

Declaration of Insurability

Use one form per insured

EQC016

Important: Please print clearly and complete each section as accurately as possible.

Contract # _____	
☐ Reinstatement ☐ Policy amendment ☐ Change from smoker to non-smoker (Urine sample required) Order no. _____	

Section A – Insured's Information

1. First name _____ Last name _____
2. Date of birth _____
3. Address _____
 City _____ Province _____ Country _____ Postal code _____
4. Telephone _____
5. Occupation _____ 6. Employer _____
7. Does the insured work 12 months of the year? ☐ Yes ☐ No If **No**, why not? _____
8. Date of the insured's last medical consultation _____
 Reason _____ Result _____

Physician's information

First name _____ Last name _____
 Address _____
 City _____ Province _____ Country _____ Postal code _____

Section B – Questions Regarding the Insured's Eligibility – Part 1

Since this policy was issued, has the insured:	Yes	No	If Yes , please provide the required details or follow the instructions.
1. Submitted an insurance application to another company or to UV Insurance?	☐	☐	Insurance amount \$ _____ Company name _____ Issue date _____
2. Had a life insurance, critical illness, disability or reinstatement application declined, modified or postponed?	☐	☐	
3. a) Engaged in, or do they intend to engage in, any aviation activities other than as a passenger on commercial flights?	☐	☐	If Yes , please complete the Aviation Questionnaire – EN-1063A (EQC044)
b) Participated in, or do they intend to participate in, sports involving particular risks, such as scuba diving, skydiving, auto racing, gliding, etc.?	☐	☐	If Yes , please complete the questionnaire(s) specific to the sport(s) they have participated in.
c) Travelled or resided, or do they intend to travel or reside, outside North America?	☐	☐	If Yes , please complete the Foreign Travel Questionnaire – EN-1063A (EQC041)
4. a) Consumed or do they consume alcoholic beverages?	☐	☐	Type of alcohol _____ Quantity per: day _____ week _____ month _____ If ceased, date ceased _____ Reason _____
b) Used or do they currently use drugs (marijuana, cocaine, amphetamines or others)?	☐	☐	If Yes , please complete the Drug Use Questionnaire – EN-1063A (FQC043)

Section B – Questions Regarding the Insured's Eligibility – Part 1 (cont.)

Since this policy was issued, has the insured:	Yes	No	If Yes, please provide the required details or follow the instructions.
5. Consulted a physician or other healthcare professional?	☐	☐	Date of consultation _____ Reason _____ Result _____ Physician's name _____ City _____
6. Ever taken or do they currently take any medications?	☐	☐	Reason _____ Name of medication _____ Dosage _____
7. Undergone any tests or examinations or is currently undergoing medical investigation for any discomfort, pain or other health problem?	☐	☐	Date _____ Reason _____ Test _____ Treatment _____ Physician's name _____ Hospital _____
8. Ever had or do they currently have acquired immunodeficiency syndrome (AIDS), an AIDS-related condition (ARC) or any other immune system deficiency, or have they undergone a test indicating the presence of the AIDS virus or antibodies to the AIDS virus?	☐	☐	
9. a) Used tobacco or tobacco products (Nicorette, nicotine patches) in any form or cannabis, marijuana or other similar substances in the past 12 months?	☐	☐	
b) When did they stop using tobacco or tobacco products?	☐	☐	Date _____
10. a) Ever had their driver's licence revoked?	☐	☐	
b) Received any demerit points on their driving record?	☐	☐	
11. a) Please indicate your height and weight: _____ in. or/ _____ cm _____ lbs or/ _____ kg			
b) In the past twelve (12) months, have you lost 10 lbs/4.5 kg or more?	☐	☐	If Yes, please indicate the cause:

12. Family history (complete the entire table for each family member, even if they are in good health)

Parents	Condition (illness)	Age at onset of illness (if applicable)	Current age	Age at death (if applicable)	Cause of death
Father					
Mother					
☐ Brother ☐ Sister					
☐ Brother ☐ Sister					
☐ Brother ☐ Sister					

Section B – Questions Regarding the Insured's Eligibility – Part 2

(To be completed only for AdapCI - Critical Illness).

