HUMANIA ASSURANCE MD®

Group Insurance
Declaration of Insurability

For more information, visit our website (www.humania.ca) or contact us at:
Saint-Hyacinthe region : 450-773-7236; Other regions : 1 800 818-7236; email : adm.col@humania.ca

Part 1 – Identification of the insured

Policy no.: Subgroup no.: Certificate no.:

Name of Employer:

Last Name:

First Name:

Date of Birth: Sex at Birth: M F
Year / Month / Day

Are you currently working? Yes No

If no, indicate the reason: disability, layoff, parental leave, other (please specify):

Profession/occupation:

In the past twelve (12) months, have you used tobacco (including chewing tobacco, electronic cigarettes or other similar devices) or nicotine substitutes such as nicotine gum or patches, or have you been given a medical prescription for or taken part in a smoking cessation program? ..... Yes No

If yes, please indicate the type and frequency of use:

If no, did you use tobacco products in the twelve (12) months preceding this period?

Part 2 – Purpose of the declaration

Please specify the purpose of this declaration:

Please specify: Benefit: Amount requested:

4200-011-en
2024/06

Part 3 – General information

1. Have you ever been subject to a premium surcharge, an exclusion clause, a reduction in coverage, a deferment, a decline of coverage or of reinstatement? ..... Yes ☐ No ☐
   If yes, please specify the type of insurance, the name of the insurance company, the dates and the reasons given:

2. Have you ever applied for disability benefits? ..... Yes ☐ No ☐
   If yes, please provide the name of the insurance company or government agency along with the dates and reasons for disability:

3. Do you presently or plan to participate in activities such as aviation, skydiving, scuba diving, hang gliding, racing or speed trials, or other high-risk sports? ..... Yes ☐ No ☐

If yes, please specify. If no, go to the next question:

- Type of activity:
- Date you first participated: Date you last participated:
- Number of times per year:
- Do you intend to participate in this activity again: ..... Yes ☐ No ☐
- Do you participate in this activity: ☐ As an amateur ☐ As a professional
- Do you participate in races during competitions? ..... Yes ☐ No ☐

4. Do you presently or have you ever consumed acoholic beverages? ..... Yes ☐ No ☐

   If yes, please indicate the quantity in the table below:

	Beer	Wine	Spirits (ounces)	Date last consumed
Per day				
Per week				
Per month				

5. Do you or have you ever used drugs or narcotics (with or without a prescription)? ..... Yes ☐ No ☐

   If yes, please indicate the quantity in the table below:

Type of drug	Start date	End date	Quantity	Frequency (per day, month, or year)

6. Have you ever been treated for drug and/or alcohol use or been advised to undergo therapy or treatment? ..... Yes ☐ No ☐

   If yes, please indicate the treatment start and end dates:

7. Has your driver's license been suspended or revoked in the past three (3) years? ..... Yes ☐ No ☐

   If yes, please indicate the date and nature of the offence:

Part 3 – General information (continued)

8. Have you ever been found guilty of impaired driving? ☐ Yes ☐ No

   If yes, please specify:

   A. Number of episodes:

   B. Dates of episodes:

   C. Date at which licence was reinstated without restrictions:

9. Have you been found guilty of or been charged with a criminal act or offence? ☐ Yes ☐ No

   If yes, please provide details, including the date and the nature of the criminal act or offence:

10. In the past three (3) years, have you travelled or resided outside of North America or do you intend to do so in the next twelve (12) months? ☐ Yes ☐ No

    If yes, please specify the destination, date, and duration:

Part 4 – Medical information

If you answer "Yes" to any of the questions, you must provide details in part 5 "Diagnosis" or section 7 "General comments"

1. Height: ft. in./cm Weight: lbs kg

2. Are you taking medication, following a diet or taking homeopathic products? ☐ Yes ☐ No

   Type: Reason:

