HUMANIA ASSURANCE

GROUP INSURANCE

DECLARATION OF INSURABILITY

Part 1 - Identification

Policy Nº: Subdivision Nº: Certificate Nº:

Employer's name:

Employee's or dependant's last name:

Employee's or dependant's first name:

Sex: ☐ M ☐ F Date of birth: year / month / day

Are you currently employed? ☐ Yes ☐ No If yes, number of hours per week

If no, indicate the reason Profession / Occupation / Tasks:

Part 2 - General Information

Please provide details to affirmative answers in Part 6 - General Comments	Yes	No
1. Have you ever had an application for insurance coverage or reinstatement refused, postponed or accepted with a change in premium or coverage? If yes, specify the type of insurance, the insurer involved, relevant dates and reasons.	☐	☐
2. Have you ever applied for or received disability benefits? If yes, indicate the name of the insurer or the government agency, the relevant dates and the reasons.	☐	☐
3. Did you or do you plan to participate in the following activities: Aviation, Parachuting, Scuba Diving, Hang-gliding, Racing or Speed trials or any other high rise sport? **If yes, please complete the appropriate questionnaire.***	☐	☐
4. Do you use or have you ever used acoholic beverages? If yes, indicate the frequency, the type of alcohol, the amount per week, per month or per year and since when you have been drinking at this level?	☐	☐
5. Have you ever been treated for alcoholism, alcohol abuse or been advised to reduce your consomption? **If yes, please complete the alcohol questionnaire.***	☐	☐
6. Do you use or have you ever used drugs or narcotics without a medical prescription? **If yes, please complete the drug questionnaire.***	☐	☐
7. In the past 3 years, has your driver's licence been suspended or restricted? Have you ever been accused or convicted of driving while intoxicated? **If yes, please complete the driving questionnaire.***	☐ ☐	☐ ☐
8. Have you ever been convicted of a criminal act or are you currently under indictment for a criminal offence?	☐	☐
9. In the past three (3) years, have you travelled outside Canada or do you intend to do so except for vacation?	☐	☐
10. Do you have a illness or are you affected by a mental or physical disability?	☐	☐
11. In the past twelve (12) months, have you smoked or used tobacco? If yes, indicate your daily consumption and in what form: Prior to the past twelve (12) months, have you used tobacco?	☐ ☐	☐ ☐

* **Questionnaires are available on our website at : www.humania.ca/Forms/Group Insurance Forms/New Enrolment**

Part 3 - Medical Information

Please provide details to affirmative answers in Part 6 - General Comments

HAS OR IS THE PERSON TO BE INSURED	Yes	No
1. Taking medication, following a diet or taking homeopathic products ?	☐	☐
Type: _____ Reason: _____		
2. Has ever suffered from an illness or presented one of the following health problems:		
a) Cardio-vascular system: chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, high cholesterol or other disorder of the heart or blood vessels?	☐	☐
b) Respiratory system: Asthma, chronic bronchitis, emphysema, spitting of blood, tuberculosis, pneumonia, or other respiratory disorder?	☐	☐
c) Digestive System: colitis, ulcers, intestinal bleeding, gastritis or other disorder of the stomach, gall bladder, liver (hepatitis, cirrhosis), pancreas or intestines?	☐	☐
d) Genitourinary system: Sugar, albumin, blood or pus in the urine, stone or other disorder of the kidneys, bladder, prostate or genitals?	☐	☐
e) Endocrine system: diabetes, thyroid disorder or other endocrine disorder?	☐	☐
f) Musculo-skeletal system: arthrosis, arthritis, gout or disorder of the muscles or bones, including the spine, sciatica problems, back and joints?	☐	☐
g) Any disorder of the eyes, ears, nose, mouth or throat, venereal disease, any skin disease?	☐	☐
h) Nervous System: Convulsions, epilepsy, migraine, headache, paralysis, anxiety, stress, chronic fatigue, fibromyalgia, stroke, transient ischemic attack, degenerative, neurological disorder or other mental or nervous problem?	☐	☐
i) Anemia or other blood disease, cyst, tumor, cancer?	☐	☐
j) Other non-physical or mental disorder not mentioned above, specify: _____	☐	☐
3. In the past three years, had to leave her job or her regular occupation for a period of 30 days or more due to illness or injury?	☐	☐
Date: _____ Reason: _____		
4. Has been Aware of any symptom or disease, for which no doctor has been consulted and no treatment has been received?	☐	☐
5. Plans to consult a doctor or any other health professional or undergo surgery?	☐	☐
6. In the past five years, has consulted a physician or any other health professionnal or has been admitted to hospital or any other health facility?	☐	☐
If yes, complete Part 4		
7. Has undergone, is to undergo or has been advised to undergo testing for HIV or AIDS?	☐	☐
Date: _____ Reason: _____		
Result: _____		

8. Height _____ ft _____ cm _____ Weights _____ pds _____ kg

Part 4 - Questionnaire to be completed for any medical consultation

Reason for consultation:

Doctor's diagnosis (name of disease):