1. Since this policy was issued, has the insured consulted, been diagnosed with or suffered from any of the following conditions:	Yes	No
a) Ear, eye, nose or throat disorders	☐	☐
b) Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), coughing up blood, sleep apnea, sarcoidosis or other respiratory/pulmonary disorders	☐	☐
c) Nervous system disorders, epilepsy, dizziness, tremors, seizures, multiple sclerosis: optic neuritis, numbness, tingling, loss of balance, weakness in the extremities, vision problems or sensation of vision loss, or other neurological or brain disorders	☐	☐
d) Nervous disorders, attention deficit, hyperactivity, depression, anxiety, burnout, work-related exhaustion, panic disorders, suicidal thoughts or attempts, or other psychiatric, emotional or mental disorders	☐	☐
e) Heart or vascular disorders: chest pain, palpitations, hypertension, rheumatic fever, heart murmur, stroke/cerebrovascular accident (CVA), high cholesterol, transient ischemic attack (TIA), angina, valve abnormalities, bypass surgery, thrombophlebitis or other heart disease or heart surgery	☐	☐
f) Abdominal organ disorders: bleeding, ulcerative colitis, Crohn's disease, hepatitis of any type, hepatitis carrier, steatosis, polyps, diverticulitis or other diseases of the liver, stomach or intestines	☐	☐
g) Kidney, bladder or genital organ disorders: sugar, blood or protein in the urine, kidney stones, prostate enlargement, kidney failure, hysterectomy, precancerous cervical cells or other kidney, bladder or genital organ disorders	☐	☐
h) Blood or gland disorders: diabetes, thyroid gland disorder, pituitary gland disorder, lymphatic gland disorder, anemia, coagulation disorder, hemochromatosis, skin conditions, lupus or other gland, blood or skin disorders	☐	☐
i) Musculoskeletal disorders: paralysis, disorders of the back, neck, muscles, bones, joints, tendons or ligaments, back pain, rheumatism, arthritis, gout, osteoporosis, osteoarthritis, fibromyalgia or other musculoskeletal disorders	☐	☐
j) Benign or malignant tumour, cyst, mole, cancer, tumour, mass, skin lesion, nodule, nevus or has undergone radiotherapy or chemotherapy	☐	☐
k) Genetic disease, incurable disease, physical or mental disability, including intellectual disability	☐	☐
l) Do they have any illness, syndrome or disorder not mentioned in the previous questions?	☐	☐

Please complete the table below for each response where you answered "yes."

References	Details: Tests, results, treatment, date of recovery, sequelae, name of physician or hospital consulted
Question no. _____ Date _____ Reason _____	
Question no. _____ Date _____ Reason _____	
Question no. _____ Date _____ Reason _____	
Question no. _____ Date _____ Reason _____	
Question no. _____ Date _____ Reason _____	

Section B – Questions Regarding the Insured's Eligibility – Part 2 (cont.)

2. Has the insured ever applied for or received benefits, a disability pension or compensation, or requested additional assistance as a result of injury, illness or disability? ☐ Yes ☐ No If **Yes**, please provide details:

3. Is the insured aware of any symptoms or discomfort for which they have not yet consulted a physician or received treatment? ☐ Yes ☐ No If **Yes**, please provide details:

Section C – Notice of Collection of Personal Information and Consent to Such Collection

One of the main objectives of UV Insurance Company is to provide insurance at an affordable cost. Risk assessment is necessary not only to keep the cost low, but also to ensure that each insured person contributes their fair share of the cost. To assess your application, we must obtain information from various sources. This information is provided to us via your medical examination, if required, and via any reports we may receive from physicians who have treated you and from hospitals where you have been admitted, as well as reports containing personal or credit information.

Please note that your personal information is treated as confidential. However, a brief report of your information may be shared with MIB Inc. (Medical Information Bureau), a non-profit organization that centralizes and exchanges information for its member life insurance companies. If you apply for life or health insurance, or if you submit a claim to a member company of the Bureau, the Bureau will provide that company, upon request, with the information it has about you.

