



INDIVIDUAL INSURANCE

**DECLARATION OF INSURABILITY  
FOR PROHEALTH INCOME INSURANCE - ACCIDENT**



### Part 3 - Employment

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 1. Is the insured currently employed and working a minimum of 21 hours a week for, at least, 35 weeks a year? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has there been a change in the insured's occupation since this insurance contract was applied for? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| • If yes, please confirm the current occupation: _____   |                          |                          |
| 3. Which of the following best represents the insured's situation?   |                          |                          |
| <input type="checkbox"/> Salaried employee <input type="checkbox"/> Self-employed <input type="checkbox"/> Business owner  |                          |                          |
| • <b>If Salaried employee:</b>   |                          |                          |
| - What was the gross annual employment income as indicated on the last Federal Income Tax Return ( <i>Box 14 of the T4 slip or line 10100 of the T1 form</i> ): _____                      |                          |                          |
| • <b>If Self-employed:</b>   |                          |                          |
| - Net income as indicated on your last federal income tax return: _____  |                          |                          |
| • <b>If Business owner:</b>  |                          |                          |
| - Based on the percentage of shares held by the insured, what were the company's net profits before taxes for the last completed fiscal year? ( <i>Company's income statement</i> ): _____ |                          |                          |

### Part 4 - Authorizations and Signatures

**I, the undersigned, as the Policyowner or the proposed Insured, declare that the information provided is complete and true, and I accept that it is an integral part of my application for insurance. I acknowledge that any false declaration or omission could void the coverage obtained through this application.**

I authorize Humania Assurance Inc. to exchange the personal information collected about me with its Business Partners, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector*, including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

**The Insurer may contest any fraudulent statement beyond the contestability period. I acknowledge that I have understood any Conditional Insurance Receipt and that I have received and read the Personal Information Notice, and the Disclosure Statement under the *Financial Institutions Act*. An insurance contract is based on good faith. Any incomplete disclosure of important facts in this declaration of insurability constitutes a breach that may result in the cancellation of the policy. Any policy issued in connection with this declaration of insurability will take effect on the date the Insurer approves the risk, provided that it is approved without change, the first premium has been paid, and no change has occurred in the proposed Insured's insurability since this declaration of insurability was signed.**

Signed at: \_\_\_\_\_ On: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_ Signature of Person to be insured: \_\_\_\_\_

Signature of Policyowner: \_\_\_\_\_

## TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

### Personal Information

#### Notice Concerning Files and Personal Information

For the purposes of administering your insurance file and ensuring its confidential nature, Humania Assurance Inc. will create an insurance file containing the information regarding your (Policyowner and/or Insured) application for insurance, as well as information on any insurance claims.

Only employees or agents responsible for underwriting, investigations or claims, as well as any other people authorized by you, will have access to this file. Your file will be kept at the Company's head office.

You have the right to review the personal information contained in this file and, if required, have it corrected by submitting a written request to:

**Access to Information Officer: Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6.**

You also have the right to withdraw, at any time, any authorization given in connection with the communication and use of the personal information contained in your file.

As part of the standard processing of insurance proposals, all insurance companies, including Humania Assurance Inc., may request a personal investigation or a consumer report containing personal information on the individuals to be insured. You may be contacted to this effect.

**HUMANIA ASSURANCE INC.**

1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6  
Web site: [www.humania.ca](http://www.humania.ca)