La Capitale

CHILDREN'S CRITICAL ILLNESS RIDER QUESTIONNAIRE

Policyholder's last name

Policyholder's first name

Application or Contract No.

1 CHILDREN'S INFORMATION FOR THE CHILDREN'S CRITICAL ILLNESS RIDER

	Last name	First name	Gender	Date of birth Year Month Day
Child 1			☐ M ☐ F	
Child 2			☐ M ☐ F	

2 INSURED AMOUNT

Insured amount: $ _____ The insured amount must be the same for all children.

3 PERSONAL INFORMATION

3.1 OTHER INSURANCE IN FORCE OR PENDING

CHILD 1

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	Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required.
☐	☐	$	$			☐	☐ Yes ☐ No
☐	☐	$	$			☐	☐ Yes ☐ No

CHILD 2

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	Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required.
☐	☐	$	$			☐	☐ Yes ☐ No
☐	☐	$	$			☐	☐ Yes ☐ No

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3 PERSONAL INFORMATION (cont)

3.2 PREVIOUS INSURANCE COVERAGE

CHILD 1

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 on these applications.

Year	Month	LIFE	CI	Company name	Decision	Reason
		☐	☐			
		☐	☐			

CHILD 2

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 on these applications.

Year	Month	LIFE	CI	Company name	Decision	Reason
		☐	☐			
		☐	☐			

3.3 CHILD'S FAMILY HISTORY

3.3.1 Child's brothers and sisters

Does the child have any brothers or sisters?

If so, how many?

	CHILD 1		CHILD 2	
	Yes	No	Yes	No
	☐	☐	☐	☐

3.3.2 Previous insurance coverage of the child's family members

CHILD 1

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
		☐	☐	☐	$			☐
		☐	☐	☐	$			☐

CHILD 2

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
		☐	☐	☐	$			☐
		☐	☐	☐	$			☐

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3 PERSONAL INFORMATION (cont.)

3.4 TOBACCO USE

CHILD 1

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	Frequence

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

CHILD 2

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	Frequence

If the child 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, available in the illustration software.	CHILD 1		CHILD 2	
	Yes	**No**	**Yes**	**No**
ALCOHOL				
3.5 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				
3.6 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				
3.7 Has the child ever been charged with or found guilty of impaired driving? **If so**, complete the driving record questionnaire.	☐	☐	☐	☐
3.8 Has the child's driver's licence ever been suspended or revoked? **If so**, complete the driving record questionnaire.	☐	☐	☐	☐
3.9 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				
3.10 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				
3.11 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				
3.12 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				
3.13 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.	☐	☐	☐	☐
3.14 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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4 MEDICAL INFORMATION

4.1 MEDICAL HISTORY

Check YES or NO. For each "YES" answer:
- **Circle the relevant illness, condition or situation.**
- **Provide details in Section 4.2 Additional Information or complete the requested questionnaire, available in the illustration software.**

		CHILD 1		CHILD 2	
		Yes	No	Yes	No
4.1.1	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?	☐	☐	☐	☐
4.1.2	Is the child under 1 year old?	☐	☐	☐	☐
	If so, was he or she born more than 4 weeks prematurely?	☐	☐	☐	☐
4.1.3	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 4.1.3 a) in j1?	☐	☐	☐	☐
4.1.4	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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4 MEDICAL INFORMATION (cont.)

4.1 MEDICAL HISTORY (cont.)

		CHILD 1		CHILD 2	
		Yes	No	Yes	No
4.1.5	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?	☐	☐	☐	☐
4.1.6	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?	☐	☐	☐	☐
4.1.7	In the last 2 years, has the child undergone a mammography or breast ultrasound?	☐	☐	☐	☐
4.1.8	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?	☐	☐	☐	☐
4.1.9	Is the child taking any medication? **If so**, specify which medications.	☐	☐	☐	☐
4.1.10	Does the child have any symptoms or signs for which he or she has not yet consulted?	☐	☐	☐	☐
4.1.11	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?	☐	☐	☐	☐
4.1.12	Has the child previously had complications during a pregnancy or at childbirth (gestational diabetes, preeclampsia, caesarian section, postpartum depression)?	☐	☐	☐	☐
4.1.13	a) Is the child pregnant?	☐	☐	☐	☐
	b) **If so**, what is the due date?	Year Month		Year Month	

4.2 ADDITIONAL INFORMATION

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

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

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4 MEDICAL INFORMATION (cont.)

4.3 HEIGHT AND WEIGHT

CHILD 1

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: _____

CHILD 2

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: _____

4.4 PHYSICIANS

4.4.1 Personal physician

CHILD 1

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)

CHILD 2

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)

4.4.2 Last physician consulted

CHILD 1

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)

CHILD 2

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)

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CHILDREN'S CRITICAL ILLNESS RIDER QUESTIONNAIRE

4 MEDICAL INFORMATION (cont.)

4.5 FAMILY HISTORY

	CHILD 1		CHILD 2	
	Yes	No	Yes	No
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? **If so**, provide required information below.	☐	☐	☐	☐

Child's name	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

5 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_____.

POLICYHOLDER'S SIGNATURE

_____
Policyholder's signature

LEGAL GUARDIAN'S SIGNATURE, IF NOT THE POLICYHOLDER

_____ _____
Legal guardian's signature, if not the policyholder | Legal guardian's name, if applicable (please print)

ADVISOR'SIGNATURE

_____
Advisor's signature

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