

DECLARATION OF HEALTH CONDITION

Firm # or Employer's Name: _____ Certificate # _____ Employee's Name: _____

Type of application: new employee late entrant excess salary increase other: _____ Gross monthly earnings as declared to Revenue Canada: \$ _____

Name of the Applicant: _____ Gender: M F

S.I.N. _____ Date of birth _____ Occupation _____

Answer each of the following questions. If you have answered "yes" to any of the questions, please provide all information requested. If not enough space is provided, please attach an additional sheet dated and signed.

	YES	NO
1 a) Current height: _____ ft _____ in _____ cm Current weight: _____ lb _____ kg b) Has your weight changed by more than 10 pounds (4.5 kg) in the last year? How much: _____ Why? _____	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you ever consulted a health professional for, or experienced symptoms of, any of the following conditions: heart or blood vessel problems, heart murmur, high cholesterol, high blood pressure, kidney problems, diabetes, hepatitis, ulcerative colitis, Crohn's disease, back disorders, arthritis, pulmonary disorder, asthma, cancer or tumor, HIV or AIDS, mental or nervous disorders, depression, multiple sclerosis, health problems due to an accident or any other illness? Date: _____ Condition(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
3 Within the last 5 years, have you been admitted to a hospital or other healthcare facility? Date: _____ Length of stay: _____ Reason(s) and operation(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
4 a) Within the last 5 years, have you consulted a physician or other healthcare professional such as a psychologist, chiropractor, physiotherapist, homeopath, etc.? If not enough space is provided, please attach an additional sheet dated and signed. Name and address of physician or professional consulted: _____ Reason for consultation: _____ Diagnosis (name of illness): _____ Date of first visit: _____ Date of most recent visit: _____ Total number of consultations: _____ Describe your current state of health: Fully cured <input type="checkbox"/> Improvement <input type="checkbox"/> No significant change <input type="checkbox"/> b) Have you taken, or are you currently taking, medication, or have you undergone, or are you currently undergoing, treatment with a healthcare professional?	<input type="checkbox"/>	<input type="checkbox"/>
i) Medication or treatment: _____ Dosage or no. of visits: _____ Monthly cost: _____ Start date: _____ Ongoing: YES <input type="checkbox"/> NO <input type="checkbox"/> If no, End date: _____ ii) Medication or treatment: _____ Dosage or no. of visits: _____ Monthly cost: _____ Start date: _____ Ongoing: YES <input type="checkbox"/> NO <input type="checkbox"/> If no, End date: _____	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you undergone a blood or urine test, x-rays, electrocardiograms or other diagnostic tests? Specify: _____ Date: _____ Results: _____	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you undergone, do you have to undergo or have you been advised to undergo an HIV/AIDS screening test? Date: _____ Reason: _____ Results: _____	<input type="checkbox"/>	<input type="checkbox"/>

Do not answer questions 6 to 11 for children under 18

6 Within the last 5 years, have you been absent from work or had to stop your ordinary activities for a period of 7 days or more owing to illness(es) or injury(ies)? Date: _____ Duration: _____ Reason: _____	<input type="checkbox"/>	<input type="checkbox"/>
7 Within the last 5 years, have you used tobacco products? Current quantity per week: _____ Quantity per week a year ago: _____	<input type="checkbox"/>	<input type="checkbox"/>
8 a) Do you consume alcoholic beverages? Quantity per week: Beer: _____ bottle(s), Wine: _____ glass(es), Hard liquor: _____ ounce(s) b) Have you ever been advised to drink less alcohol or received treatment or joined an organization because of alcohol? Give details: _____	<input type="checkbox"/>	<input type="checkbox"/>
9 Have you ever taken drugs (marijuana, hashish, cannabis, LSD, heroin, cocaine, or other narcotic drugs) or received treatment for drug addiction? Specify drugs: _____ Date of most recent consumption: _____	<input type="checkbox"/>	<input type="checkbox"/>
10 Within the last 5 years, have you practised a high-risk sport such as mountain climbing, parachuting, motor vehicle racing, hang gliding, scuba diving, or flying in an ultra-light or privately-owned aircraft or other? Sport: _____ Date of most recent participation: _____	<input type="checkbox"/>	<input type="checkbox"/>
11 Has any application for insurance filed by you been refused or been modified or accepted with an extra premium or exclusion? Date: _____ Reason: _____ Insurer: _____	<input type="checkbox"/>	<input type="checkbox"/>

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 and I agree that they shall be part of my application for insurance. I have kept a completed and duly signed copy of this form. I agree that any misrepresentation or withholding of information may void any benefit issued as a result of this application. I have read both notices printed overleaf regarding File and Personal Information and the Medical Information Bureau and I concur with the contents thereof.

I hereby authorize SSQ, Life Insurance Company Inc., its mandataries and its reinsurers:

- a) to obtain information, to the extent required for processing my file, from any individual or corporation, or any public or para-public organization which has personal information about me or about my dependants according to the terms and conditions of this contract, including any physician, any medical facility, the Medical Information Bureau and any insurance company,
- b) to disclose the personal information that they may have about me or about my dependants according to the terms and conditions of this contract, to the extent required, to such individual or organization,
- c) to use the necessary personal information contained in any other file already held by them which has been completed,

as required for determining insurability and for insurance management including claim settlement purposes.

A photocopy 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: _____

Signature of the Applicant: _____
 (Parent or guardian if a child under age 18)

MEDICAL INFORMATION BUREAU NOTICE

Information regarding your insurability will be treated as confidential. SSQ, Life Insurance Company Inc., or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau will, upon request, supply such company with information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction. The Bureau's address is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number: (416) 597-0590.

SSQ, Life Insurance Company Inc., or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FILE AND PERSONAL INFORMATION NOTICE

To maintain the confidentiality of the personal information about you, SSQ, Life Insurance Company Inc., and / or its mandataries open an insurance file to hold information on your application for insurance, as well as information on insurance claims.

Only employees or agents who are responsible for underwriting, investigations and claims, and any other person you may authorize, have access to the file.

Your file is kept at the company's office in Sainte-Foy.

You have the right to consult the personal information held in this file and, if need be, have it corrected by sending a written request to the following address: SSQ, Life Insurance Company Inc., P.O. Box 10500, Sainte-Foy, Quebec G1V 4H6, to the attention of:

- The person responsible for access to information.