



Last name First name Date of birth File number

Telephone no.

Agent (name) Code SU Agency (name) Agency (code)

1 Name and address of your family physician or medical facility:

Date and reason for last consultation:

Describe the symptoms that motivated this consultation:

Tests ordered? Results?

Future tests recommended? Treatment or medication prescribed?

2 Family history
Father, mother, siblings (grandparents if the insured is under 20 years of age):

Do any of these family members suffer or have they ever suffered from heart disease, cancer, diabetes, polycystic kidney disease, mental illness, cerebrovascular disease, neurological conditions, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's disease, haemophilia or any other hereditary disorder?

Yes No

	Current age	State of health	Age at diagnosis	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					
Grandparents					

AFFIRMATIVE ANSWERS: Indicate the number of the question and circle the disease or symptom. Provide details and diagnosis, dates, duration, medication or treatments, results, names and addresses of attending physicians and hospitals.

3 Indicate whether you ever had symptoms, been told you have symptoms, sought medical attention or received treatment for any of the following:

Yes No

- a) Eye, ear, nose or throat disorders;
- b) Dizziness, fainting, convulsions, paralysis, neurological condition, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease;
- c) Shortness of breath, persistent hoarseness or cough, coughing up blood, bronchitis, pleurisy, asthma, emphysema, sleep apnea or other respiratory disorders;
- d) Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, angina, abnormal EKG, stroke (CVA), transient ischemic attack (TIA), dizziness, cardiac arrhythmia, peripheral vascular disease, phlebitis or any other disorders of the heart or blood vessels;
- e) Jaundice, intestinal bleeding, ulcer, colitis, hepatitis, carrier of hepatitis, cirrhosis, Crohn's disease, ileitis, diverticulitis, or other disorders of the stomach, intestine, liver or pancreas;
- f) Sugar, blood, pus or protein in urine, stones or other disorders of the kidneys, bladder, prostate or reproductive organs, sexually transmitted disease, breast disorder including lumps, cysts, other physical changes or abnormal mammogram findings or biopsy;
- g) Diabetes, thyroid or other endocrine disorders;
- h) Lupus, neuritis, arthritis, rheumatism, gout, or other disorders of the bones or muscles;
- i) Pain or discomfort in back, neck or any joint;
If yes: How many times? _____
Date of first occurrence: _____
Date of last occurrence: _____
Cause: _____
- j) Physical deformity, amputation, lameness or disability;
- k) Cancer or tumor, cyst, polyp, mole, mass or growth, lump, skin or lymph gland disorders;
- l) Anemia, immunodeficiency or other blood disorders;
- m) Exposure to AIDS, hepatitis B and/or C virus;
- n) AIDS, positive HIV screening test or AIDS-related complex (ARC);
- o) Anxiety, depression, burnout or other psychiatric, psychological or nervous disorders, chronic fatigue syndrome, mental retardation or other mental disorder;
- p) Any other disease not listed above.

