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Desjardins Insurance
LIFE • HEALTH • RETIREMENT

Health and lifestyle questionnaire (Evidence of insurability)

GROUP INSURANCE

3 steps to follow after completing this questionnaire:

- Make a complete copy for your records
- Attach a copy of your insurance application to the questionnaire
- Mail this questionnaire with the copy of your insurance application to the following address: Desjardins Insurance, C.P. 3000, Lévis (Québec) G6V 9X8

Contract number

Account number

Certificate number

A. Member

First name, last name and address of member

Address - No., street, apt. | City | Province | Postal Code

Telephone numbers
Home (Area code + No.): | Work (Area code + No.):

Occupation:

This information is required to process your application.

Place of birth (province, state, country)

Are you presently working? ☐ Yes ☐ No

If so, number of hours worked each week – If you are not working, state reason

B. Employer

Name and address of employer

C. Proposed insureds

Member			Spouse		
First name / Last name			First name / Last name		
Sex ☐ F ☐ M	Date of birth yyyy - mm - dd		Sex ☐ F ☐ M	Date of birth yyyy - mm - dd	
Height ☐ ft in ☐ cm	Weight ☐ lb ☐ kg	Weight one year ago ☐ lb ☐ kg	Height ☐ ft in ☐ cm	Weight ☐ lb ☐ kg	Weight one year ago ☐ lb ☐ kg
Reason for change in weight (if applicable)			Reason for change in weight (if applicable)		

Child 1		Child 2		Child 3	
First name / Last name		First name / Last name		First name / Last name	
Sex ☐ F ☐ M	Date of birth yyyy - mm - dd	Sex ☐ F ☐ M	Date of birth yyyy - mm - dd	Sex ☐ F ☐ M	Date of birth yyyy - mm - dd
Height ☐ ft in ☐ cm	Weight ☐ lb ☐ kg	Height ☐ ft in ☐ cm	Weight ☐ lb ☐ kg	Height ☐ ft in ☐ cm	Weight ☐ lb ☐ kg
Weight one year ago ☐ lb ☐ kg		Weight one year ago ☐ lb ☐ kg		Weight one year ago ☐ lb ☐ kg	
Reason for change in weight (if applicable)		Reason for change in weight (if applicable)		Reason for change in weight (if applicable)	

D. Health questionnaire

		Member Yes	Member No	Spouse Yes	Spouse No
1.	Are you currently being treated by a physician or another health care professional or taking any medication?	☐	☐	☐	☐
2.	Are you intending to consult a physician or another health care professional, or to undergo surgery?	☐	☐	☐	☐
3.	Have you ever suffered from an infirmity, a deformity or any other physical, nervous or mental disorder?	☐	☐	☐	☐
4.	Have you ever undergone an electrocardiogram, an X-ray, a mammography, a colonoscopy, a blood test or any other examination?	☐	☐	☐	☐
5.	Have you ever undergone or been advised to undergo laboratory tests for the detection of the AIDS virus or antibodies to the virus?	☐	☐	☐	☐
6.	Have you ever been prescribed a diet, medication, treatment or surgery?	☐	☐	☐	☐
7.	Have you ever been treated in a hospital, clinic or rehabilitation centre?	☐	☐	☐	☐
8.	Have you ever claimed or received benefits or been absent from work for more than 10 consecutive days because of an illness or accident?	☐	☐	☐	☐
9.	Have you ever received abnormal diagnostic test results?	☐	☐	☐	☐
10.	Have you ever experienced symptoms for which you have not yet consulted a health care professional?	☐	☐	☐	☐
11.	Have you ever consulted a physician or another health care professional for any physical or mental disorder not mentioned above?	☐	☐	☐	☐
12.	Have any of the **children to be insured** ever suffered from heart, lung, neurological or mental problems, cancer or diabetes or had an application for insurance rejected, rated, modified or deferred?	☐ Yes	☐ No		

Complete the table below for each question to which you answered yes. Use an additional sheet if needed.

No.	First name	Nature of illnesses, surgery, accidents, consultations, examinations, treatments, medication, results	Date	Length of illness/ disability	Length of hospitalization (if applicable)	Name and address of physicians or hospitals
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	

E. Lifestyle questionnaire

		Member Yes	Member No	Spouse Yes	Spouse No
1.	In the last 10 years, have you had an application for insurance declined or modified, or approved with an exclusion or extra premium? If yes, indicate the reason and the dates:	☐	☐	☐	☐
2.	In the last 5 years, have you had your driver's license suspended or revoked? If yes, indicate the reason and the dates:	☐	☐	☐	☐
3.	In the last 12 months, have you used any form of tobacco, including e-cigarettes or other tobacco substitutes?	☐	☐	☐	☐
4.	Have you ever been treated for alcohol or substance abuse or been advised to decrease consumption of alcohol or drugs? If yes, indicate the reason and the dates:	☐	☐	☐	☐

5. What is your weekly consumption or use of:	Member	Spouse
tobacco, e-cigarettes or other tobacco substitutes		
alcoholic beverages		
narcotics or drugs		

F. History – ⚠ Complete for each proposed insured

Is there any history in your family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron diseases or other hereditary diseases?

☐ Yes ☐ No If yes, please complete the table below. For cancer, indicate the type.

Check the family member					Illness(es) (if cancer: type)	Age at onset of the illness	Age if alive	Age at death
Member	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				
Spouse	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				
Children	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				

G. Statement and authorization regarding your personal information

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, Inc. 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.

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original. 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 physician: _____

Remember your signature and the date!

_____ Signature of member

_____ Date (yyyy - mm - dd)

_____ Signature of spouse

_____ Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

H. Authorization regarding your personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

Remember your signature and the date!

_____ Signature of member

_____ Date (yyyy - mm - dd)

_____ Signature of spouse

_____ Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

Personal information management

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you can benefit from the financial services (insurance, annuities, credit, etc.) it offers. This information is consulted solely by DFS employees who need to do so in the course of their work.

You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2.

DFS can send promotional information or offer new products to individuals whose names appear on its client list. DFS may also give its client list to another component of the Desjardins Group for the same purposes. If you do not want to receive such offers, you may have your name removed from the list by sending a written request to the Privacy Officer at DFS.

Notice applicable to MIB, Inc.

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Financial Security Life Assurance Company (DFS), its reinsurers and MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you submit an application for life or health insurance coverage for an individual or a benefit claim for an insured to another MIB, Inc. member company, upon request, MIB, Inc. will supply such company with the information it has on file about this person.

MIB, Inc. receives personal information for which the collection, use and disclosure is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Accordingly, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to DFS's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, Inc. is also bound by U.S. laws regarding the disclosure of personal information. If you have any questions about MIB, Inc.'s commitment to ensuring the confidentiality of insureds' personal information, contact the MIB, Inc. Privacy Department at privacy@mib.com.

Upon request, MIB, Inc. will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, Inc. at 416 597-0590. Insureds who dispute the accuracy of the information MIB, Inc. has on record for them can seek a correction in accordance with the procedures set forth on MIB, Inc.'s Website at www.mib.com. They can also write to MIB, Inc.'s information office at 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7.

DFS and its reinsurers can also release information from their files to other insurance companies to which an application for life or health insurance or a benefit claim has been submitted. Consumers can obtain additional information about MIB, Inc. at www.mib.com.