Date (first consultation): Date (last): Number of consults:

Name and address of doctor or hospital:

On this consultation, there has been a:	Yes	No
Hospitalisation?	☐	☐
Date: Lenght:		
Surgery?	☐	☐
Date: Name of the surgery:		
Prescription medications or treatments?	☐	☐
Specify:		
Beginning date: Date of termination:		
Blood tests, X-rays, ECG, other tests?	☐	☐
Specify:		
Date: Results:		

Please indicate your current status or state of health:

Part 5 - Family history

Has there ever been in your family: diabetes, cancer (specify the type), tuberculosis, high blood pressure, heart disease, mental illness, transient ischemic attack or cerebrovascular accident, kidney disease, alcoholism, Huntington's Chorea, amyotrophic lateral sclerosis, motor neuron disease, multiple sclerosis, Alzheimer's disease or any other hereditary disease?	Yes	No
	☐	☐

Family member	Age at onset	Current age if alive	Age at death	Health status or cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

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Part 6 - General comments

Details of your affirmative answers: Begin by indicating the number of the question number.

Part 7 - Authorizations and Signatures

I, the undersigned, as the Policyowner or the proposed Insured, declare that the statements, answers and information provided in this application and in any documents which by agreement form part of this application are complete and true. I understand that any misrepresentation or omission may result in the cancellation of any insurance coverage obtained through this application. I authorize Humania Assurance Inc., its reinsurers, other insurers and its teleunderwriting agent, to obtain from any organization or person, any physician or practitioner, hospital, clinic or medically related facility, other insurance or reinsurance companies, the Medical Information Bureau, financial institutions, third party investigation agencies, any personal information, medical history on record on me and my health or my insurability for the purpose of underwriting my application and for administering any claim. I relieve these parties or their obligation of confidentiality and further authorize them to release full particulars including prior medical history to Humania Assurance, its reinsurers or other insurance companies. I authorize Humania Assurance, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize Humania Assurance, its reinsurers, other insurance companies and third party investigation agencies hired by Humania Assurance to acquire personal information about me and to include this information in any other files which they currently hold respecting me, or which may be opened in the future. I further authorize Humania Assurance to exchange information about me with its reinsurers and other insurance companies. I also authorize Humania Assurance to refer to any existing files, opened or closed, which they currently hold regarding me. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period.

A photographic copy of this signed consent shall be as valid as the original. The insurer can contest fraudulent declarations beyond the contestable period. **I acknowledge receiving the pre-notice form describing the procedures of the Medical Information Bureau, the Notice concerning Files and Personal Information and the notice regarding the advisor disclosure statement.** No financial advisor or representative is authorized to modify this application form or the policy. **Insurance is a contract based on trust. Failure to fully disclose facts material to this application form can render the contract void.** Any policy issued on this application takes effect only upon acceptance of this application by the Insurer without modification and then only if the first premium is paid in full and there has been no change in the insurability of the proposed insured subsequent to the completion of this application.

Signed at _____ (city/province)

Signature of Representative _____

Date _____

Signature of Policyowner _____

Signature of Parent or Guardian _____ (if other than the Policyowner/children 14 and over must also sign)

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

Personnal Information

Medical Information Bureau Pre-Notice

The information on your insurability will be kept confidential. However, Humania Assurance Inc., may submit a brief report to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies wich operates an information exhange on behalf of its members. If you apply for life, critical illness or health insurance to another MIB member company, or if a claim for benefits is submitted to a member company, the Bureau will supply such company with the information in this file.

Upon receipt of a request from you, the Bureau will arrange a disclosure of any information it may have in your life. If you question the accuracy of information in the Burea's life, you may contact the Bureau and seek a correction.

The Bureau's address is : Medical Information Bureau, 330 University Avenue, Toronto, Ontario, MG5 1R7 • Telephone no. 866-692-6901 • (TTY) 866-346-3642.

Humania Assurance Inc., may also release information in its file to other insurance companies to wich you may apply for life, critical illness or disability insurance.

Notice Concerning Files and Personal Information

In order to ensure the confidentiality of the personal information held concerning you, Humania Assurance Inc., will establish a file in which the information concerning your application for insurance and information concerning any insurance claim will be held.

Access to this file will be restricted to Humania Assurance employees, reinsurers or mandatories who will be responsible for underwritting, administration, investigation and claims, or any other person designated or authorized by you. Your file will be kept at the Company's head office.

You are entitled to examine the personal information contained in this file and, if required, to have the information corrected by submitting a written request to the address below:

Access to Information Officer, Humania Assurance, 1555, Girouard Street West, Postal Box 10000, Saint-Hyacinthe (Quebec) J2S 7C8.

Please be informed that, in the regular process of examining your application, Humania Assurance may request an investigation report to gather information based on personal interviews with your acquaintances. The investigation may cover your reputation, lifestyle and finances. A representative of the company retained to prepare these reports may also visit or telephone you.

Humania Assurance Inc.

1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8
Web site: www.humania.ca

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