beneva

☐ TOTAL LOSS OF AUTONOMY ☐ LONG-TERM CARE
Insured's statement

Insured's last name _____ Insured's first name _____

Date of birth: ____ ____ ____ (Year Month Day) Sex: ☐ F ☐ M

Contract No. _____ Client No. _____

Address (No., street, apartment, city, province) _____ Postal code _____

Area code _____ Telephone _____

When disclosing medical and health information, the results of any genetic test should not be included.

1 Is the insured represented by a legal guardian to a person of full age? ☐ Yes ☐ No – **If so:**

Guardian's last name _____ Guardian's first name _____

Relationship to the insured _____

Address (No., street, apartment, city, province) _____ Postal code _____

Area code _____ Home telephone _____ Area code _____ Work telephone _____

2 Does the insured reside at the above-mentioned address? ☐ Yes ☐ No

If so, with whom does the insured reside?
- ☐ Alone
- ☐ Spouse
- ☐ Family member
- ☐ Other: _____

If not, where does he or she reside?
- ☐ In a residential care institution
- ☐ In a hospital
- ☐ At the residence of a family member
- ☐ Other: _____

3 Has the insured travelled outside of Canada and the United States since the onset of dependency? ☐ Yes ☐ No

If so, from ____ ____ ____ (Year Month Day) to ____ ____ ____ (Year Month Day)

4 Has the insured undergone a psychosocial or functional assessment by a healthcare professional at a CLSC?
☐ Yes ☐ No – **If so,** name and address of the CLSC:

_____

5 Name and address of the insured's family physician:

Name of physician _____

Address (No., street, city, province) _____ Postal code _____

Beneva Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

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6 Names and addresses of all physicians and other healthcare professionals consulted:

Name	Address	Date of consultation
		Year Month Day
		Year Month Day
		Year Month Day

7 Names and addresses of hospitals or institutions the insured visited or to which the insured was admitted:

Name (hospital or institution)	Address	Length of hospitalization
		From Year Month Day to Year Month Day
		From Year Month Day to Year Month Day
		From Year Month Day to Year Month Day

8 State the reasons why the insured has not stayed in a hospital or other institution: _____

9 Additional information: _____

I acknowledge and agree that the answers in this form are true and complete.

Signed at _____ on _____ this day of _____ 20 _____ .

X _____
Signature of insured or his or her representative

Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the Personal Information Protection Statement located at beneva.ca.

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