La Capitale

DECLARATION OF INSURABILITY FOR ACCIDENT (disability or hospital care)

Policyholder/insured's last name

Policyholder/insured's first name

Date of birth: Year Month Day

Application or Contract No.

1 MEDICAL INFORMATION

Medical information

Check YES or NO. Circle each relevant illness, condition or situation. Provide details for each YES answer in the "Explanations" section on the next page or complete the relevant additional questionnaire.

		Yes	No
1.	Are you currently taking any medication?	☐	☐
2.	Within the last 5 years, have you been hospitalized?	☐	☐
3.	Within the last 5 years, have you been advised to have a diagnostic test or undergo surgery that has not yet been done or has been done but the results not yet received?	☐	☐
4.	Within the last 5 years, have you ever been diagnosed with, treated for or showed symptoms of the following conditions:		
a)	Arthritis, rheumatism or disorders of the bones, back, neck, joints, muscles or paralysis, deformity or amputation?	☐	☐
b)	Insulin-dependent diabetes mellitus, dizziness/fainting, convulsions or epilepsy? If yes, complete the Diabetes Questionnaire available in the illustration software.	☐	☐
c)	Chronic pain or fatigue, fibromyalgia, Epstein-Barr syndrome or any other nervous or neurological disorder?	☐	☐
d)	Depression, burnout, suicide attempt or other psychological, psychiatric or mental disorder? If yes, complete the Psychological Disorders Questionnaire available in the illustration software.	☐	☐
5.	Within the last 5 years, have you received disability benefits from any source whatsoever?	☐	☐

Explanations

To be completed for each of the YES answers in the previous section. If you need extra space, attach an extra sheet to this questionnaire and ensure it is signed and dated by the proposed insured or legal guardian if a minor.

Question No.	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited, name of medication, dose, reason for medication.

La Capitale Financial Security Insurance Company
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1 MEDICAL INFORMATION (cont.)

Height and weight

Height: ☐ cm ☐ ft./in. Weight: ☐ kg ☐ lb.

______________ ______________

Have you lost 4.5 kg (10 lb.) or more in the last year? ☐ Yes ☐ No

If yes, number of kg (lb.) lost: ________ ☐ kg ☐ lb.

Reason: ____________________

Personal physician

Name of physician

Address

Tel. (extension)

Last physician consulted, if different

Date of last consultation: Year Month Day

Reason

Results (consultations or treatments recommended)

Family history

	Yes	No
Have any immediate family members (father, mother, brothers, sisters) ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, muscular dystrophy, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease?	☐	☐

If yes:

	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

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2 NON-MEDICAL INFORMATION > MUST ALWAYS BE COMPLETED EVEN WHEN PARAMEDICAL TESTS ORDERED <

If any of the questions are answered "Yes" (except questions 1 and 5), complete the appropriate section of the additional questionnaire available in the illustration software.

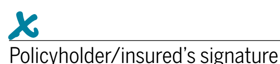
		Yes	No
Alcohol	1. Do you drink alcohol?	☐	☐
	If yes, current weekly consumption (number of glasses of beer, wine and/or spirits). ____________________		
	2. Has your consumption of alcohol changed in the last 5 years?	☐	☐
	3. Have you ever received treatment or counselling for alcoholism, alcohol abuse or have you been advised by a physician to reduce your alcohol consumption?	☐	☐
Bankruptcy	4. Have you declared bankruptcy in the past 5 years?	☐	☐
	If so, indicate the date you were discharged from bankruptcy: ____________________		
Criminal record	5. Have you ever been charged with or found guilty of any criminal offence or are you awaiting the outcome of proceedings for a criminal offence?	☐	☐
	If yes, specify the type, date, sentence and probation for each offence. ____________________		
Driving record	Within the last 3 years:		
	6. Has your driver's licence been suspended or revoked?	☐	☐
	7. Have you been found guilty of 3 or more violations of the Highway Safety Code?	☐	☐
Drug use	8. Do you take, or have you ever taken, drugs?	☐	☐
Hazardous sports	9. Do you plan to take part in or, in the last 5 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity?	☐	☐
Travel or residence abroad	10. In the last 2 years, have you travelled or resided outside of Canada or the United States? **If so,** complete the travel and residence abroad questionnaire.	☐	☐
	11. Are you planning to travel or reside outside of Canada or the United States in the next 2 years? **If so,** complete the travel and residence abroad questionnaire.	☐	☐

3 DECLARATIONS AND AUTHORIZATIONS

1. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of determining my insurability, managing my file and considering my claims. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., for such purposes.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
3. In case of death, I expressly authorize the beneficiary, the heirs or the liquidator of my estate to provide the Insurer or its assigns, when required, with any information or authorizations needed to process my file.
4. A photocopy of this authorization shall be considered as valid as the original.
5. I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete and I consent to these being included as part of my application for insurance.

Signed at ______________________ on this ______ day of ______________ 20 ______.

POLICYHOLDER/INSURED'S SIGNATURE



Policyholder/insured's signature

ADVISOR'S SIGNATURE

Advisor's signature

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