La Capitale

DECLARATION OF INSURABILITY
(Proposed insured Age 18 and over)

Proposed insured's last name

Proposed insured's first name

Date of birth: Year Month Day

Application or Contract No.

1 PERSONAL INFORMATION

1.1 OTHER INSURANCE IN FORCE OR PENDING

Do you currently hold a life (**LIFE**), critical illness (**CI**), long-term care (**LTC**) or disability (**DI**) insurance contract or have a pending application for any of these types of insurance? ◯ Yes ◯ No **If so**, provide the details of these contracts or applications.

LIFE	CI	LTC	DI	Insured amount	Accidental Death	Company name	Year and month issued (check if pending) Year	Month	Pending	Personal/ business P	B	Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required.
◯	◯	◯	◯	$	$				☐	◯	◯	◯ Yes ◯ No
◯	◯	◯	◯	$	$				☐	◯	◯	◯ Yes ◯ No
◯	◯	◯	◯	$	$				☐	◯	◯	◯ Yes ◯ No

1.2 PREVIOUS INSURANCE COVERAGE

Have you ever had a life (**LIFE**), critical illness (**CI**) or disability (**DI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium? ◯ Yes ◯ No **If so**, provide details of these applications.

Year	Month	LIFE	CI	DI	Company name	Decision	Reason
		◯	◯	◯			
		◯	◯	◯			

1.3 TOBACCO USE

In the last 12 months, have you smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as gum, nicotine patch or electronic cigarette? ◯ Yes ◯ No **If so**:

Type	Quantity	Frequency

If you quit smoking in the last 12 months, indicate the date: Year Month

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1 PERSONAL INFORMATION (cont.)

Check YES or NO. For each "YES" answer, provide details or complete the requested questionnaire.

		Oui	Non
	ALCOHOL		
1.4	Do you drink alcohol? **If so**, indicate your current weekly consumption (number of glasses of beer, wine and spirits). _____	○	○
1.5	In the last 5 years, has your consumption of alcohol changed? **If so**, complete the alcohol use questionnaire.	○	○
	DRUG AND OPIATE USE		
1.6	Do you take, or have you ever used, drugs or opiates or narcotics such as cocaine, LSD, barbiturates, amphetamines or other similar substances? **If so**, complete the drug or opiate use questionnaire.	○	○
	DRIVING RECORD		
1.7	Have you ever been charged with or found guilty of impaired driving? **If so**, complete the driving record questionnaire.	○	○
1.8	In the last 5 years, has your driver's licence been suspended or revoked? **If so**, complete the driving record questionnaire.	○	○
1.9	In the last 5 years, have you been found guilty of 3 or more violations of the Highway Safety Code? **If so**, complete the driving record questionnaire.	○	○
	CRIMINAL RECORD		
1.10	Have you ever been charged with or found guilty of any criminal offence? **If so**, specify the type, date, sentence and probation for each offence. _____ _____ _____	○	○
	AVIATION		
1.11	Do you plan to take part in or, in the last 2 years, have you taken part in any flights other than as a passenger? **If so**, complete the aviation questionnaire.	○	○
	HAZARDOUS SPORTS		
1.12	Do you plan to take part in or, in the last 2 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity? **If so**, complete the appropriate questionnaire.	○	○
	TRAVEL OR RESIDENCE ABROAD		
1.13	In the last 2 years, have you travelled or resided outside of Canada or the United States? **If so**, complete the travel and residence abroad questionnaire.	○	○
1.14	Are you planning to travel or reside outside of Canada or the United States in the next 2 years? **If so**, complete the travel and residence abroad questionnaire.	○	○

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2 MEDICAL INFORMATION

2.1 MEDICAL HISTORY

Check YES or NO. For each "YES" answer:
– Identify the relevant illness, condition or situation.
– Provide details in Section 2.2 Additional Information or complete the requested questionnaire.

