La Capitale

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	Employer	Class	ID

1 IDENTIFICATION

OF THE PARTICIPANT (YOU)

Last name and first name	Name at birth (if different)	Gender ☐ M ☐ 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 ☐ M ☐ F	Date of birth Year / Month / Day

OF YOUR CHILDREN (IF COVERAGE IS DESIRED) **Please use a second form if you have more than two children.*

	Last name and first name	Gender ☐ M ☐ F	Date of birth Year / Month / Day
Child 1			
Child 2			

2 PARTICIPANT'S EMPLOYMENT INFORMATION

Profession					
Are you currently employed? ☐ Yes ☐ No	If not, since when?	Year	Month	Day	Reason for absence from work:

3 HEIGHT AND WEIGHT OF PROPOSED INSUREDS

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				

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	☐	☐				
Spouse	☐	☐				
Child 1	☐	☐				
Child 2	☐	☐				

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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you quit in the last 12 months, indicate the date that you quit.	Year / Month	Year / Month	Year / Month	Year / Month
▪ 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

Continued on reverse

6 MEDICAL AND PERSONAL INFORMATION

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

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, indicate the period and the reason.**	☐ 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, 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.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Suffered from an infirmity, malformation or other physical, nervous or mental illness? **If so, please specify.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Taken medication, used homeopathic products, received treatment or followed a diet? **If so, please specify.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Undergone, or been asked or encouraged to undergo, an HIV (AIDS) screening test? **If so, indicate the date and the results.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12. Consumed alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.

P015 (11-2017)

100%

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

X _____ Participant's signature or, if a minor, signature of legal guardian — _____ Date

X _____ Spouse's signature — _____ Date

X _____ Signature of dependent age 18 or over — _____ Date

X _____ Signature of dependent age 18 or over — _____ Date

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