SSQ insurance

DECLARATION OF INSURABILITY

Name of Participant	Name of Employer
Participant's Address	
Home Telephone	Work Telephone
Name of Proposed Insured	☐ Participant ☐ Spouse ☐ Child
Occupation	Date of Birth Y M D ☐ Male ☐ Female

1. a) Height: _____ ft _____ in or _____ cm Weight: _____ lb or _____ kg

1.b) Weight loss over the past year? ☐ Yes ☐ No If yes, how much: _____ lb _____ kg Cause: _____

2. a) Name and address of your family physician or medical facility: _____

b) Date and reason for last consultation: _____ Results? _____

c) Describe the symptoms that motivated this consultation: _____

d) Tests performed? _____ Results? _____

e) Future tests recommended? _____ Treatment or medication prescribed? _____

	3. Indicate whether you ever had symptoms, been told you have symptoms, sought medical attention or received treatment for any of the following:	Yes	No
a)	Eye, ear, nose or throat disorders;	☐	☐
b)	Dizziness, fainting, convulsions, epilepsy, headaches, paralysis, paresthesia, numbness, neurological condition, meningitis, motor neuron disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease, degenerative disease;	☐	☐
c)	Shortness of breath, persistent hoarseness or cough, coughing up blood, chronic bronchitis, pleurisy, asthma, emphysema, sleep apnea or other respiratory disorders;	☐	☐
d)	Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, angina, cardiomyopathy, heart enlargement, pulmonary hypertension, abnormal ECG, stroke (CVA), transient ischemic attack (TIA), cardiac arrhythmia, peripheral vascular disease, ankle swelling, phlebitis or any other disorders of the heart or blood vessels;	☐	☐
e)	Hepatitis, carrier of hepatitis, cirrhosis, jaundice, intestinal bleeding, ulcer, colitis, ulcerative colitis, Crohn's disease, ileitis, diverticulitis, or other disorders of the esophagus, stomach, intestine, liver or pancreas;	☐	☐
f)	Sugar, blood, pus or protein in urine, chronic kidney disease, renal failure, nephritis, stones or other disorders of the kidneys, bladder, prostate, testicles or reproductive organs, sexually transmitted disease, breast disorder including lumps, cysts, other physical changes or abnormal mammogram findings or biopsy;	☐	☐
g)	Diabetes, thyroid, high cholesterol or other endocrine disorders;	☐	☐
h)	Depression, anxiety, adjustment disorder, panic disorder, burn-out, bipolar disorder, chronic fatigue, insomnia, suicide attempts, suicidal thoughts, eating disorder, attention deficit with hyperactivity (ADHD), schizophrenia, mental deficiency, autism spectrum disorder or any other mental health disorder;	☐	☐
i)	Lupus, scleroderma, muscular dystrophy, gout, back and neck pain or disorder, osteoarthritis, herniated disc, sprain, tendinitis, bursitis, arthritis, rheumatoid arthritis or any other disorder affecting bones, muscles, ligaments or joints such as shoulders, elbows, wrists, hands, hips, knees, ankles or feet;	☐	☐
j)	Physical deformity, amputation, lameness or disability;	☐	☐
k)	Cancer or tumor, cyst, polyp, mole, mass or growth, lump, skin or lymph gland disorders;	☐	☐
l)	Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), HIV positive or any other disorder of the immune system, test indicating the presence of the AIDS virus or antibodies to the AIDS virus or blood disorders such as anemia and coagulation disorder;	☐	☐
m)	Any mental or physical disorder not mentioned above.	☐	☐
4.	Within the past 5 years, have you:		
	a) consulted a chiropractor, physiotherapist, psychologist, acupuncturist, audiologist, speech therapist, osteopath, podiatrist or any other health care professional?	☐	☐
	b) had an electrocardiogram (resting or stress), echocardiogram, X-Ray, MRI, blood test, biopsy or any other test?	☐	☐
	c) been a patient in a hospital or a clinic?	☐	☐
5.	Are you currently taking any medications, receiving any treatment(s) or following a special diet?	☐	☐
6.	Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done, which was not completed?	☐	☐
7.	Do you intend to consult a health care professional such as a psychologist, chiropractor, osteopath or other?	☐	☐
8.	Do you have any signs or symptoms for which you have not sought treatment or consulted a doctor?	☐	☐
9.	Within the past 5 years, have you been absent from work or had to stop your ordinary activities for a period of 7 days or more due to illness(es) or injury(ies)?	☐	☐

Please provide details for any question answered "YES" in questions 3 to 9. If additional space is required, please attach a separate sheet duly dated and signed.