		Yes	No
2.1.1	Have you ever consulted for, been treated for or shown signs or symptoms of any of the following conditions?		
	a) CARDIOVASCULAR SYSTEM: High blood pressure, high level of cholesterol or triglicerides, chest pain, palpitations, irregular heart beat, heart murmur, acute rheumatic fever, heart attack, cerebrovascular accident, aneurysm or any other heart or blood vessel disorder?	○	○
	b) RESPIRATORY SYSTEM: Asthma, emphysema, shortness of breath, chronic bronchitis, sleep apnea or any other pulmonary or respiratory disorder? **If so**, complete the respiratory disorders questionnaire.	○	○
	c) GASTROINTESTINAL SYSTEM:		
	c1. Hepatitis, cirrhosis of the liver, pancreatitis or other liver disorder?	○	○
	c2. Ulcerative colitis, Crohn's disease, hemorrhage, esophagus, stomach, gallbladder or intestine disorder? **If so**, complete the intestinal disorders questionnaire.	○	○
	d) GENITOURINARY SYSTEM: Urine abnormalities, kidney, bladder, prostate or genital organ disorder, sexually transmitted diseases or abnormal PAP tests?	○	○
	e) ENDOCRINE SYSTEM:		
	e1. Thyroid gland disorder or other endocrine condition?	○	○
	e2. Diabetes? **If so**, complete the diabetes questionnaire.	○	○
	f) MUSCULOSKELETAL SYSTEM:		
	f1. Back or neck pain or disorder? **If so**, complete the back or neck disorders questionnaire.	○	○
	f2. Arthritis, gout, bursitis, tendonitis, sprain or other muscle, ligament, bone or joint disorder? **If so**, complete the musculoskeletal disorders questionnaire.	○	○
	g) NERVOUS SYSTEM: Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness, tingling or any other neurological disorder?	○	○
	h) MENTAL HEALTH: Depression, burnout, adjustment disorder, anxiety, fatigue/overstress or any other psychological, psychiatric or mental disorder? **If so**, complete the psychological disorders questionnaire.	○	○
	i) IMMUNE SYSTEM: Lupus, AIDS-related complex, AIDS or test results indicating possible exposure to AIDS or HIV (Human Immunodeficiency Virus) or any other immune system disorder?	○	○
	j) GENERAL:		
	j1. Anemia or other blood disease, leukemia, lymph node disorder, cancer, tumour, cyst, polyp, nodule, skin disease or abnormal skin lesion, eye or ear condition or breast disorder including lumps?	○	○
	j2. Any other physical or mental disorder not mentioned in Question 2.1.1 a) in j1?	○	○
2.1.2	Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of drugs or alcohol?	○	○
2.1.3	In the last 5 years,		
	a) Have you had an electrocardiogram, X-ray, CT scan, MRI, blood tests or follow-up, screening or diagnostic tests?	○	○
	b) Have you been admitted as a patient to any hospital or clinic?	○	○
2.1.4	In the last 5 years, have you been disabled or absent from work for a period of 4 consecutive weeks or more due to illness or injury?	○	○

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2 MEDICAL INFORMATION (cont.)

2.1 MEDICAL HISTORY (cont.)

		Yes	No
2.1.5	In the last 2 years, have you undergone a mammography or breast ultrasound?	◯	◯
2.1.6	Have you ever consulted or been advised to consult a physician or a specialist or been advised to receive treatment following abnormal findings of an ultrasound, biopsy or mammography?	◯	◯
2.1.7	Are you taking any medication? **If so**, specify which medications.	◯	◯
2.1.8	Do you have any symptoms or signs for which you have not yet consulted?	◯	◯
2.1.9	Do you have to consult a physician or a specialist, undergo a treatment or surgery or take follow-up or diagnostic tests which have not yet been performed?	◯	◯
2.1.10	Have you previously had complications during a pregnancy or at childbirth (gestational diabetes, preeclampsia, cesarian section, postpartum depression)?	◯	◯
2.1.11	a) Are you pregnant?	◯	◯
	b) **If so**, what is the due date?	Year	Month

2.2 ADDITIONAL INFORMATION

If you need extra space, attach an extra sheet, duly dated and signed.

Question No.	Diagnosis, date of diagnosis, dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited

2.3 HEIGHT AND WEIGHT

Height: _____ ◯ cm ◯ ft/in WEIGHT: _____ ◯ kg ◯ lb.

In the last twelve months, have you lost 4.5 kg (10 lb.) or more? ◯ Yes ◯ No

If so, how much weight was lost? _____ ◯ kg ◯ lb. Reason for the weight loss: _____

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2 MEDICAL INFORMATION (cont.)

2.4 PHYSICIANS

2.4.1 Personal physician

Name of personal physician

Address — Area code Tel.

Reason for last consultation — Date of last consultation: Year Month Day

Results and current condition (consultations or treatments recommended)

2.4.2 Last physician consulted

Name of last physician consulted, if different

Address — Area code Tel.

Reason for last consultation — Date of last consultation: Year Month Day

Results and current condition (consultations or treatments recommended)

2.5 FAMILY HISTORY

Have any of the proposed insured's immediate family members, meaning father, mother, brother or sister, whether living or deceased, ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? ◯ Yes ◯ No – **If so**, provide required information below.

Relationship to Proposed Insured	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death

3 DECLARATION AND SIGNATURES

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

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

PROPOSED INSURED'S SIGNATURE

X _____
Proposed insured's signature

ADVISOR'S SIGNATURE

X _____
Advisor's signature

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Contract No.: Leave this blank

4 AUTHORIZATION

1. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of determining my insurability, managing my file and considering my claims. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., for such purposes.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
3. A photocopy of this authorization shall be considered as valid as the original.

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

PROPOSED INSURED'S SIGNATURE

X _____
Proposed insured's signature

ADVISOR'S SIGNATURE

X _____
Advisor's signature

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