Desjardins
Insurance | LIFE · HEALTH · RETIREMENT

INSURABILITY QUESTIONNAIRE

Policy number:	Name of proposed insured:

SECTION A – INSTRUCTIONS

The following information applies only if the above-mentioned policy was issued following an insurance application **that required evidence of insurability** (whether an initial application for insurance or an application to amend the policy).

Complete **section B** if your insurability conditions have changed since the date the insurance application for the above-mentioned policy was signed.

If you answer **"Yes"** to at least one question in **section B, the policy will not be delivered.** If this is the case, use **section C** to provide detailed information about any question you answered **"Yes"** to. Your representative will tell you what can be done or what changes need to be made so that Desjardins Financial Security Life Assurance Company can modify or deliver the policy.

SECTION B – QUESTIONS

Since the date the insurance application for the above-mentioned policy was signed:

1. Have there been any changes to the information you provided about your health, lifestyle, smoking habits, tobacco use, occupation, travel abroad or participation in extreme sports? ..... ☐ Yes ☐ No
2. Have you suffered an accident, illness, disease, disorder or injury or undergone any operation or treatment? ..... ☐ Yes ☐ No
3. Have you had any consultations, examinations or treatments by a healthcare professional, or have you received a recommendation for a medical appointment or consultation with a healthcare professional that has not yet taken place? ..... ☐ Yes ☐ No
4. Are you scheduled to undergo a medical test or have you received a recommendation to undergo a medical test that has not yet taken place, or have you received the results of any medical tests that were abnormal?..... ☐ Yes ☐ No
5. Have you committed a highway traffic offence (e.g., violation of the Highway Safety Code or other similar laws) or a Criminal Code offence? ... ☐ Yes ☐ No

SECTION C – DETAILED INFORMATION

Please provide detailed information about any question(s) you answered "**Yes**" to above. You may also be required to complete a questionnaire.

If you have new medical information, please provide the name of the healthcare professional you consulted, the date of the consultation, the reason for the consultation, and the results and recommendations.

Question No.	Explanation	Date (YYYY/MM)	Name and address of healthcare professional

I, the proposed insured, hereby declare that all of the above information is true, accurate and complete, and I acknowledge that this information forms an integral part of the policy.

X _____
Signed at (city or town, province)

X _____
Date (YYYY/MM/DD)

X _____
Signature of proposed insured – including children age 14 and older (Quebec) or 16 and older (provinces other than Quebec)

X _____
Signature of guardian/legal representative for children under 18 years (Quebec) or under 16 years (provinces other than Quebec)

X _____
First and last name of representative (BLOCK LETTERS)

X _____
Signature of representative ☐ Check if trainee

X _____
Signature of supervisor (Quebec only)

SECTION D - AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

For the sole purpose of determining my insurability, managing my file and processing claims, I authorize Desjardins Financial Security Life Assurance Company or its reinsurers:

1. To collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers;
2. To disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file;
3. To request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed;
4. To disclose to my personal physician, any medical information about me that was obtained during the evaluation of my file;
5. To disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance;
6. To provide a brief report of my personal information to MIB, Inc., including information on my health.

This authorization also applies to collecting, using and disclosing personal and medical information concerning my minor children, insofar as they are subject to my application.

A photocopy of this authorization is as valid as the original.

The proposed insured, including children age 14 and older (Quebec) or 16 and older (provinces other than Quebec), has read this section before signing it.

X _____
Date (YYYY/MM/DD)

X _____
Signature of proposed insured – including children age 14 and older (Quebec) or 16 and older (provinces other than Quebec)

X _____
Signature of guardian/legal representative for children under 18 years (Quebec) or under 16 years (provinces other than Quebec)