4	Have you ever received a blood transfusion or been refused as a blood donor?	Yes <input type="checkbox"/>	No <input type="checkbox"/>						
5	Do you have any physical or mental condition that limits your ability to perform your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>						
6	<p>Within the past 5 years, have you:</p> <p>a) Consulted a chiropractor? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes: Reason for the first consultation _____ Date of the first treatment: _____ Date of the last treatment: _____ Number of consultations per year: _____ Diagnosis: _____</p> <p>b) Consulted a physiotherapist, psychologist, acupuncturist, audiologist, speech therapist, osteopath or podiatrist? <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Had an electrocardiogram (resting or stress), echocardiogram, X-ray, MRI, blood test, biopsy or any other test? <input type="checkbox"/> <input type="checkbox"/></p> <p>d) Had a positive result for a hepatitis B or C screening test? <input type="checkbox"/> <input type="checkbox"/></p> <p>e) Been a patient in a hospital or a clinic? <input type="checkbox"/> <input type="checkbox"/></p>								
7	Do you take any medication other than that mentioned previously?	<input type="checkbox"/>	<input type="checkbox"/>						
8	Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done in the next year?	<input type="checkbox"/>	<input type="checkbox"/>						
9	Do you have any signs or symptoms for which you have not sought treatment or consulted a doctor?	<input type="checkbox"/>	<input type="checkbox"/>						
10	Have you ever applied for a disability or health benefit due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>						
11	<p>In the past 12 months, have you used any kind of tobacco, including nicotine or tobacco products (gum, patch, etc.)?</p> <p>a) If no, have you ever used tobacco? <input type="checkbox"/> <input type="checkbox"/></p> <p>b) If yes, when did you quit? _____</p>	<input type="checkbox"/>	<input type="checkbox"/>						
12	<p>a) Height (in shoes): _____ ft. _____ in. _____ m _____ cm</p> <p>b) Weight (clothed): _____ lb. _____ kg</p> <p>c) Height verified? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight verified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Variation in weight over past year: _____ lb. _____ kg <input type="checkbox"/> Gained <input type="checkbox"/> Lost</p> <p>e) Cause of variation: _____</p> <p>f) Measurements:</p> <p>Chest (men only) Full inspiration: _____ Forced expiration: _____ Abdomen at umbilicus (men and women): _____</p>	Please provide details of all abnormal medical conditions observed.							
13	<p>Blood pressure (3 readings compulsory)</p> <p>Time _____</p> <p>Systolic _____</p> <p>Diastolic _____</p>								
14	<p>Pulse at rest</p> <p>Rate _____</p> <p>Irregularities per minute _____</p>								
15	Did you notice any abnormal behaviour during the interview?	<input type="checkbox"/>	<input type="checkbox"/>						
16	<p>Urinalysis (summary report compulsory)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Protein</td> <td style="width: 33%;">Sugar</td> <td style="width: 33%;">Blood</td> </tr> <tr> <td></td> <td></td> <td>If female, is proposed insured menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Protein	Sugar	Blood			If female, is proposed insured menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Collect urine sample ONLY upon request or in the following cases:</p> <p>1- The summary analysis is abnormal.</p> <p>2- The present blood pressure is higher than 150/90.</p> <p>3- The proposed insured is overweight.</p> <p>4- There is a history of high blood pressure, diabetes or kidney disease.</p> <p>Check here if a urine specimen was sent to the laboratory. <input type="checkbox"/></p>	
Protein	Sugar	Blood							
		If female, is proposed insured menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No							

17 ALCOHOL AND DRUGS

Do you or have you ever used:

- Alcohol? Yes No
 Narcotics, illegal drugs, performance-enhancing drugs or herbs? Yes No

If yes, answer the following questions and complete the corresponding section below.

- a) Have you ever been treated for alcohol and/or drug use or been advised to receive treatment or to reduce your consumption? Yes No
 b) Did your alcohol and/or drug consumption ever play a role in the loss of work or marital problems? Yes No
 c) Are you or have you ever been a member of a support group (AA, AN, other group)? Yes No

If yes: Name: _____
 For how long: _____
 Have you terminated your membership: Yes No
 If yes, state why: _____

- d) Have you ever been arrested for driving under the influence of alcohol or drugs or convicted of any drug-related charges Yes No

ALCOHOL

Consumption (1 unit = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)

Units per	Present			Past				
	day	week	month	year	day	week	month	year
Wine	_____	_____	_____	_____	_____	_____	_____	_____
Beer	_____	_____	_____	_____	_____	_____	_____	_____
Liquor	_____	_____	_____	_____	_____	_____	_____	_____

(If a reduction, specify date and reason) _____

NARCOTICS, ILLEGAL DRUGS, PERFORMANCE-ENHANCING DRUGS, HERBS

- a) When did you start using drugs? (provide date) _____
 b) Give the reasons why you started using drugs _____
 c) If you are no longer using drugs, why did you stop? _____
 d) Do you intend to use drugs in the future? Yes No

e) Consumption details: For each drug listed below, please indicate which ones you are currently using or have used in the past. If applicable, specify the quantities, frequency and consumption date for each one.

