

La Capitale Insurance and Financial Services 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	Employer	Class	ID
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1 IDENTIFICATION

OF THE PARTICIPANT (YOU)

Last name and first name	Name at birth (if different)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
Address (number, street and apartment)			Home phone () -
City	Province	Postal code	Work phone () -

OF YOUR SPOUSE (IF COVERAGE IS DESIRED)

Last name and first name	Name at birth (if different)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
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OF YOUR CHILDREN (IF COVERAGE IS DESIRED) *Please use a second form if you have more than two children.

Child 1	Last name and first name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
Child 2	Last name and first name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day

2 PARTICIPANT'S EMPLOYMENT INFORMATION

Profession			
Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, since when? Year Month Day	Reason for absence from work:

3 HEIGHT AND WEIGHT OF PROPOSED INSURED

Proposed insured	Height		Current weight		Weight one year ago		Reason for variation, if any
	<input type="checkbox"/> cm	<input type="checkbox"/> ft/in	<input type="checkbox"/> kg	<input type="checkbox"/> lb.	<input type="checkbox"/> kg	<input type="checkbox"/> lb.	
Participant							
Spouse							
Child 1							
Child 2							

4 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 Year/month	Name of insurer	Type of insurance	Reason for decision
Participant	<input type="checkbox"/>	<input type="checkbox"/>				
Spouse	<input type="checkbox"/>	<input type="checkbox"/>				
Child 1	<input type="checkbox"/>	<input type="checkbox"/>				
Child 2	<input type="checkbox"/>	<input type="checkbox"/>				

5 TOBACCO OR DRUG USE

	PARTICIPANT	SPOUSE	CHILD 1	CHILD 2
■ During the last 12 months, have you smoked cigarettes, cigarillos, a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum? If you quit in the last 12 months, indicate the date that you quit.	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month
■ Have you ever taken medication or drugs for other than medical reasons? Name of substance: Date last used:	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month	<input type="checkbox"/> Yes <input type="checkbox"/> No Year Month

Continued on reverse

6 MEDICAL AND PERSONAL INFORMATION

IMPORTANT: Please answer all questions and provide details regarding any "Yes" answers in Section 7.

	PARTICIPANT	SPOUSE	CHILD 1	CHILD 2
Has the proposed insured:				
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, indicate the period and the reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ever exhibited symptoms, consulted a physician or been treated for one of the following: cardiac or blood vessel disorder, kidney disorder, pulmonary disorder, anxiety disorder, neurological disorder, psychological disorder, back trouble, 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? Provide the name and address of your attending physician.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Suffered from an infirmity, malformation or other physical, nervous or mental illness? If so, please specify.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Taken medication, used homeopathic products, received treatment or followed a diet? If so, please specify.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Consulted a physician, therapist or other healthcare professional (psychologist, chiropractor, etc.), including alternative medicine, or been admitted to a hospital or other medical establishment in the last five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Got plans to consult a physician, therapist or other healthcare professional (psychologist, chiropractor, etc.), including alternative medicine, or undergo a surgical procedure in the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Undergone, or been asked or encouraged to undergo, an HIV (AIDS) screening test? If so, indicate the date and the results.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Taken part in flights other than as a passenger in the last two years, or does he or she have plans to do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Had his or her driver's licence suspended or revoked in the last three years? If so, indicate the date and the reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. 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, indicate the country, the date, the reason and the length of the period abroad.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Consumed alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so:	Weekly amount Now/one year ago	Weekly amount Now/one year ago	Weekly amount Now/one year ago	Weekly amount Now/one year ago
Beer (glasses)				
Wine (glasses)				
Spirits (ounces)				
13. Undergone detoxification for drugs or alcohol or been encouraged to do so? If so, indicate the date and the reason for treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7 EXPLANATIONS

To be completed for each of the YES answers in Section 6. If you need extra space, attach an extra sheet to this application and ensure it is signed and dated by the proposed insured or legal guardian if a minor.

Question	Name of person concerned	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 or any other information relevant to the questions included in Section 6.

8 AUTHORIZATION AND DECLARATION

"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 Insurance and Financial Services 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 application on this information. I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled."

	_____		_____
Participant's signature or, if a minor, signature of legal guardian	Date	Spouse's signature	Date
	_____		_____
Signature of dependent age 18 or over	Date	Signature of dependent age 18 or over	Date

KEEP A COPY FOR YOUR FILE AND RETURN THE ORIGINAL COPY TO THE INSURER