3. Have you ever had any of the following medical conditions or health problems:

a) Cardiovascular system: high blood pressure, high cholesterol, heart attack, chest pain, palpitations, rhumatic fever, heart murmur, or other disorder of the heart or blood vessels? ☐ Yes ☐ No

b) Respiratory system: asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), tuberculosis, pneumonia, sleep apnea or any other respiratory disorders? ☐ Yes ☐ No

c) Digestive system: colitis, ulcer, intestinal bleeding, gastritis, hernia, Crohn's disease, irritable bowel syndrome, celiac disease or other stomach, gallbladder, liver (hepatitis, cirrhosis), pancreatic or intestinal disorders? ☐ Yes ☐ No

d) Genitourinary system: blood, infection or other urinary problems, kidney stones or other kidney, bladder or propostate disorders, or problems with other genitourinary organs (including sexually transmitted diseases)? ☐ Yes ☐ No

e) Endocrine system:

   1. Diabetes (Type 1, Type 2, or diabetes insipidus), prediabetes, glucose intolerance, gestational diabetes? ☐ Yes ☐ No
   2. Thyroid problems or any other endocrine disorders? ☐ Yes ☐ No

f) Any eye (except myopia and presbyopia), ear, nose, mouth, throat, or skin disorder? ☐ Yes ☐ No

g) Anemia or any other blood diseases? ☐ Yes ☐ No

Part 4 – Medical information (continued)

h) Cyst, tumour, cancer? ..... Yes No

i) Musculoskeletal system:

1. Fibromyalgia, rheumatism, arthritis, osteoarthritis, gout, or muscle or bone disorders? ..... Yes No

If Yes, complete the questionnaire below. If no, go to question #2)

Condition diagnosed:

Number of episodes: Date of first episode: Year / Month / Day Date of last episode: Year / Month / Day

Treatment (dates and frequency), including medication or any treatment with a healthcare professional:

Do you have any limitations? Yes No If yes, please provide details:

Are you fully recovered? Yes No If yes, since when?

Have you missed work or school due to this condition? Yes No If yes, please specify the date(s) and duration of your absence:

2. Joints ..... Yes No

If yes, please complete the questionnaire below. If no, go to question #3

Wrists Hands Shoulders Hips Knees Ankles Feet Other Specify:

Condition diagnosed:

Number of episodes: Date of first episode: Year / Month / Day Date of last episode: Year / Month / Day

Treatment (dates and frequency), including medication or any treatment with a healthcare professional:

Do you have any limitations? Yes No If yes, please provide details:

Are you fully recovered? Yes No If yes, since when?

Have you missed work or school due to this condition? Yes No If yes, please specify the date(s) and duration of your absence:

Part 4 – Medical information (continued)

3. Spine, sciatica problems?

Neck (cervical spine) ☐ Middle back (thoracic spine) ☐ Lower back (Lumbar and/or lumbosacral spine) ☐

Condition diagnosed:

Number of episodes: Date of first episode: Year / Month / Day Date of last episode: Year / Month / Day

Treatment (dates and frequency), including medication or any treatment with a healthcare professional:

Do you have any limitations? ☐ Yes ☐ No If yes, please provide details:

Are you fully recovered? Yes ☐ No ☐ If yes, since when?

Have you missed work or school due to this condition? ☐ Yes ☐ No If yes, please specify the date(s) and duration of your absence:

j) Anxiety, depression, fatigue, major depression, insomnia, burnout, adjustment disorder, stress, bipolar disorder, suicidal thoughts, attempted suicide, ADD/ADHD, or other mental health problems? ..... ☐ Yes ☐ No

If yes, please complete the questionnaire below. If no, go to question k)

Condition diagnosed:

Number of episodes: Date of first episode: Year / Month / Day Date of last episode: Year / Month / Day

Causes of symptoms:

Treatment (dates and frequency), including medication or any treatment with a healthcare professional:

Do you have any limitations? ☐ Yes ☐ No If yes, please provide details:

Are you fully recovered? ☐ Yes ☐ No If yes, since when?