	DOSAGE OR AMOUNT USED	FREQUENCY	DURATION	
			FROM	TO
1)- OPIATES: Opium (op), Heroin (junk, horse, H, smack), Morphine, Codeine, Demerol, Methadone <input type="checkbox"/> Yes <input type="checkbox"/> No				
2) BARBITURATES (goof balls, downers, barbs, jackets, candy, blues, pinks, reds, yellows, etc.): Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital <input type="checkbox"/> Yes <input type="checkbox"/> No				
3) AMPHETAMINES (speed, uppers, pep pills, wake-up, ice, bennies, MDMA, Ecstasy, etc.): Benzedrine, Dexedrine, Methedrine, Crystal meth <input type="checkbox"/> Yes <input type="checkbox"/> No				
4) COCAINE (crack, cane, coke, snow, whiff, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No				
5) HALLUCINOGENS (acid, angel dust (PCP), haze, microdots, LSD, etc.): Mescaline, DMT, Peyote, Psilocybine <input type="checkbox"/> Yes <input type="checkbox"/> No				
6) CANNABIS (marijuana, pot, grass, weed, joint, hashish, hemp, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No				
7) HERBS: Catnip, cinnamon, damiana, hydrangea, poppy, kavakava, lobelia, passion flower, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No				
8) PERFORMANCE-ENHANCING DRUGS: Anabolic steroids, DHEA, Erythropoietin (EPO), GABA, Human Growth Hormone (HGH), nandrolone, stanozol, testosterone, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No				
9) OTHER SUBSTANCES (sedatives, solvents, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No				

Provide details for all affirmative answers (date, reason, names and addresses of physician, medical facility, hospital, etc.)

18 FOREIGN RESIDENCE OR TRAVEL

During the next 2 years, do you intend to travel or live outside Canada, the United States or your country of residence (for clients from the Caribbean) for more than 2 months (total duration of all trips to be taken)? Yes No

If yes, answer the following questions:

- a) What is your citizenship? _____
 b) What is your departure date?

Y	M	D

 c) Which country(ies) and city(ies) do you plan to visit? _____
 d) How long will you be staying in each country and each city? _____
 e) What are the reasons for your foreign travel or residence? Vacation Studies Work Other (specify) _____
 f) If the foreign residency is for work or business, please specify:
 The type of job _____
 The name of the employer or organization in charge _____
 The signature date of your work contract _____
 The duration of your work contract _____
 g) Have you ever lived in a foreign country? Yes No
 If yes, specify the place, the period, the dates and the reason _____
 h) Are you likely to travel or live abroad in the future? Yes No
 If yes, specify the place, the period, the dates and the reason _____

19 DRIVING RECORD (Complete questions a) and b))

a) Within the past five (5) years, have you been convicted of three (3) or more violations to the highway code or have you had your driver's licence suspended? Yes No

DRIVER'S LICENCE NUMBER

If yes, provide your driver's licence number, complete the tables below and answer the following questions:

VIOLATION	NUMBER OF CONVICTIONS	DATE OF CONVICTIONS	NUMBER OF DEMERIT POINTS
Illegal parking, unbuckled seat belt			
Speeding (specify how much over the speed limit)			
Failure to obey traffic signals, failure to make a mandatory stop, illegal passing, following too closely			
Accident (not at fault)			
Accident (at fault)			
Unpaid fines			
Other (specify)			

LICENCE SUSPENDED	REASON FOR SUSPENSION	DATE OF SUSPENSION	DURATION OF SUSPENSION	LICENCE REINSTATEMENT DATE	DRIVING WHILE UNDER SUSPENSION / HOW OFTEN
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No _____
					<input type="checkbox"/> Yes <input type="checkbox"/> No _____

b) Within the past five (5) years, have you been arrested for any of the following offences? Yes No

OFFENCE	ARRESTED		FOUND GUILTY			LICENCE SUSPENDED				DRIVING WHILE SUSPENDED		
	Yes	No	Yes	No	Date	Yes	No	Duration	Reinstatement date	Yes	No	Frequency
Driving under the influence (alcohol or drugs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Hit-and-run*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Reckless driving*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Criminal negligence*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

* Circumstances: _____

Additional remarks: _____

20 CRIMINAL RECORD

Have you ever been convicted of a criminal offence or are there any charges pending against you? Yes No

If yes, answer the following questions.

- a) Type of criminal offence _____
- b) Dates: _____
- c) Sentence: _____
- d) On probation? Yes No Date started _____ Date ended _____

21 INDIVIDUALS OVER 70 YEARS OF AGE

- a) Do you live with someone? (Indicate the relationship if not a family member) _____
- b) In what type of dwelling do you live? (privately-owned home, apartment, condo, retirement home) _____
- c) Indicate which of the following activities you can perform:
 Dress Do housework Prepare meals Go shopping Use public transportation unaided
 Take medication unaided Manage your own finances
- d) What do you do in your free time? (Indicate each activity with a checkmark)
 Volunteer work Exercise Recreation Take courses Social activities Other (specify) _____
- e) Can you walk a full block without difficulty and without the use of a cane or walker? Yes No
 If not, explain. _____
- f) Can you go up a flight of stairs without difficulty? Yes No If not, explain. _____
- g) Do you drive an automobile? Yes No
- h) On what date was your driver's license last renewed? _____
- i) Have you ever been refused the right to renew your driver's license? Yes No
 If yes, provide the date of the refusal _____ and explain why _____

Last name

First name

Date of birth

File number

Y M D

22 AVIATION

Have you ever made or intend to make aerial flights other than as a passenger?

