HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

DECLARATION OF INSURABILITY

Part 1 - Identification

Policy n°:

Insured First Name:

Insured Last Name: Sexe : ☐ F ☐ M

Phone number:

Date of birth:
year / month / day

Occupation:

Part 2 - Purpose of declaration

☐ Reinstatement*

☐ Request for non smoker rate

☐ Revision of terms

☐ Policy delivery

* Include the premium due payment and if the policy payment method is by pre-authorized debit, the Pre-Authorized Debit Agreement (PDA) form.

Part 3 - General Information

Please provide details to affirmative answers in Part 8 - 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 and the relevant dates.		
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?	☐	☐
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 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?	☐	☐

Part 3 - General Information (...continued)

	Please detail your affirmative answers to Part 8 - General Comments	Yes	No
9	Is there an other application pending or issued with an other company in the past 6 months?	☐	☐
10.	In the past three (3) years, have you travelled outside Canada or do you intend to do so except for vacation?	☐	☐
11.	Have you traveled outside of Canada in the last 14 days?	☐	☐
12.	Do you have a illness or are you affected by a mental or physical disability?	☐	☐
13.	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?	☐	☐

Part 4 - Medical Information

Please provide details to affirmative answers to Part 8 - General Comments

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

	HAS OR IS THE PERSON TO BE INSURED	Yes	No
2.	Taking medication, following a diet or taking homeopathic products ?	☐	☐
	Type: _____ Reason: _____		
3.	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: _____	☐	☐
4.	In the past three years,had to leave her job or her regular occupation for a period of 30 day or more due to illness or injury?	☐	☐
	Date: _____ Reason: _____		
5.	Has been Aware of any symptom or disease, for which yet no doctor has been consulted and no treatment has been received?	☐	☐
6.	Plans to consult a doctor or any other health professional or undergo surgery?	☐	☐
7.	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 5		

Part 4 - Medical Information (...continued)

Please provide details to affirmative answers in Part 8 - General Comments

HAS OR IS THE PERSON TO BE INSURED	Yes	No
8. Has undergone, is to undergo or has been advised to undergo testing for HIV or AIDS?	☐	☐

Date: _____ Reason: _____

Result: _____

Part 5 - 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 viewed: _____

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 6 - 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)				

Part 7 - Authorizations and Signatures

I, the undersigned, as the Policyowner or the proposed Insured, declare that the information provided is complete and true, and I accept that it is an integral part of my application for insurance. I acknowledge that any false declaration or omission could void the coverage obtained through this application.

I authorize Humania Assurance Inc., its agents, service providers, reinsurers and other partners (hereinafter *"Business Partners"*) to collect, by any electronic means, email, fax or mail, and to use all personal information relevant to the determination of my insurability in connection with this insurance policy.

I further authorize Humania Assurance Inc. to exchange the personal information collected about me with its *Business Partners*, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate. I also authorize Humania Assurance Inc. to make a brief report of the personal information pertaining to my insurability to the *Medical Information Bureau (MIB)*.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or health professional, any public or private health and social services institution, any insurance or reinsurance company, the *Medical Information Bureau (MIB),* any financial institution, and any personal information officer or investigative agency.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector*, including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

The Insurer may contest any fraudulent statement beyond the contestability period. I acknowledge that I have understood any Conditional Insurance Receipt and that I have received and read the Personal Information Notice, the *Medical Information Bureau (MIB)* text, and the Disclosure Statement under the *Financial Institutions Act*. An insurance contract is based on good faith. Any incomplete disclosure of important facts in this declaration of insurability constitutes a breach that may result in the cancellation of the policy. Any policy issued in connection with this declaration of insurability will take effect on the date the Insurer approves the risk, provided that it is approved without change, the first premium has been paid, and no change has occurred in the proposed Insured's insurability since this declaration of insurability was signed.

Signed at: _____ On: _____

Signature of Representative: _____ Signature of Person to be insured (if aged 13 or older): _____

Signature of the Parent/Guardian of the person to be insured (if aged 13 or under): _____

Signature of Policyowner: _____

Part 8 - Authorizations in case of death

During my lifetime and in the event of my death, I authorize Humania Assurance Inc., its agents, service providers and other partners (hereinafter *"Business Partners"*) to collect, by any electronic means, email, fax or mail and to use all personal information relevant to the adjudication of any claim submitted under this insurance policy.

I further authorize Humania Assurance Inc. to exchange the personal information collected about me with its *Business Partners,* whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

In the event of my death, the holder, the subrogated holder and the beneficiary of my insurance policy, the heir and the liquidator of my estate are expressly authorized to provide Humania Assurance Inc. and its *Business Partners* with all authorizations and personal information for the purpose of adjudicating the claim.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician, psychologist or other health professional, any public or private health and social services institution, any occupational health and safety plan, motor vehicle accident insurance plan or health insurance plan, including the various provincial health plans, including but not limited to the Régie de l'assurance-maladie du Québec, any pharmacy, any financial institution including insurance or reinsurance companies, any personal information officer, and any investigative, police or security agency. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector*, including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

Signed at: _____ On: _____

Signature of the Person to be insured (if aged 14 or older): _____

Part 9 - General comments

Details of your affirmative answers must be preceded by the number of the concerned issue.

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 file.

If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. Please contact MIB to Canadadisclosure@mib.com or calling 866-692-6901. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

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

For the purposes of administering your insurance file and ensuring its confidential nature, Humania Assurance Inc. will create an insurance file containing the information regarding your (Policyowner and/or Insured) application for insurance, as well as information on any insurance claims.

Only employees or agents responsible for underwriting, investigations or claims, as well as any other people authorized by you, will have access to this file. Your file will be kept at the Company's head office.

You have the right to review the personal information contained in this file and, if required, have it corrected by submitting a written request to: **Access to Information Officer: Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6.**

You also have the right to withdraw, at any time, any authorization given in connection with the communication and use of the personal information contained in your file.

As part of the standard processing of insurance proposals, all insurance companies, including Humania Assurance Inc., may request a personal investigation or a consumer report containing personal information on the individuals to be insured. You may be contacted to this effect.

HUMANIA ASSURANCE INC.

1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

Web site: www.humania.ca

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