Declaration of Insurability
Group Insurance

La Capitale Civil Service Insurer Inc.
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@lacapitale.com

Group No. | Employer No. | Identification No.

1 INFORMATION ABOUT PROPOSED INSURED

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 labour market, please skip the next question and proceed directly to providing identifying information concerning your spouse.

Are you currently at work? ☐ 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 chidren.*

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

2 HEIGHT AND WEIGHT OF PROPOSED INSURED

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

3 INSURANCE HISTORY

Have you ever had a Life, Critical Illness of 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 health conditions: heart or kidney disease, polycystic kidney disease, Alzheimer's disease, Huntington's disease, motor neuron disease, cerebrovascular accident (stroke), diabetes, cancer, multiple sclerosis, hypertension 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										
Brother(s)										
Sister(s)										

5 TOBACCO OR DRUG USE

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

6 MEDICAL AND PERSONAL INFORMATION

Has the proposed insured:	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 you physician in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Suffered from a limitation, a 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 does he or she plan 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 or 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 have plans to do so ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Taken part in mountain climbing, motor vehicle racing, hand gliding, skydiving, scuba diving or any other hazardous sport or activity in the last two years, or have plans to do so? **If so, please provide details concerning the nature of the activity 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, including date and reason, in Section 7.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Travelled or resided outside Canada or United States in the last two years, or plans to do so in the next two years? **If so, please indicate the country, the date, the reason and the lenght 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 Section 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 Section 5 and Section 6.

8 AUTORIZATION 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, as the case may be, to provide to La Capitale Civil Service Insurer Inc. (La Capitale) or its agents or mandataries, any information it may hold that may be required for the processing of my file.

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

This authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered 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 shall base its decision to approve or decline my applicationon 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

This form may be sent to the Insurer by mail, fax or email, using the above contact information.
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.

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