Yes No

If yes, complete the tables below and answer the following questions.

a) Statement of hours flown and expected number of flight hours:

Table with columns: Solo, IFR or ATR, Hours accumulated, During the past 12 to 24 months, During the past 12 months, In the next 12 months. Rows: UNPAID FLIGHTS, PAID FLIGHTS, MILITARY OR OTHER FLIGHTS.

- b) Licence: Student, Private pilot, Commercial pilot, Airline pilot (ATR), Instructor, Flight instruments (IFR), None, Other (specify):
c) Type of flights: Pleasure, Instructor, Taxi, passenger, Taxi, goods, Crop-dusting, Night flight, Business (specify):
d) Date of last flight

- e) Type of aircraft: Single engine, Multiengine, Ultralight motorized, Motorized hang-glider, Homebuilt (amateur-built), Helicopter, Glider, Balloon (hot air), Freeflight, Tethered, Record attempts, Other (specify):

- f) Who owns the aircraft?
g) Who performs the maintenance?
h) Over what areas are most flights made?
i) Have you ever had an accident or incurred any injuries during a flight?
j) Do you intend to continue flying?
k) Do you expect future flights to differ from those done in the past?
l) In the event you do not qualify for full coverage at standard rates, would you prefer:

23 HAZARDOUS SPORTS

In the last two (2) years, have you taken part in any hazardous sports, such as:

- Skin or scuba diving, Parachuting and/or skydiving, Mountain climbing, Automotive sports, Flying using hang-gliders, delta wings, etc., Other (specify):

If yes, complete the questionnaire on the overleaf (section 24).

SIGNATURE

I hereby declare that the answers and statements provided herein form an integral part of my application to Industrial Alliance Insurance and Financial Services Inc., that they are full, complete and true, and that no circumstances have been concealed that might affect the risk of insurance for which I have applied.

Signed at _____, on _____ Signature of the proposed insured (if aged 16 years or over)

Has the proposed insured's identity been verified? Yes No

Signature of the physician or nurse

Type of ID used to verify the client's identity

APPENDIX - DANGEROUS SPORTS

Answer the compulsory section below and complete the corresponding questionnaire.

In the last two (2) years, have you taken part in any hazardous sports, such as:

- Skin or scuba diving
- Parachuting and/or skydiving
- Mountain climbing
- Automotive sports
- Flying using hang-gliders, delta wings, etc.
- Other (specify): _____

If yes, complete the following compulsory section and corresponding questionnaire.

- Are you certified in this sport? If yes, explain. _____ Yes No
- How long have you been practicing this sport? _____
- How often do you practice this sport? Indicate frequency per month/year. _____
- When did you last practice this sport? _____
- Are you a member of a club? If yes, specify. _____ Yes No
- Do you practice this sport as: an amateur or a professional
If professional: Full-time Part-time (specify) _____
- Have you ever had an accident or incurred any injuries while practicing this sport? Yes No
- Do you intend to continue practicing this sport in the future? Yes No
- Do you expect any changes to your participation in this sport? If yes, specify. _____ Yes No
- In the event you do not qualify for full coverage at standard rates, would you prefer:
 to be covered for the sport you practice for an extra premium?
 not to be covered for the hazardous sport you practice?

