La Capitale
Insurance and
Financial Services

625 Saint-Amable St, PO Box 1500, Quebec QC G1K 8X9

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# DECLARATION OF INSURABILITY
# ENROLMENT CAMPAIGN
# MODULAR PLAN

fneeq CSN
Fédération nationale des enseignantes et des enseignants du Québec

**FILL OUT ONLY IF APPLYING INSURANCE OR INCREASING THE NUMBER OF OPTIONAL LIFE INSURANCE UNITS.**

| GROUP NO. | EMPLOYER NO. | IDENTIFICATION NO. |
|---|---|---|
| | | |

**A- PARTICIPANT'S LAST NAME (MAIDEN NAME IF APPLICABLE)** FIRST NAME

NO. STREET APT. CITY PROVINCE POSTAL CODE

ADDRESS

| TELEPHONE | CURRENT DUTIES (employment) | ARE YOU CURRENTLY WORKING? | IF NO, WHY NOT? |
|---|---|---|---|
| HOME: ( ) - WORK: ( ) - | | ☐ YES ☐ NO | |

**B- PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH OF THE PROPOSED INSUREDS:**

| | LAST NAME (MAIDEN NAME IF APPLICABLE) | FIRST NAME | DATE OF BIRTH YEAR / MONTH / DAY | HEIGHT FT. IN/CM | CURRENT WEIGHT LB/KG | WEIGHT A YEAR AGO LB/KG |
|---|---|---|---|---|---|---|
| PARTICIPANT | | | | | | |
| **DEPENDENTS (FAMILY OR SINGLE-PARENT COVERAGE)** | | | | | | |
| SPOUSE | | | | | | |
| CHILD | | | | | | |
| CHILD | | | | | | |
| CHILD | | | | | | |

**C- MEDICAL QUESTIONNAIRE**

**IMPORTANT: ANSWER ALL QUESTIONS AND EXPLAIN ANY ANSWERS UNDER SECTION D ON THE REVERSE, IF NECESSARY**

| PLEASE SPECIFY WHETHER ANY OF THE PROPOSED INSUREDS: | PARTICIPANT YES | PARTICIPANT NO | SPOUSE YES | SPOUSE NO | CHILDREN YES | CHILDREN NO | FIRST NAME |
|---|---|---|---|---|---|---|---|
| 1) IS CURRENTLY, **OR HAS BEEN WITHIN THE LAST 3 YEARS,** ABSENT FROM HIS OR HER REGULAR DUTIES DUE TO CONVALESCENCE, ILLNESS OR INJURY? DATE: _____ REASON: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 2) HAS EVER SUBMITTED AN APPLICATION FOR INSURANCE THAT WAS DECLINED, DEFERRED OR APPROVED WITH A HIGHER PREMIUM? DATE: _____ CO.: _____ REASON: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 3) PRACTISES OR PLANS TO PRACTISE A PROFESSIONAL SPORT OR A HAZARDOUS LEISURE ACTIVITY? PLEASE SPECIFY: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 4) IS TAKING ANY PRESCRIPTION DRUGS OR HOMEOPATHIC MEDICINES? NAME: _____ QTY/DAY: _____ REASON: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 5) TAKES, OR HAS EVER TAKEN DRUGS OR NARCOTICS? TYPE: _____ DATE LAST USED: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 6) SUFFERS FROM ANY PHYSICAL OR MENTAL ABNORMALITY, DISABILITY OR ANY AFTER-EFFECTS OF AN ACCIDENT? PLEASE SPECIFY: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 7) SUFFERS OR HAS EVER SUFFERED FROM AN ILLNESS, OR HAS EVER HAD A HEALTH PROBLEM? DATE: _____ PLEASE SPECIFY: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 8) IS CONSULTING, PLANS TO CONSULT OR HAS BEEN ADVISED TO CONSULT A **PHYSICIAN** OR HAS BEEN TOLD HE OR SHE NEEDS TO HAVE AN OPERATION? PLEASE SPECIFY: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 9) IS CONSULTING OR PLANS TO CONSULT **ANOTHER HEALTH CARE PROFESSIONAL,** INCLUDING ALTERNATIVE MEDICINE? PLEASE SPECIFY: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 10) **WITHIN THE LAST 5 YEARS**, HAS CONSULTED A PHYSICIAN, THERAPIST OR OTHER HEALTH CARE PROFESSIONAL, INCLUDING ALTERNATIVE MEDICINE, OR BEEN ADMITTED TO A HOSPITAL OR OTHER MEDICAL ESTABLISHMENT? IF YES, EXPLAIN UNDER SECTION D | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 11) HAS UNDERGONE, IS DUE TO UNDERGO, OR HAS EVER BEEN ADVISED TO UNDERGO A HIV (AIDS) TEST? DATE: _____ REASON: _____ RESULT: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |



