HUMANIA ASSURANCE MD®

Health Declaration Group Association Insurance Application

Identification of the insured

Policy Number(s):

First Name:

Middle Name:

Last Name:

Group Association Insurance Application Health Declaration.
To be eligible for Group Association Insurance, the insured must answer NO to all the questions. A maximum of $2,000 per Pro Health Accident Sickness and Pro Health Payments Insurance can be issued for a maximum combined total amount of $3,000. This declaration is also used to determine the admissibility for the life insurance up to a maximum of $100,000 of ProHealth Insurance Payment Plan.

Admissibility and Insurability

Question		Yes	No
1.	In **the last 6 months**, have you experienced any physical or mental discomforts or symptoms for which you have not yet consulted a healthcare professional?	☐	☐
2.	In **the last 2 years**, have you undergone treatment (including participation in a support group or counseling), been advised to reduce your consumption, or sought treatment for drug or alcohol uses?	☐	☐
3.	Has the person to be insured been diagnosed with or consulted a healthcare professional for any of the following conditions:		
	a) Musculoskeletal disorders or symptoms (including skeleton, muscles, and joints) and spinal conditions that caused an absence from work of five (5) or more working days during the last twenty-four (24) months;	☐	☐
	b) Alzheimer's Disease;	☐	☐
	c) Thoracic or abdominal aortic aneurysm;	☐	☐
	d) Rheumatoid or psoriatic arthritis;	☐	☐
	e) Breast cancer;	☐	☐
	f) Cancer diagnosed within the last 5 years, except basal cell skin cancer and in situ cervical cancer;	☐	☐
	g) Hepatic cirrhosis;	☐	☐
	h) Diabetes (type 1 or 2);	☐	☐
	i) Epilepsy (grand mal, seizure within the last 6 months);	☐	☐
	j) Chronic fatigue syndrome;	☐	☐

4100-139-en
2025/03

Admissibility and Insurability (cont.)

Question		Yes	No
	k) Fibromyalgia;	☐	☐
	l) Hepatitis B or C;	☐	☐
	m) Chronic renal failure;	☐	☐
	n) Leukemia;	☐	☐
	o) Lymphoma;	☐	☐
	p) Systemic lupus erythematosus;	☐	☐
	q) Any heart or blood vessel disorder, stroke, or transient ischemic attack; excluding functional heart murmurs, controlled and treated hypertension, or controlled and treated cholesterol?	☐	☐
	r) Inflammatory bowel disease that caused an absence from work of more than fifteen (15) working days during the last twenty-four (24) months;	☐	☐
	s) Chronic obstructive pulmonary disease;	☐	☐
	t) Peripheral vascular disease;	☐	☐
	u) Chronic pancreatitis;	☐	☐
	v) Parkinson's disease;	☐	☐
	w) Multiple sclerosis;	☐	☐
	x) Amyotrophic lateral sclerosis;	☐	☐
	y) Acquired immunodeficiency syndrome (AIDS);	☐	☐
	z) Myeloproliferative syndrome;	☐	☐
	aa) Organ transplantation;	☐	☐
	bb) Psychological or psychiatric disorders currently under treatment or requiring treatment for more than one year in the past;	☐	☐
4.	Is the person to be insured hospitalized or disabled on the date of signing this Group Association Insurance application?	☐	☐
5.	In the past ten (10) years, has the person to be insured ever been subject to a surcharge (rated), amendment instead of endorsement, or medical exclusion, reduction in coverage, instead of deferred request use postponement or refusal of insurance application, refusal of insurance application, or reinstatement?	☐	☐

Signatures

Exclusion for pre-existing conditions
(applicable for disability benefits in the case of accident and sickness and for the critical illness benefit included).

With regard to any amount granted with the Association Form declaration, no benefit will be payable for a claim relating to an event occurring within (12) months following the effective date of the coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed medication, treatments or diagnostic tests in the twelve (12) month period preceding the effective date of coverage.

I, the undersigned, as 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.

Signed at _____ Date _____

Signature of Representative _____

Signature of the Insured _____

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6