SKIN OR SCUBA-DIVING (remember to also complete the compulsory section above)

- a) Provide a brief description of the equipment you use: _____
- b) Provide a brief description of your diving habits (security measures): _____
- c) Where do you dive? (rivers, lakes, shallow seas, deep-seas, high seas, other (specify)) _____
- d) Type of diving: Open water Cave diving Ice diving
 External exploration of wrecks Internal exploration of wrecks
 Treasure diving Salvage diving Other (specify) _____
- e) Do you dive alone? If yes, specify. _____ Yes No
- f) Have you ever suffered any ill effects due to diving. If yes, specify. _____ Yes No
- g) Details of dives

PERIOD	DEPTH								Specify depth: _____ ft.	
	60 ft. or less		61 ft. to 75 ft.		76 ft. to 100 ft.		101 ft. to 150 ft.		Number of dives	Number of hours
	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours		
24 to 36 months ago										
12 to 24 months ago										
Last 12 months										
Next 12 months										

PARACHUTING AND/OR SKYDIVING (remember to also complete the compulsory section above)

- a) Indicate the type of parachuting you practice:
 - Sport parachuting
 - Parachuting with respiratory equipment
 - Record attempts (specify): _____
 - Base jumping
 - Competition / acrobatics
 - Other (specify): _____
 - Para-sailing
 - Parachuting with experimental equipment
 - Marine parachuting
 - Para-skiing
- b) How many jumps have you made? In the last 12 to 24 months: _____
In the last 12 months: _____
- c) How many jumps do you plan to make in the next 12 months? _____

Last name _____ First name _____ Date of birth _____ File number _____

Y M D

CLIMBING AND MOUNTAINEERING (remember to also complete the compulsory section on the previous page)

- a) Specify the type of climbing and mountaineering you practice and where:
- Rock climbing Ice climbing Alaska → Mt McKinley Elsewhere
- Trail climbing Indoor climbing (ACW) In North America (excluding Alaska)
- Glacier climbing Other (specify) _____ Andes
- Elsewhere (specify) _____
- b) Do you climb alone? Specify: _____ Yes No
- c) Do you use a rope? Specify: _____ Yes No
- d) Height of climbs _____ Level of difficulty _____ Time of year you climb _____

AUTOMOTIVE AND MOTORCYCLE RACING (remember to also complete the compulsory section on the previous page)

- a) Indicate the types of races you participate in, how often you participate and the types of tracks.

	12 TO 24 MONTHS AGO	LAST 12 MONTHS	NEXT 12 MONTHS	TRACK	
				Oval-shaped	Other (specify)
Automobile racing					
Championship					
Stock-car					
Sprinting (drag)					
Demolition					
Sports car					
Midget					
Other (specify)					
Motorcycle racing					
Hill-climbing					
Sprinting (drag)					
Cross-country					
Motocross					
Other (specify)					

- b) Maximum speed: _____ mph or _____ kph
- c) Average speed: _____ mph or _____ kph
- d) Driving surface: Paved Unpaved Dirt road Other (specify): _____
- e) Modified vehicle: Yes → Safety purposes Performance purposes No
- Make: _____ Model: _____ Cylinders: _____ HP _____
- f) Fuel: Top Fuel Top alcohol Other (specify) _____
- g) Do you participate in races outside Canada? Yes No
- h) Specify the names of the tracks on which you race. _____
- i) Specify your reasons for practicing this sport (pleasure, cash, prizes, etc.). _____

HANG-GLIDERS, PARAFOILS, PARAGLIDING (remember to also complete the compulsory section on the previous page)

- a) Maximum altitude of under 50 feet? Yes No
- b) Do you use any equipment that is not manufactured, that is of an experimental nature or that represents any other particular risks? Yes No
- If yes, specify: _____
- c) Are you making record attempts? Yes No
- If yes, specify: _____

OTHER SPORTS

- a) Specify the sport practiced: _____
- b) If applicable, describe your level of certification, the equipment used when you practice this sport, the environment you practice it in and the frequency: _____

SIGNATURE

I hereby declare that the answers and statements provided herein form an integral part of my application to Industrial Alliance Insurance and Financial Services Inc., that they are full, complete and true, and that no circumstances have been concealed that might affect the risk of insurance for which I have applied.

Signed at _____, on _____ Signature of the proposed insured (if aged 16 years or over)

Has the proposed insured's identity been verified? Yes No

Type of ID used to verify the client's identity _____ Signature of the physician or nurse



**INDUSTRIAL
ALLIANCE**

INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

AUTHORIZATION

We hereby authorize any healthcare professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or professional investigation agencies and any public body holding information concerning ourselves or our family, particularly medical information, and any other body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance Insurance and Financial Services Inc. and its reinsurers for the risk assessment or the investigation necessary for the study of any claim. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Signed at _____ this _____ day of _____ 20 _____

Signature of proposed insured

Signature of witness