes ☐ No Now I 1 year ago	☐ Yes ☐ No Now I 1 year ago	☐ Yes ☐ No Now I 1 year ago	☐ Yes ☐ No Now I 1 year ago
Beer (glasses)				
Wine (glasses)				
Spirits (ounces)				
4. Have you ever undergone detoxification for drugs or alcohol or been encouraged to do so? **If so, please indicate the date and the reason for treatment in Section 7 (see over).**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6 MEDICAL AND PERSONAL INFORMATION

Have the proposed insureds:	Participant	Spouse	Child 1	Child 2
1. Been unable to go about his or her regular duties as a result of convalescence, illness or injury in the last three years? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Ever exhibited symptoms, consulted a physician or been treated for one of the following: cardiac or blood vessel disorder, back, kidney or pulmonary disorder, anxiety, neurological or psychological disorder, high cholesterol, arthritis, high blood pressure, diabetes, hepatitis, ulcerative colitis, Crohn's disease, cancer, tumor, HIV positivity, AIDS, multiple sclerosis or health problem resulting from an accident? **If so, please provide details and include the name and address of your physician in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Suffered from a limitation, malformation or other physical, nervous or functional deficiency? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Taken medication, used homeopathic products, received treatment or followed a diet? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Consulted a physician, therapist or other healthcare professional (psychologist, chiropractor, etc.), including alternative medicine, been admitted to a hospital or some other medical establishment or undergone surgery in the last five years, or is he or she likely to do so in the next 12 months? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Undergone, or been asked or encouraged to undergo an HIV (AIDS) screening test? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Taken part in flights other than as a passenger in the last two years, or does he or she have plans to do so?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity in the last two years, or does he or she have plans to do so? **If so, please provide details, including date and reason, in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Had his or her driver's licence suspended or revoked in the last three years? **If so, please provide details in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Travelled or resided outside Canada or the United States in the last two years, or does he or she plan to do so in the next two years? **If so, please indicate the country, the date, the reason and the length of the period abroad in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7 EXPLANATIONS

To be completed for each of the YES answers in Sections 5 and 6. If necessary, please use a second form dated and signed by the proposed insured, or by the proposed insured's legal guardian, if he or she is less than 18 years of age, and attach it to this form.

Question	Name of person concerned	Date YYYY/MM	Dates and reasons for medical consultations, illnesses, diagnoses, hospitalizations, surgical procedures, treatments, medications and dosages, test results, names and addresses of physicians or hospitals visited, length of absences from work, nature of activity, or any other information relevant to the questions included in Sections 5 and 6

8 NOTICE TO PROPOSED INSURED(S) AND POLICYOWNER(S)

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva[1]. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you;
- establish and update your profile, needs and objectives;
- evaluate your applications and eligibility for our products and services;
- provide you with advice related to your situation;
- administer your contracts as well as your products or services (e.g. : pricing, underwriting, enrolment, claims processing, etc.);
- comply with legal and regulatory requirements (e.g. : preventing, detecting or deterring violations, cyber threats, fraud, etc.);
- obtain your feedback on our products and services;
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications;
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you.

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers;
- other organizations or entities that have information about you, including insurance, fraud or claims information;
- intermediaries;
- credit assessment agencies;
- government departments, agencies or regulatory authorities;
- employers;
- claims-related service providers, such as healthcare professionals and auto repair shops;
- other agents and service providers (technology services, printing and mailing services, etc.).

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Personal Information Protection Officer

Beneva
625 rue Jacques-Parizeau
Quebec QC G1R 2G5
ResponsablePRP@beneva.ca

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at www.beneva.ca.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services

1. The term “Beneva” refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. Affiliates of Beneva Inc. designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L’Unique General Insurance Inc. and Unica Insurance Inc.

9. DECLARATIONS

The undersigned:

1. Agree that all information they disclosed during a telephone interview **recorded** by a paramedical company or any other person authorized to represent Beneva Inc. or acting on its behalf, including but not limited to medical history and health status, is deemed to be part of this application and this information can be used to issue the contract underwritten by Beneva Inc. The undersigned agrees also that any recording, transcription or other reproduction of this information by Beneva Inc. or on its behalf will be considered as accurate, complete and binding as a written document.

2. Agree that if the recorded information is found to be inaccurate or incomplete (including, but not limited to, information provided to support non-smoking rates for an insured person in accordance with the terms of the contract they have applied for), the contract is null and void for that insured person.

3. Declare having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applications. This is the case for the electronic application, which allows for assessing a person’s risk profile in order to provide the best possible premium. The undersigned agrees that submitting an application activates this process.

4. Declare having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.

5. Declare that the preceding statements are true, complete and correctly entered and are part of the application for insurance from Beneva Inc. Any misrepresentations or omissions by proposed insured persons concerning circumstances known to them that may significantly influence a reasonable insurer in determining the premium, assessing the risk or deciding to accept the risk could result in the contract being declared null and void, upon the insurer’s request, even with regard to claims that are not related to risks that have been misrepresented or omitted.

6. Declare having been made aware of the personal information protection notice as well as all other notices to the insured person.

x _____ Date: _____
Participant's signature or, if a minor, signature of legal guardian — YYYY/MM/DD

x _____ Date: _____
Spouse’s signature — YYYY/MM/DD

x _____ Date: _____
Signature of dependent age 18 or over — YYYY/MM/DD

x _____ Date: _____
Signature of dependent age 18 or over — YYYY/MM/DD

10. AUTHORIZATIONS

Your authorizations are necessary in order to provide and administer your products and services.

1. Authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.

2. Authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.

3. Authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.

4. Authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

x _____ Date: _____
Participant's signature or, if a minor, signature of legal guardian — YYYY/MM/DD

x _____ Date: _____
Spouse’s signature — YYYY/MM/DD

x _____ Date: _____
Signature of dependent age 18 or over — YYYY/MM/DD

x _____ Date: _____
Signature of dependent age 18 or over — YYYY/MM/DD