La Capitale

DECLARATION OF INSURABILITY FOR ACCIDENT AND SICKNESS (DISABILITY AND HOSPITAL CARE)

Policyholder/insured's last name

Policyholder/insured's first name

Date of birth: Year Month Day

Application or contract No.

1 MEDICAL INFORMATION

Check YES or NO. Circle each relevant illness, condition or situation. Provide details for each YES answer in the "Explanations" section on the next page or complete the relevant additional questionnaire.

	Yes	No
1. Have you ever consulted for, been treated for, been informed of or shown signs or symptoms of the following conditions:		
a) Heart attack, high blood pressure, chest pain, heart murmur, high cholesterol levels, cerebrovascular accident (stroke), transient ischemic attacks, aneurysm, any type of heart surgery, congestive heart failure or any other heart or blood vessel disorder?	○	○
b) Cancer, tumor, leukemia, lymph node disorder, cyst, polyp, skin disorder, melanoma or breast disorder, including lumps, unusual discharge or other physical changes?	○	○
c) Multiple sclerosis, muscular dystrophy or amyotrophic lateral sclerosis (Lou Gehrig's disease), coma, optic neurosis, blurred vision or numbness?	○	○
d) Hepatitis, hepatitis carrier, cirrhosis, ulcerative colitis, Crohn's disease or any other disorder of the liver, pancreas, stomach, spleen or intestines?	○	○
e) Asthma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), sleep apnea or any other pulmonary or respiratory disorder? If yes, complete the Respiratory Disorders Questionnaire available in the illustration software.	○	○
f) Anemia, phlebitis or other blood disorder, bladder or prostate disorder, elevated PSA, genital or reproductive system disorder including HPV, sexually transmitted disease, kidney disease or blood in the urine or other urine abnormalities?	○	○
g) Immune system disorder, AIDS or positive test results for HIV (human immunodeficiency virus)?	○	○
h) Organ transplant or awaiting an organ transplant?	○	○
i) Disorder of the thyroid gland or other endocrine disorder?	○	○
j) Eye, ear, nose or throat disorder or any other disorder not mentioned above in item 1 of this section?	○	○
2. Are you currently pregnant? If yes, what is the expected date of childbirth? _____	○	○
3. Are you currently taking any medication?	○	○
4. Within the last 2 years, have you undergone a mammography or breast ultrasound?	○	○
5. Within the last 5 years, have you been absent from work for more than 10 consecutive days as a result of sickness or injury?	○	○
6. Within the last 5 years, have you been hospitalized?	○	○
7. Within the last 5 years, have you been advised to have a diagnostic test or undergo surgery that has not yet been done or has been done but the results not yet received?	○	○
8. Within the last 5 years, have you received disability benefits from any source whatsoever?	○	○
9. Within the last 10 years, have you ever been treated for, been informed of or showed signs or symptoms of the following conditions:		
a) Disorder of the spine, back, neck, hips, sciatic nerve or joints? If yes, complete either the Back Disorder or the Musculoskeletal Disorders Questionnaire available in the illustration software.	○	○
b) Arthritis, rheumatism, gout, neuritis, muscular disorders, bone disorders (sprain, tear, pulled muscle or fracture) or any other deformity, amputation or paralysis?	○	○
c) Dizziness, fainting, loss of balance, convulsion or epilepsy?	○	○
d) Depression, burnout, mental health issue, suicide attempt or other mental health or nervous disorder? If yes, complete the Psychological Disorders Questionnaire available in the illustration software.	○	○
e) Alzheimer's disease, Parkinson's disease, schizophrenia, any other organic brain disease or neurological disorder?	○	○
f) Chronic pain or fatigue, fibromyalgia, Epstein-Barr syndrome or any other neurological disorder?	○	○
g) Diabetes, elevated sugar in blood or urine? If yes, complete the Diabetes Questionnaire available in the illustration software.	○	○
10. Do you have any reason to believe that you are not in good health or do you have any symptoms for which you have not yet consulted or requested treatment?	○	○

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga, ON L5W 0E5

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1 MEDICAL INFORMATION (cont.)

Explanations

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

Question No.	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited, name of medication, dose, reason for medication

Height and weight

Height: ○ cm ○ ft./in. Weight: ○ kg ○ lb.

Have you lost 4.5 kg (10 lb.) or more in the last year? ○ Yes ○ No

If yes, number of kg (lb.) lost: _____ ○ kg ○ lb.

Reason: _____

Personal physician

Name of physician

Address (No., street, suite)

Office tel. (extension)

Last physician consulted, if different

Date of last consultation: Year Month Day

Reason

Results (consultations or treatments recommended)

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1 MEDICAL INFORMATION (cont.)

Family history

Have any immediate family members (father, mother, brothers, sisters) ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, muscular dystrophy, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? Yes ○ No ○

If yes:

	Name of disease (if cancer, specify type)	Age at onset of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

2 NON-MEDICAL INFORMATION >>> MUST ALWAYS BE COMPLETED EVEN WHEN PARAMEDICAL TESTS ORDERED <<<

If any of the questions are answered "Yes" (except questions 1 and 5), complete the appropriate section of the additional questionnaire available in the illustration software.

Alcohol

1. Do you drink alcohol? Yes ○ No ○

   If yes, indicate current weekly consumption (number of glasses of beer, wine and/or spirits).

   _____

   _____

   _____

2. Has your consumption of alcohol changed in the last 5 years? Yes ○ No ○
3. Have you ever received treatment or counselling for alcoholism, alcohol abuse or have you been advised by a physician to reduce your alcohol consumption? Yes ○ No ○

Bankruptcy

4. Have you declared bankruptcy in the last 5 years? Yes ○ No ○

   If yes, indicate the date you were discharged from bankruptcy: _____

Criminal record

5. Have you ever been charged with or found guilty of any criminal offence or are you awaiting the outcome of proceedings for a criminal offence? Yes ○ No ○

   If yes, specify the type, date, sentence and probation for each offence.

   _____

   _____

   _____

   _____

Driving record

Within the last 3 years:

6. Has your driver's licence been suspended or revoked? Yes ○ No ○
7. Have you been found guilty of 3 or more violations of the Highway Safety Code? Yes ○ No ○

Drug use

8. Do you take, or have you ever taken, drugs? Yes ○ No ○

Hazardous sports

9. Do you plan to take part in or, in the last 5 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity? Yes ○ No ○

Travel or residence abroad

10. In the last 2 years, have you travelled or resided outside of Canada or the United States? Yes ○ No ○
    If yes, complete the Travel and Residence Abroad Questionnaire.
11. Are you planning to travel or reside outside of Canada or the United States in the next 2 years? Yes ○ No ○
    If yes, complete the Travel and Residence Abroad Questionnaire.

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3 DECLARATIONS AND AUTHORIZATIONS

1. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, 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 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. In case of death, I expressly authorize the beneficiary, the heirs or the liquidator of my estate to provide the Insurer or its agents, when required, with any information or authorizations needed to process my file.
4. A photocopy of this authorization is considered as valid as the original.
5. I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete, and I consent to these being included as part of my application for insurance.

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

POLICYHOLDER/INSURED'S SIGNATURE

X _____

Policyholder/insured's signature

ADVISOR'S SIGNATURE

X _____

Advisor's signature

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