

C. P. 3000 Lévis (Québec) G6V 9X8

EVIDENCE OF INSURABILITY

Always attach copy of enrollment form or insurance application when submitting this form

GROUP INSURANCE

CONTRACT OR GROUP POLICY NO.
ACCOUNT OR DIVISION NO.

First name, la	st name and address of participa	ant			Name a	and addres	s of emplo	oyer						
-														
			Po	stal Code								Pos	tal Code	e
Place of birth (province, state, country) Certificate number Occupation						Telephone numbers Home								
Are you presently If so, number of hours w				veek – If you are	not wo	rking, state	reason			Work:	Α	rea cod	le + No).
working?														
	FIRST NAME	LAST NAME	SEX	DATE OF B		HEIGHT	WEIGHT	Weight one year	ago REASON FOR	CHANGE	IN WEI	GHT (IF	APPLIC	ABLE)
PARTICIPANT			□F □M	DD/MM/Y	YYY									
SPOUSE			□F□M	DD/MM/Y	YYY									
			□F□M	DD/MM/Y	YYY									
CHILDREN			□F□M	DD/MM/Y	YYY									
			□F□M	DD/MM/Y	YYY									
										Г	DADTI	CIPANT	SPO	
QUESTION	NAIRE (to be completed for	or all purposes)									YES	NO	YES	NO
1. Have yo	ou ever had an application for it	nsurance declined or mo	dified, or ap	proved with an	exclusi	on or extra	a premium	1?						
2. Have yo	ou ever used tobacco in any for	m during the past 12 mc	onths?											
3. Are you	currently being treated by a ph	nysician or another healt	h care profe	ssional or takin	g any m	nedication'	?							
4. Are you	intending to consult a physicia	ın or another health care	professiona	al, or to undergo	surger	y?								
5. Have yo	ou ever suffered from an infirmi	ty, a deformity or any oth	ner physical	, nervous or me	ntal dis	order?								
6. Have yo	ou ever undergone an electroca	ardiogram, an X-ray, a m	ammograph	ıy, a blood test	or any o	other exam	nination?							
7. Have yo	ou ever undergone or been adv	rised to undergo laborato	ory tests for	the detection of	the AID	OS virus or	r antibodie	es to the virus	•					
8. Have yo	ou ever been prescribed a diet,	medication, treatment o	r surgery?											
Have you ever been treated in a hospital, clinic or rehabilitation centre?														
10. Have you ever claimed or received benefits or been absent from work for more than 10 consecutive days because of an illness or accident?														
11. Have you ever been treated for alcohol or substance abuse?														
12. Have yo	ou ever received abnormal diag	nostic test results?												
13. Have yo	ou ever experienced symptoms	for which a health care	professiona	I was not consu	Ilted?									
14. Have yo	ou ever consulted a physician o	or another health care pr	ofessional fo	or any physical	or ment	al disorde	r not men	tioned above?						
	ny of the children to be insure ce rejected, rated, modified or o		art, lung, ne	eurological or m	nental p	roblems, c	cancer or	diabetes or h	ad an application	for	ı	□ YES	□ NC)
If the reque	sted coverages are for depend	dent children, please als	o answer q	uestion 17.										

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS.

Ques- tion No.	First name	Nature of illnesses, surgeries, accidents, consultations, examinations, treatments, medication, results	Date	Duration Illness Hosp.		Name and address of physicians or hospitals				
	Use separate sheet if necessary.									



16. What is y	our weekly tion or use	of: PAF	RTICIPANT		tobacco	alcoholic beve	erages	narcotics or drugs	SPOUSE	tobacco	alcoholic bevera	ges nai	cotics or drugs
17. Is there a	ny history i	n your fam						l nigh cholesterol, high blo		I s, kidney disease, multip	le sclerosis, Hunting	ton's chorea	, polyposis coli,
Cancer, A	Izneimer's ☐ No				the table below.			se or other hereditary dis location.	eases?				
	Cir	cle the fa	nily memb	er				Illness(es) (if cancer: t	ype)		Age at onset of the illness	Age if aliv	e Age at death
PARTICIPAN	Father	Mother	Brother	Sister									
	Father	Mother	Brother	Sister									
SPOUSE	Father	Mother	Brother										
	Father	Mother		Sister									
CHILDREN	Father	Mother	Brother										
						dles the persor	nal infori	mation it has on you in tion is consulted solely	a confidential man				ay benefit from
								monstrate that it is inac ompany, 200, rue des				nust send a	written request
					surance product to the Privacy (erminatio	on of their group insura	ance. If you do not v	vish to receive these o	offers, you may have	e your nam	e removed from
transferred t	o another at www.c	country a lsf-dfs.cor	nd be subj n, or write	ect to th to the D	ne laws of that o	ountry. For info	ormation	ities in its normal cour n about DFS's policies cated above. The Priva	and practices in te	rms of transferring per	sonal information of	utside of C	anada, visit the
							NOTIC	CE REGARDING THE	MIB				
MIB, Inc., fo	rmerly kn to anothe	own as N r MIB me	ledical Info	ormatic	on Bureau, a no	n-profit memb	ership o	ncial Security Life Ass organization of insura or a claim for benefits	ince companies, w	hich operates an info	ormation exchange	on behalf	of its member.
	y contact	MIB and	seek a cor					n your file. Please cor et forth on its website					
								release information f mers about MIB may				ay apply fo	or life or health
	DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. This consent is also for the collection, use and communication of personal information concerning my minor children, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original. I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance. If the Desjardins Financial Security Life Assurance Company medical director deems appropriate, I authorize him to send the information that he obtained to analyze my application or that supports the Company's decision to the following physician: Name and address of participant Signature of participant Signature of participant												
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