Question #	Nature of disorder	Date of first occurrence	Frequency of episodes	Medication / Treatment	Date of recovery or current status

10. Family history Do any of the family members suffer or have they ever suffered from heart disease, primary pulmonary hypertension, cancer, diabetes, polycystic kidney disease, mental illness, stroke, cerebrovascular disease, neurological conditions, motor neuron disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's disease, haemophilia, muscular dystrophy or any other hereditary disorder?If yes, provide details:

Yes ☐ No ☐

	Illness(es)	Age at onset	Age if alive	Age at death		Illness(es)	Age at onset	Age if alive	Age at death
Father					Brother(s)				
Mother					Sister(s)				

Answer questions 11 to 18. Children under the age of 16 do not have to answer these questions. Yes ☐ No ☐

11. a) Do you consume alcoholic beverages? If yes, quantity per week: Beer: _____ bottle(s), Wine: _____ glass(es), Liquor: _____ ounce(s) ☐ ☐

b) Has your level of consumption been higher in the past? If yes, state when and why you changed your consumption habits: ☐ ☐

Date: Y M Reason: _____

Previous quantity per week: Beer: _____ bottle(s), Wine: _____ glass(es), Liquor: _____ ounce(s)

c) Do you use or have ever used drugs such as cannabis (marijuana, haschich, etc), LSD, cocaine, heroin, amphetamines (speed), anabolic steroids or other narcotics? ☐ ☐

If yes, provide details:

Type: _____ quantity: _____ frequency: _____ duration: from Y M to Y M

Type: _____ quantity: _____ frequency: _____ duration: from Y M to Y M

d) Have you ever undergone drugs or alcohol detoxification treatment or been advised to do so? ☐ ☐

If yes, date: Y M Name of Institution: _____

12. Within the past 12 months, have you used tobacco in any form, including cigarettes, cigarillos (small cigars), cigars, pipe, chewing tobacco or snuff, shisha, betel nuts, Nicorette chewing gum, electronic cigarette or any other tobacco-derivative or nicotine-containing product? ☐ ☐

If yes, type: _____ daily quantity: _____ date of last use: Y M

13. a) In the last 2 years, have you travelled or lived outside of Canada or the United States? ☐ ☐

If yes, date: Y M Destination: _____ Duration of trip: _____

b) In the next 2 years, do you intend to travel or live outside of Canada or the United States? ☐ ☐

If yes, date: Y M Destination: _____ Duration of trip: _____

14. Within the past 5 years, has your driver's licence been suspended or taken away from you? ☐ ☐

If yes, date: Y M Reason: _____

15. Have you ever been convicted of a criminal offence or are there any charges pending against you ? ☐ ☐

If yes, date: Y M Type of criminal offence: _____ Sentence: _____

16. Within the past 2 years, have you practiced a high-risk activity such as mountain climbing, parachuting, motor vehicle racing, hang-gliding, scuba diving, flying in an ultra-light or privately owned aircraft or other? ☐ ☐

If yes, activity: _____ Date of most recent participation: Y M

Do you intend to practice any of these activities in the next 2 years? If yes, activity: _____ ☐ ☐

17. Has any application for insurance filled by you been refused or been modified or accepted with an extra premium or exclusion? ☐ ☐

If yes, date: Y M Reason: _____ Insurer: _____

18. For women only: Are you currently pregnant? Yes ☐ No ☐

If yes, a) Expected due date: Y M

b) Are you experiencing any complications with the pregnancy? Yes ☐ No ☐ If yes, provide details: _____

c) Is the delivery anticipated to be normal? Yes ☐ No ☐ If no, provide details: _____

MIB, Inc.

Information regarding your insurability will be treated as confidential. SSQ, Life Insurance Company Inc. (hereinafter called "SSQ") or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, health or accident insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, ON M5G 1R7. SSQ or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life, health or accident insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL INFORMATION PROTECTION

To safeguard the confidentiality of your personal information, SSQ, Life Insurance Company Inc. (hereinafter called "SSQ") constitutes an insurance file to hold information about your application for insurance and any claims you make.

Access to your file is restricted to those employees, mandataries, service providers and reinsurers of SSQ who must consult your file for purposes of insurance contract management, risk assessment, investigations and claims adjudication, as well as any other person you may authorize.

Your file is kept at SSQ's offices. You may consult the personal information contained in your file, and have any errors or inaccuracies rectified, by making a written request to the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Blvd, P.O. Box 10500, Station Sainte-Foy, Quebec, QC G1V 4H6, to the attention of the Personal Information Protection Officer. SSQ has a strict Personal Information Protection Policy. To obtain a brochure outlining this policy, you may send a request in writing to SSQ's Personal Information Protection Officer at the address provided above or visit the website ssq.ca

DECLARATION AND AUTHORIZATION TO OBTAIN AND TO DISCLOSE PERSONAL INFORMATION TO OTHERS

I hereby declare that I have read this statement and I certify that the answers recorded above are full, complete, true and consistent with the statements I have made. I understand that these answers shall form the basis of the insurance contract. I also understand that any misrepresentation or concealment on my part may lead to insurance being cancelled. I acknowledge that I have kept a complete and duly signed copy of this form.I have read both notices above regarding personal information protection and the MIB, Inc. and I concur with the contents thereof.

I hereby authorize SSQ, Life Insurance Company Inc., as well as its mandataries, service providers and reinsurers, as required for determining insurability and for insurance management, including claim settlement purposes:

a) to obtain information, solely to the extent required for processing my file, from any individual or corporation, or any public or parapublic organization which has personal information about me or about my dependents, according to the terms of the contract, including any physician or health care professional, any medical facility, the MIB, Inc. and any other insurer; and

b) to only disclose the personal information that they may have about me or about my dependents, according to the terms of the contract, to the extent required, to such individual or organization.

A copy of this authorization shall be as valid as the original. This authorization shall be valid only for the period necessary to effect the purposes stated herein.

Date: **X** Y M D

Signature of Proposed Insured: **X** _____

(Parent or guardian if for a child under age 18)