Declaration of Insurability

Please send this application form to the appropriate address or number shown below

By mail or fax: La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St., PO Box 1500, Quebec, QC G1K 8X9
t: +1.418.781.7640 or 1.844.580.7640 | f: +1.418.780.9489 or 1.855.896.9489
By email: perspective@lacapitale.com

Policy no.: 103999 **Identification no. (for changes to an existing policy):**

1. Identification

Policyholder (you):

Last name and first name: ____________ **Name at birth (if different):** ____________

Gender: ☐ M ☐ F **Date of birth:** (yy/mm/dd) ____________

Mailing address: ____________

City: ____________ Prov.: ____________ Postal code: ____________

Home phone: ____________ **Other phone:** ____________

Your spouse (couple coverage):

Last name and first name: ____________ **Name at birth (if different):** ____________

Gender: ☐ M ☐ F **Date of birth:** (yy/mm/dd) ____________

2. Policyholder employment information

Occupation: ____________

3. Height and weight of proposed insureds

Proposed insured	Height ☐ cm ☐ ft./in.	Current weight ☐ kg. ☐ lb.	Weight one year ago ☐ kg. ☐ lb.	Reason for variation if any
Policyholder				
Spouse				

4. Insurance history

Have you ever had a life, critical illness, travel or disability insurance application declined, postponed, modified or subject to a rating or exclusion?

Proposed insured	No	Yes	Date (year/month)	Name of insurer	Type of insurance	Reason for decision
Policyholder	☐	☐				
Spouse	☐	☐				

5. Tobacco or drug use

	Policyholder	Spouse
During the last 12 months, have you smoked cigarettes, cigarillos, a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum?	☐ Yes ☐ No	☐ Yes ☐ No
If you quit in the last 12 months, please indicate the date that you quit. (year/month):		
Have you ever used medication or drugs for other than medical reasons?	☐ Yes ☐ No	☐ Yes ☐ No
Name of substance:		
Date last used (year/month):		

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6. Medical and personal information

Important: Please answer all questions and provide details regarding any "Yes" answers in section 7.

	Has the proposed insured:	**Policyholder**		**Spouse**	
1.	Been unable to go about his or her regular duties as a result of convalescence, illness or injury in the last three years? If so, indicate the period and the reason.	☐ Yes ☐ No		☐ Yes ☐ No	
2.	Ever exhibited symptoms, consulted a physician or been treated for one of the following: cardiac or blood vessel disorder, kidney disorder, pulmonary disorder, anxiety disorder, neurological disorder, psychological disorder, back trouble, high cholesterol, arthritis, high blood pressure, diabetes, hepatitis, ulcerative colitis, Crohn's disease, cancer, tumor, HIV positivity, AIDS, multiple sclerosis or health problem resulting from an accident? If so, provide the name and address of your attending physician.	☐ Yes ☐ No		☐ Yes ☐ No	
3.	Suffered from a disability, malformation or other physical, nervous or mental illness? If so, please specify.	☐ Yes ☐ No		☐ Yes ☐ No	
4.	Taken medication, used homeopathic products, received treatment or followed a diet? If so, please specify.	☐ Yes ☐ No		☐ Yes ☐ No	
5.	Consulted a physician, therapist or other healthcare professional (psychologist, chiropractor, etc.), including alternative medicine, or been admitted to a hospital or other medical establishment in the last five years?	☐ Yes ☐ No		☐ Yes ☐ No	
6.	Plan to consult a physician, therapist or other healthcare professional (psychologist, chiropractor, etc.), including alternative medicine, or undergo a surgical procedure in the next 12 months?	☐ Yes ☐ No		☐ Yes ☐ No	
7.	Undergone, or been asked or encouraged to undergo, an HIV (AIDS) screening test? If so, indicate the date and the results.	☐ Yes ☐ No		☐ Yes ☐ No	
8.	Taken part in flights other than as a passenger in the last two years, or does he or she have plans to do so?	☐ Yes ☐ No		☐ Yes ☐ No	
9.	Taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity in the last two years, or does he or she have plans to do so?	☐ Yes ☐ No		☐ Yes ☐ No	
10.	Had, in the last three years, his or her driver's licence suspended or revoked? If so, indicate the date and the reason.	☐ Yes ☐ No		☐ Yes ☐ No	
11.	Travelled or resided outside Canada or the United States in the last two years, or does he or she plan to do so in the next two years? If so, indicate the country, the date, the reason and the length of the period abroad.	☐ Yes ☐ No		☐ Yes ☐ No	
12.	Consumed alcoholic beverages?	☐ Yes ☐ No		☐ Yes ☐ No	
		Weekly amount:			
	If so:	Now	One year ago	Now	One year ago
	Beer (glasses):				
	Wine (glasses):				
	Spirits (ounces):				
13.	Undergone, or been encouraged to undergo detoxification for drugs or alcohol? If so, indicate the date and the reason for treatment.	☐ Yes ☐ No		☐ Yes ☐ No	

7. Explanations

To be completed for each of the **yes** answers in section 6. If you need extra space, attach an extra sheet to this application and ensure it is signed and dated by the proposed insured.

Question no.	Name of insured	Dates and reasons for medical consultations, illnesses, diagnoses, hospitalizations, surgical procedures, treatments, medications and dosages, test results, names and addresses of physicians or hospitals visited, length of absences from work or any other information relevant to the questions included in section 6.

8. Authorization and declaration

"I authorize any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency, any market intermediary, any employer or ex-employer, as well as any person holding personal files or information, particularly medical records pertaining to myself or my spouse, as the case may be, to provide to La Capitale Civil Service Insurer Inc. (La Capitale) or its agents or mandataries, any information it may hold that may be required for the processing of my file.

I also authorize La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file."

This authorization shall be valid for the purposes of this policy and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original.

"I hereby confirm that the information provided in this form is true and complete, in the knowledge that La Capitale shall base its decision to approve or decline my application on this information. I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance policy to be cancelled."

Policyholder's signature	Date	Spouse's signature	Date

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