Evidence of Insurability
Group Insurance

La Capitale Civil Service Insurer Inc.
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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 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 AUTHORIZATION AND DECLARATION

If you are submitting an application for a person age 18 or over, that person must provide consent and sign below.

"**I authorize** any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that may receive such a mandate, any market intermediary, any employer or ex-employer, the Policyholder as well as any person holding personal files or information, particularly medical records pertaining to myself and any of my dependents, to provide to La Capitale Civil Service Insurer Inc. (La Capitale) or its agents or mandataries, any information that may be required for the processing of my file.

I also authorize La Capitale to transmit such information to the above-mentioned persons when necessary, within the scope of its activities and the processing of my file."

This authorization is valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization is as valid as the original.

"I hereby confirm that the information provided in this form is true and complete, in the knowledge that La Capitale will base its decision to approve or decline my application on this information. I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled."

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

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This form may be sent to the Insurer by mail, fax or email.
If you do not send the original document, make sure you store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.