UV INSURANCE

INDIVIDUAL INSURANCE

Musculoskeletal System Questionnaire

EQC067

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Collection, Use, and Disclosure of Personal Information

The personal information we collect in this form allows UV Insurance to make a decision about your insurance application.

The personal information is used to:

- Identify the individual;
- Establish and update information and the needs of the individual, as appropriate
- Comply with legal and regulatory requirements, including tax rules and the prevention, detection and enforcement of offences, cyber threats and fraud.

The information disclosed on this form will be forwarded to the UV Insurance staff in charge of processing the claim, as well as to any other person authorized by law.

Section B – Insured's Information

1. Application or contract # _____
2. Insured's first name _____ Last name _____
3. Date of birth Y M D

Section C – Questionnaire

1. Please enter the date of the event related to the musculoskeletal system Y M D
2. What is the exact location of the pain or injury? _____
3. How did this injury happen to you?

4. How often do you experience pain? _____
5. What is the medical diagnosis? _____
6. Have any drugs been prescribed? ☐ No ☐ Yes If **Yes**, fill out the following table:

Name of medication	Dose	Frequency	Date of last use
			Y M D
			Y M D
			Y M D

7. Have you undergone treatments such as physiotherapy, chiropractic care, osteopathy, or other treatments? ☐ No ☐ Yes
   If **Yes**, fill out the following table:

Type of treatment	Name of therapist or clinic	Address	Frequency	Date of last consultation
				Y M D
				Y M D
				Y M D

8. Did your injury require you to wear any kind of orthopedic device? ☐ No ☐ Yes
   If **Yes**, please provide details: _____

Section C – Questionnaire (cont.)

9. Have you had an operation? ☐ No ☐ Yes If **Yes**, please specify the type of operation: _____

Date Y M D Location _____

10. How long is the work stoppage? From Y M D to Y M D

If more than one: From Y M D to Y M D

11. Are you fully recovered? ☐ No ☐ Yes If **Yes**, since when? Y M D

If **No**, please provide details:

12. Do you have any permanent scars? ☐ No ☐ Yes If **Yes**, please specify: _____

13. Please provide the name(s) and address(es) of the physician(s) consulted:

Physician's name	Address

14. Will you have further medical consultations? ☐ No ☐ Yes If **Yes**, please specify:

Physician's name	Address

Section D – Consent and Signatures

By signing, you understand that if any of your personal information is inaccurate, incomplete, or ambiguous, you may request a correction by contacting UV Insurance. You also have the right to request information about how your personal information is used.

In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by making a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For further details, please visit our website and consult our **Privacy Policy.**

The undersigned confirms that they have reviewed the above information and agree to the collection, use and disclosure of the personal information contained herein. This consent also applies to the collection, use and disclosure of the beneficiaries' personal information, and the undersigned confirms that prior consent has been obtained from such beneficiaries.

I, the undersigned and person to insure, declare that the above information is complete and accurate and that it will form part of my insurance application with UV Insurance.

Signed in _____ Y M D

X _____ _____

Signature of person to be insured | Signatory's name in block letters

X _____ _____

Owner's signature | Signatory's name in block letters

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