You may, upon request, be informed of the personal information collected about you. If any of your personal information is inaccurate, incomplete or unclear, you may request to have it corrected by submitting a request to UV Insurance, addressed to the Privacy Officer, or to MIB Inc. at the following address: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7 – Tel.: 416-597-0590. Website: www.mib.com

We may also, upon request, disclose our information to life insurance companies to which you apply for life or health insurance or submit a claim for benefits. The purpose of the Bureau is to protect its members and their policyholders from additional costs caused by a small number of individuals concealing facts relating to their insurability. The information provided by the Bureau may prompt the insurance company to conduct a more in-depth investigation, but the Bureau's own regulations prohibit using the information it provides as the sole basis for risk assessment. The Bureau does not hold hospital or physician reports, and the information it possesses does not indicate whether an insurance application was accepted at standard rates or with an additional premium, nor whether it was declined.

Section D – Agreement Regarding the Creation of a Personal File

Personal information, including your social insurance number, that UV Insurance holds or will hold about you will be treated as confidential and will be kept on file for the purpose of providing you with insurance coverage and other financial services that it offers. It will be accessed only by UV Insurance employees who need to access it in the course of performing their duties.

You may access your file and have information corrected if you demonstrate that it is inaccurate, incomplete, unclear, outdated or unnecessary. To do so, you must submit a written request to the attention of the UV Insurance Privacy Officer at the following address: P.O. Box 696, Drummondville, Quebec J2B 6W9

Section E – Consent to the Collection and Disclosure of Personal Information to Third Parties

For the purposes of determining insurability, managing our file and assessing claims, we authorize any individual, legal entity or public or parapublic body that possesses personal information about us concerning, among other things, our state of health, medical history or eligibility for benefits, including but not limited to any physician or other practitioner, hospital, medical or paramedical clinic, laboratory, insurance or reinsurance company, the Medical Information Bureau, personal information agents, market intermediaries, any financial institution, the policyholder, our employer or former employer, the CSST, the RRQ, the SAAQ, the RAMQ, investigative and security agents, risk and claims data agencies, and organizations responsible for the prevention, detection or prosecution of crimes and offences, to disclose it to UV Insurance or its reinsurers upon request.

Similarly, we authorize UV Insurance to disclose such information to said third parties and to its reinsurers. For the same purposes and to collect the same type of information, we also consent to The Union Life Mutual Assurance Company or its reinsurers requesting an investigation report about us and using the information they hold in other files in their possession.

This consent also applies to the collection, use and disclosure of personal information concerning our minor children. No modification or alteration of this consent will affect its content or bind the insurer. We understand that we may withdraw our consent to the disclosure or use of our personal information at any time. We understand that withdrawing our consent may have legal or contractual consequences.

Section F – Declaration

We, the undersigned, the person to be insured and the owner, certify that we have read and understood all the questions contained in this declaration. The answers provided have been accurately recorded and are complete and truthful. Furthermore, we consent to these answers being used as the basis for the insurance policy and acknowledge that any false statement or omission may result in the termination of the insurance policy obtained pursuant to this declaration of insurability.

We agree that coverage will take effect upon the company's acceptance of this declaration, provided it is accepted without amendment, the premiums have been paid and there has been no change in the person's insurability since the declaration was signed.

We acknowledge that we have read and understood the agreement regarding the creation of a personal file.

A photocopy of this consent form has the same value as the original.

Section G – Signatures

Signed in _____ Date

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X _____ **X** _____
Signature of the person to be insured (if 14 years of age or older) Signature of the owner (if a company, authorized signatory)

X _____
Signature of the father, mother or legal guardian
(if the person to be insured is a minor)

Section H – For head office use only

Following the submission of proof of insurability for the insured, spouse and/or owner, and upon payment of all premiums due and unpaid to date, UV Insurance certifies that the aforementioned policy is reinstated.

Accepted in Drummondville Date

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X _____
Authorized company signature

