La Capitale

DECLARATION OF INSURABILITY
CHILD (under age 18)

Proposed insured's (child) last name

Proposed insured's (child) first name

Date of birth: Year Month Day

Application or Contract No.

1 PERSONAL INFORMATION

1.1 OTHER INSURANCE IN FORCE OR PENDING

Does the child currently hold a life (**LIFE**) or critical illness (**CI**) 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	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

1.2 PREVIOUS INSURANCE COVERAGE

Has the child ever had a life (**LIFE**) or critical illness (**CI**) 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	Company name	Decision	Reason
		☐	☐			
		☐	☐			

1.3 CHILD'S FAMILY HISTORY

1.3.1 Child's brothers and sisters

Does the child have any brothers or sisters? ☐ Yes ☐ No **If so**, how many? ________

1.3.2 Previous insurance coverage of the child's family members

List below any life (**LIFE**), critical illness (**CI**) or disability (**DI**) insurance in force or pending on the lives of parents, brothers and sisters:

Name of the child's family member	Relationship to the child	LIFE	CI	DI	Insured amount	Company name	Year issued	Pending
		☐	☐	☐	$			☐
		☐	☐	☐	$			☐

1.3.3 Child's parents' financial information

Complete if the insured amount applied for is greater than $100,000.

a) Parents' annual income: $ ________

b) Parents' net worth (assets-liabilities): $ ________

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625 Jacques-Parizeau St, Quebec QC G1R 2G5

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1 PERSONAL INFORMATION (cont.)

1.4 TOBACCO USE

In last 12 months, has the child 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

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

		Yes	No
1.5	**ALCOHOL** Does the child drink alcohol? **If so**, indicate the child's current weekly consumption (number of glasses of beer, wine and spirits). ______________________	☐	☐
	DRUG AND OPIATE USE		
1.6	Does the child take, or 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	Has the child ever been charged with or found guilty of impaired driving? **If so**, complete the driving record questionnaire.	☐	☐
1.8	Has the child's driver's licence ever been suspended or revoked? **If so**, complete the driving record questionnaire.	☐	☐
1.9	Has the child been found guilty of one or more violations of the Highway Safety Code? **If so**, complete the driving record questionnaire.	☐	☐
	CRIMINAL RECORD		
1.10	Has the child 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	Does the child plan to take part in or, in the last 2 years, has he or she taken part in flights other than as a passenger? **If so**, complete the aviation questionnaire.	☐	☐
	HAZARDOUS SPORTS		
1.12	Does the child plan to take part in or, in the last 2 years, has he or she 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, has the child travelled or resided outside of Canada or the United States? **If so**, complete the travel and residence abroad questionnaire.	☐	☐
1.14	Is the child 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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DECLARATION OF INSURABILITY
CHILD (under age 18)

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.

	Question	Yes	No
2.1.1	Has the child ever consulted a physician for, been diagnosed with or shown any signs or symptoms of any of the following conditions:		
	a) Cardiac malformation or other congenital abnormality?	☐	☐
	b) Cerebral palsy, amyotrophic lateral sclerosis, muscular dystrophy, cystic fibrosis or delay in physical or mental development?	☐	☐
2.1.2	Is the child under 1 year old?	☐	☐
	If so, was he or she born more than 4 weeks prematurely?	☐	☐
2.1.3	Has the child ever consulted for, been treated for or shown signs or symptoms 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: Attention deficit disorder, autism, depression, 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 skin lesion, eye or ear condition or breast disorder including lumps?	☐	☐
	j2. Any other physical or mental disorder not mentioned in Question 2.1.3 a) in j1?	☐	☐
2.1.4	Has the child ever received treatment or has he or she been advised to undergo treatment or to consult a physician regarding his or her consumption of drugs or alcohol?	☐	☐

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IND044E (11-2017)

2 MEDICAL INFORMATION (cont.)

2.1 MEDICAL HISTORY (cont.)

		Yes	No
2.1.5	In the last 5 years,		
	a) Has the child had an electrocardiogram, X-ray, CT scan, MRI, blood tests or follow-up, screening or diagnostic tests?	☐	☐
	b) Has the child been admitted as a patient to any hospital or clinic?	☐	☐
2.1.6	In the last 5 years, has the child been disabled or absent from work or school for a period of 4 consecutive weeks or more due to illness or injury?	☐	☐
2.1.7	In the last 2 years, has the child undergone a mammography or breast ultrasound?	☐	☐
2.1.8	Has the child 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?	☐	☐
2.1.9	Is the child taking any medication? **If so**, specify which medications.	☐	☐
2.1.10	Does the child have any symptoms or signs for which he or she has not yet consulted?	☐	☐
2.1.11	Does the child 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?	☐	☐
2.1.12	Has the child previously had complications during a pregnancy or at childbirth? (gestational diabetes, preeclampsia, caesarian section, postpartum depression)	☐	☐
2.1.13	a) Is the child 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, has the child 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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DECLARATION OF INSURABILITY CHILD (under age 18)

2 MEDICAL INFORMATION (cont.)

2.4 PHYSICIANS

2.4.1 Personal physician

Name of personal physician

Address

Area code Tel.

Date of last consultation

Reason for 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.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

2.5 FAMILY HISTORY

Have any of the child's immediate family members, meaning father, mother, brother, sister or maternal or paternal grandparents, 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 the child	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death

3 DECLARATIONS AND SIGNATURES

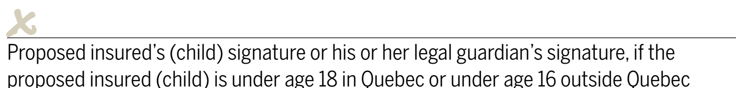
I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at ____________ on this ______ day of ____________ 20______.

POLICYHOLDER'S SIGNATURE

Policyholder's signature

PROPOSED INSURED' S (CHILD) SIGNATURE



Proposed insured's (child) signature or his or her legal guardian's signature, if the proposed insured (child) is under age 18 in Quebec or under age 16 outside Quebec

Legal guardian's name , if applicable (please print)

ADVISOR'SIGNATURE

Advisor's signature

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CHILD (under age 18)

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

Proposed insured's signature (authorized to sign if age 14 or over in Quebec and if age 16 or over outside Quebec)

Signature of a parent or legal guardian if proposed insured is a minor

Please print the parent's or legal guardian's name

ADVISOR'S SIGNATURE

Advisor's signature

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