HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

DECLARATION OF INSURABILITY

FOR INSURANCE WITHOUT MEDICAL EXAM

HUMANIA ASSURANCE MD®

Declaration of insurability for Insurance Without Medical Exam

Instructions

- **This document is used when requesting a change to a non-smoker rate for any Insurance Without Medical Exam or when requesting a reinstatement of Insurance Without Medical Exam on life coverages.**
- Include the premium payment due and the the "Pre-Authorized Debit Payment Agreement" form, if the policy is paid monthly by a bank account, or the "Pre-Authorized Credit Card Payment Agreement" if the policy is paid monthly by a credit card.
- Write legibly in blue or black ink in block letters.
- The form must be signed by the person insured.
- This form must be signed by the policyowner.
- In the event of a reinstatement, this form is used to reinstate this policy under the terms and conditions of your contract on the date it was cancelled.
- In the event of a reinstatement, the period related to incontestability and suicide apply again as of the date of the last reinstatement.

Part 1 - Identification

Policy n°:

Insured First Name:

Insured Last Name: Sex: ☐ F ☐ M

Phone Number:

Date of Birth:

year / month / day

	Yes	No
Smoker / Non-smoker (is considered non-smoker a person who has not used tobacco in any form whatsoever, including nicotine substitutes, nicotine products, electronic cigarettes or vapor, in the twelve(12) months before the application for this insurance.).	☐	☐

Part 2 - Purpose of declaration

☐ Reinstatement on a Life coverage* ☐ Request for a non-smoker rate

*Include the premium payment due and the the "Pre-Authorized Debit Payment Agreement" form, if the policy is paid monthly by a bank account, or the "Pre-Authorized Credit Card Payment Agreement" if the policy is paid monthly by a credit card.

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Part 3 - Eligibility

		Yes	No
1.	Are you currently working? (Answer yes if you are currently receiving benefits from a parental leave plan)		
2.	In the past 12 months (or the 12 months prior to your parental leave if applicable), were you able to complete all your occupations (28 weeks, 21 hours/week) and on a regular basis?.....		
3.	In the past 2 years (or the 2 years prior to your parental leave if applicable), were you absent from work or were you unable to perform your regular occupations, including daily living activities for more than 15 consecutive days due to illness or received disability or critical illness benefits from a private, group or public insurance plan? (This refers to any private insurance plan you may have, any insurance coverage provided by your employer, professional association or other group or organization, and coverage provided by government agencies, both provincial and federal)?		
4.	I confirm that I have not received any diagnosis of cognitive impairment and confirm being able to perform regular daily living activities such as bathing, dressing, toileting, maintaining continence, moving and eating by myself?		
5.	In **the past 2 years**, did you receive treatment (including the participation in a support group), were you advised to reduce your consumption or seek treatment regarding the use of alcohol or drugs? (Treatment includes, but is not limited to participation in a support group.).		
6.	In **the past 5 years**, were you incarcerated for more than 48 hours?		
7.	In **the past 6 months**, did you have any physical or mental symptoms or discomfort for which you have not yet consulted a health professional?		

Part 4 - Health

		Yes	No
1.	Height : ft cm Weight : lbs kg		
2.	In the last 12 months, did your weight vary by more than 10%?.....		
3.	In **the past 2 years**, have you received a treatment or a therapy, been prescribed or taken prescription medication other than birth control, antibiotics or nonsteroidal anti-inflammatory drugs?.....		
	• If yes, is the treatment, therapy or medication related to DIABETES only?		
4.	In **the past 5 years**, were you diagnosed with, received treatment for or recommended therapy or medication for any of the following disorders:		
	a) Heart, stroke (cerebrovascular accident) or blood vessel disorder excluding treated and controlled high blood pressure?		
	b) Cancer, tumour, cystic fibrosis, Hodgkin's disease, lymphoma, leukemia, emphysema or chronic bronchitis?		
	c) Crohn's disease, ulcerative colitis, hepatitis B or C, or other disorder of the liver or pancreas?		
	d) Diabetes, pre-diabetes or glucose intolerance?		

If Yes (to be completed for Life Insurance only):

- Have you ever had any complications as a result of your diabetes such as vision affected (diabetic retinopathy), kidney disease (diabetic nephropathy), pain and burning sensation of the legs and/or feet(diabetic neuropathy)?
- What type of diabetes was you diagnosed with?

☐ Type 1 Diabetes
☐ Type 2 Diabetes (non-insulin-dependent-diabetes mellitus)
☐ Pre-diabetes/Glucose Intolerance
☐ Gestational Diabetes
☐ I do not know

Part 4 - Health (continued)

	Yes	No
• Has it been less than 5 years that you were diagnosed with this diabetes?		
• Has it been more than 5 years but less than 15 that you were diagnosed with this diabetes?		
• In the last 12 months, what was your HBA1C reading?		
e) Multiple sclerosis, muscular dystrophy or paralysis?		
f) Seizures or motor neuron disease?		
g) Prostate disorder, polycystic kidney disease or other kidney disorder?		
h) Acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV)?		
i) Rheumatoid arthritis, fibromyalgia or spinal disc disease?		
j) Depression, psychosis, schizophrenia or bipolar disorder?		
• If yes, **in the past 5 years**, have you been hospitalized, had suicidal thoughts, considered hurting yourself one way or another or have you been prescribed more than 2 medications for any of the listed conditions?		
5. Did **more than one member of your family** (parents, brothers or sisters) have cancer, diabetes, stroke, heart attack, angina, multiple sclerosis, polycystic kidney disease or motor neuron disease **before age 60**?		

Part 5 - 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: _____

Part 6 - Authorization is case of death

During my lifetime and in the event of my death, I authorize Humania Assurance Inc., its agents, service providers and other partners (hereinafter *"Business Partners"*) to collect, by any electronic means, email, fax or mail and to use all personal information relevant to the adjudication of any claim submitted under this insurance policy.

I further 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.

In the event of my death, the holder, the subrogated holder and the beneficiary of my insurance policy, the heir and the liquidator of my estate are expressly authorized to provide Humania Assurance Inc. and its *Business Partners* with all authorizations and personal information for the purpose of adjudicating the claim.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician, psychologist or other health professional, any public or private health and social services institution, any occupational health and safety plan, motor vehicle accident insurance plan or health insurance plan, including the various provincial health plans, including but not limited to the Régie de l'assurance-maladie du Québec, any pharmacy, any financial institution including insurance or reinsurance companies, any personal information officer, and any investigative, police or security agency. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

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.

Signed at: _____ On: _____

Signature of the Person to be insured (if aged 14 or older): _____

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

Personnal 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.

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Web site: www.humania.ca

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