Have you missed work or school due to this condition? ☐ Yes ☐ No If yes, please specify the date(s) and duration of your absence:

Part 4 – Medical information (continued)

k) Neurological system: Seizures, epilepsy, migraines, headaches, paralysis, stroke, transient ischemic attack, degenerative disease, or any other neurological problems? ..... ☐ Yes ☐ No

If yes, please complete the questionnaire below. If no, go to question l)

Condition diagnosed:

Number of episodes: Date of first episode: Year / Month / Day Date of last episode: Year / Month / Day

Treatment (dates and frequency), including medication or any treatment with a healthcare professional:

Do you have any limitations? ☐ Yes ☐ No If yes, please provide details:

Are you fully recovered? ☐ Yes ☐ No If yes, since when?

Have you missed work or school due to this condition? ☐ Yes ☐ No If yes, please specify the date(s) and duration of your absence:

l) Indicate any other physical or mental health conditions:

4. In the past three (3) years, have you had to take time off work or from your regular duties for a period of thirty (30) days or more due to illness or injury? ..... ☐ Yes ☐ No

Dates: Reasons:

5. Have you experienced or are you experiencing any symptoms or illness for which you have not consulted a physician, received treatment, been monitored, or had follow-up medical examinations or other diagnostic tests performed? ..... ☐ Yes ☐ No

6. Do you intend to consult a doctor or other health professional or undergo surgery in the near future? ..... ☐ Yes ☐ No

7. In the past five (5) years, have you seen a doctor or other healthcare professional or been admitted to a hospital or other healthcare facility? ..... ☐ Yes ☐ No

If yes, please complete Part 5 (Diagnosis).

8. Have you been, do you intend to be, or have you been advised to be tested for HIV or AIDS? ..... ☐ Yes ☐ No

Date(s): Reason:

Result:

Part 5 – Diagnosis

Reason for consultation:

Medical diagnosis (name of condition):

Date of first consultation: Year / Month / Day

Date of last consultation: Year / Month / Day

Name and address of the hospital or physician consulted:

Did this consultation result in any of the following:

1) Hospitalization? ☐ Yes ☐ No

If yes, please provide: Date: Year / Month / Day Duration:

2) Surgical procedure (surgery)? ☐ Yes ☐ No

If yes, please provide: Date: Year / Month / Day Name of surgery:

3) Prescribed treatment or medication? ☐ Yes ☐ No

If yes, please specify which ones:

Start date: Year / Month / Day End date: Year / Month / Day

4) Blood tests, X-rays, ECG, other tests? ☐ Yes ☐ No

If yes, please specify which ones:

Date: Year / Month / Day Results:

5) Please provide details about your current condition:

Part 6 – Family history

Has a member of your family ever had diabetes, cancer (specify type), tuberculosis, high blood pressure, heart disease, mental illness, transient ischemic attack or stroke, kidney disease, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis, motor neuron disease, multiple sclerosis, Alzheimer's, or other hereditary diseases?

Family Member	Age at Onset	Current Age if Alive	Age at Death	Health Status or Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Part 7 – General comments

Part 8 – Authorizations and signatures

I, the undersigned, as 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 understand that it is my responsibility to provide Humania Assurance, in the manner I deem most appropriate, with the personal information requested and required to determine my insurability and to review any claim related to this insurance policy.

To this end, I authorize Humania Assurance to use or disclose this personal information to its agents, service provides and reassurers (hereinafter "Business Partners"), whether located in Quebec or outside Quebec, as the case may be, for the purposes set out in the above paragraph.

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.

These authorizations are valid only for the purposes of this contract, its amendment or reinstatement, and during the initial risk assessment and contestability period. They also apply to all claims submitted during the said contestability period. A photocopy of these authorizations, duly signed, is as valid as the original. The Insurer may contest any fraudulent declaration beyond the contestability period.

The application, the policy, or any of its components cannot be modified. **An insurance contract is based on good faith. Any incomplete disclosure of important facts in this application constitutes a breach that may result in the cancellation of the policy.** Any policy issued in connection with this application will take effect on the date the Insurer approves the application, 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 application was signed.

Signed at Date

Signature of Insured (and consenting parent/guardian if required) _____

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6