**FOR USE BY INSURER ONLY**

(CONTINUED ON REVERSE)

**NOTE: THE DECLARATION AND AUTHORIZATION ON THE REVERSE ALSO APPLY TO THIS DECLARATION OF INSURABILITY.**

## C- MEDICAL QUESTIONNAIRE (Cont.)

**IMPORTANT: ANSWER ALL QUESTIONS AND EXPLAIN ANY ANSWERS UNDER SECTION D, IF NECESSARY**

| PLEASE SPECIFY WHETHER ANY OF THE PROPOSED INSUREDS: | PARTICIPANT YES | PARTICIPANT NO | SPOUSE YES | SPOUSE NO | CHILDREN YES | CHILDREN NO | FIRST NAME |
|---|---|---|---|---|---|---|---|
| 12) HAS SMOKED CIGARETTES, CIGARILLOS, CIGARS OR A PIPE, OR USED CHEWING TOBACCO, MARIJUANA, SMOKING CESSATION AIDS OR NICOTINE SUBSTITUTES? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| IF YES, FOR HOW LONG? | _____ year(s) | | _____ year(s) | | _____ year(s) | | |
| PRODUCT(S): | | | | | | | |
| DATE OF LAST USE (year/month): | | | | | | | |
| 13) **WITHIN THE LAST 3 YEARS,** HAS HAD HIS OR HER DRIVER'S LICENCE SUSPENDED OR REVOKED? DATE: _____ REASON: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| 14) HAS EVER UNDERGONE DETOXIFICATION TREATMENT OR BEEN ADVISED TO DO SO? DATE: _____ NAME OF PHYSICIAN OR CLINIC: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

15) DRINKS OR HAS EVER DRUNK ALCOHOL?

| | WEEKLY CONSUMPTION | | | | | |
|---|---|---|---|---|---|---|
| | BEER | | WINE | | SPIRITS | |
| | CURRENT | A YEAR AGO | CURRENT | A YEAR AGO | CURRENT | A YEAR AGO |
| **PARTICIPANT** | | | | | | |
| **SPOUSE** | | | | | | |
| **CHILD** | | | | | | |

## D- EXPLANATION OF "YES" ANSWERS TO QUESTIONS 1 TO 14

| QUEST. NO. | FIRST NAME | DIAGNOSIS, OPERATION, ACCIDENT, REASON FOR CONSULTATION, NAME OF ILLNESS | | BLOOD TESTS, X-RAYS, ECG, OTHER TESTS | | | PHYSICIAN CONSULTED OR HOSPITAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | DATE | DETAILS | TYPE | DATE | RESULT | NAME | ADDRESS | DATE | DURATION |
| | | | | | | | | | | |
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**DECLARATION**

I hereby declare that the answers to the questions above are true and complete, and I acknowledge that any application for insurance completed will be governed by the terms and conditions of a contract pertaining to each of the above-mentioned proposed insureds. I also understand that the insurance described herein shall only come into force for any of the proposed insureds once La Capitale Insurance and Financial Services Inc. has approved the application and communicated its decision to the proposed insured. This application shall be considered declined if it is not approved by the Head Office of La Capitale Insurance and Financial Services Inc. within sixty (60) days following the date on which it was completed. I also understand that any misrepresentation may result in the cancellation of my insurance.

Signed at _____, on _____ 20_____.

_____ Participant

_____ Witness

**AUTHORIZATION**

If you have applied for Family or Single-Parent coverage status, the authorization of your spouse and dependent children age 18 or over is also required.

**AUTHORIZATION**

I authorize any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, particularly medical records pertaining to myself, as the case may be, to provide to La Capitale Insurance and Financial Services Inc. (hereafter La Capitale) or its agents or mandataries, any information it may hold that may be required for the processing of my file.

I also authorize La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file.

This authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original.

_____ Signature of participant or, if a minor, signature of legal guardian

_____ Date

_____ Signature of spouse

_____ Date

_____ Signature of dependent age 18 or over

_____ Date

_____ Signature of dependent age 18 or over

_____ Date