beneva

Declaration of insurability

Plan member full name (please print) ______ Name of employer ______

Plan member's address ______

Home tel. ______ Work tel. ______

Full name of the insured ______ ☐ Plan member ☐ Spouse ☐ Dependent Child

Insured's occupation ______ Date of birth Y Y Y Y M M D D ☐ Male ☐ Female

Are you currently working? ☐ Yes ☐ No If not, reason: ______

1. a) Height: ______ ft ______ in or ______ cm
Weight: ______ lb or ______ kg

b) Weight loss in the last year? ☐ Yes ☐ No
If so, how much? ______ lb ______ kg Reason: ______

2. a) Date and reason of last medical appointment: Y Y Y Y M M D D ______

b) Name and address of the physician or clinic of last appointment: ______

c) Treatments/tests: ______ Results: ______

d) Was medication prescribed? Drug name: ______ Dose: ______

e) Were you referred to another healthcare professional? ☐ Yes ☐ No
If so, explain: ______

f) Were further tests or follow-ups recommended? ☐ Yes ☐ No
If so, explain: ______

g) Name and address of the physician or the clinic holding your medical file, if different from the one mentioned above. ☐ None

______

3. Have you ever consulted for, been treated for or shown signs or symptoms of any of the following conditions?	**Yes**	**No**
a) **Eye, ear, nose or throat disorders**: Partial or total blindness, macular degeneration, glaucoma, partial or total deafness, tinnitus, Meniere's disease, labyrinthitis or any other eye, ear, nose or throat disorder (excluding tonsillectomy, adenoidectomy, presbyopia and myopia)?	☐	☐
b) **Neurological system**: Cerebral palsy, loss of consciousness, loss of balance or dizziness, paralysis, concussion, migraines, epilepsy/convulsions, numbness, tremors, weakness in extremities, loss of sensation, blurred vision, optic neuritis, multiple sclerosis, Huntington's chorea, amyotrophic lateral sclerosis (ALS), Parkinson's disease, loss of memory, Alzheimer's disease, degenerative disease or any other cognitive disorder or condition affecting the brain, the spinal cord or the nerves?	☐	☐
c) **Respiratory system**: Asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea, sarcoidosis, spitting up blood, shortness of breath or any other respiratory disorder?	☐	☐
d) **Cardiovascular system**: High blood pressure, high cholesterol, heart murmur, aneurysm, chest pain, heart attack (infarct), angina, palpitations, transient ischemic attack (TIA), cerebrovascular accident (stroke) or any other heart, blood vessel or circulation disorder?	☐	☐
e) **Digestive system**: Crohn's disease, ulcerative colitis, celiac disease, polyps, hepatitis (including a carrier of hepatitis), cirrhosis, pancreatitis, bleeding, ulcers or any other disorder of the esophagus, stomach, liver, pancreas or intestines?	☐	☐
f) **Genitourinary system**: Urine abnormalities, disorders of the kidney, urinary tract, bladder, prostate or genital organs, including sexually transmitted diseases or abnormal PAP or PSA (prostate-specific antigen) tests?	☐	☐
g) **Endocrine system**: Diabetes, glucose abnormalities, disorder of the thyroid, pituitary gland, adrenal gland or any other glandular or hormonal disorder?	☐	☐
h) **Mental health, behavioural or developmental issues**: Depression, anxiety, panic attacks, burnout, insomnia, bipolar disorder, psychosis, suicide attempt, eating disorder, attention deficit disorder with or without hyperactivity (ADD/ADHD), autism spectrum disorder, intellectual impairment, Down syndrome or any other developmental, behavioural or mental health disorder?	☐	☐
i) **Musculoskeletal system**:		
1) Back or neck pain or disorder?	☐	☐
2) Arthritis, muscular dystrophy, fibromyalgia, or pain, disease or disorder of the muscles, bones, ligaments or joints such as the shoulders, elbows, wrists, hands, hips, knees, ankles, feet, etc.?	☐	☐
j) **Breast disorder**: Lump, bump, cyst or any other breast disorder?	☐	☐
k) **Cancer or tumour**: Leukemia, cancer, tumour, cyst, nodule, polyp, lump or excrescence?	☐	☐
l) **Immune system**: Acquired Immunodeficiency Syndrome (AIDS), positive test results for human immunodeficiency virus (HIV), lupus, scleroderma, any unexplained lymph node infection or swelling or any other immune system disorder?	☐	☐
m) **Other conditions** : Skin disease or abnormal skin lesion, blood disorder such as persistent anemia, coagulation disorder or any other physical or mental disease or disorder not mentioned above?	☐	☐

	Yes	No
4. In the last five (5) years:	☐	☐

a) Have you been admitted for more than 24 hours to a hospital, clinic, treatment home, convalescence centre or any other healthcare institution (excluding for childbirth)? If so, admission date: Y Y Y Y M M D D

Institution(s): ____________________

Reason(s): ____________________ Results: ____________________

b) Have you had a blood test, resting or exercise electrocardiogram, echocardiogram, colonoscopy, X-ray, mammogram, ultrasound, CT scan, MRI, biopsy or any other test for diagnostic purposes? If so, please indicate: ☐ Yes ☐ No

Type of test	Date	Reason	Result

c) Have you ever been absent from work or ceased performing your regular duties for more than one week due to an accident or illness? If so, what was the start date: Y Y Y Y M M D D Reason(s): ____________________ ☐ Yes ☐ No

Duration: ____________________ Sequelae or limitations: ____________________

d) Have you ever consulted a chiropractor, physiotherapist, occupational therapist, osteopath, acupuncturist, podiatrist, audiologist, psychologist or any other healthcare professional? If so, please indicate: ☐ Yes ☐ No

Professional consulted	Reason/diagnosis	Date of the first visit	Date of last visit	Number of visits per year	Date of last symptoms

5. Do you currently take medication or have you previously taken medication for more than 21 consecutive days in the last twelve (12) months (other than medication previously mentioned)? ☐ Yes ☐ No

If so, name of medication: ____________________ Dosage: ____________________ Reason: ____________________

Start date: ____________________ End date: ____________________ ☐ Still taking

6. Have you been advised to undergo treatment, surgery, diagnostic exams or tests which have not yet been performed or for which you are awaiting results? ☐ Yes ☐ No

7. Do you intend to consult a healthcare professional such as a psychologist, chiropractor, osteopath or other? ☐ Yes ☐ No

8. Do you have any symptoms, signs or discomfort for which you have not yet consulted? ☐ Yes ☐ No

Please provide details for any question answered ”YES” for questions 3 to 8. If additional space is required, please attach a separate sheet that is dated and signed.

Question No.	Illnesses/disorders	Date of diagnosis or start date	Frequency of episodes	Medications/treatments	Recovery date or current status

9. a) Has your father, mother, a brother or sister (living or deceased) ever been diagnosed with one or more of the following conditions: Polycystic kidney disease, Huntington’s chorea, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease), multiple sclerosis, familial adenomatous polyposis, muscular dystrophy or any other hereditary disease? If so, please indicate: ☐ Yes ☐ No

	Condition(s)	Age at diagnosis	Age if living	Age at death		Condition(s)	Age at diagnosis	Age if living	Age at death
Father					Brother(s)				
Mother					Sister(s)				

b) Has your father, mother, a brother or sister (living or deceased) ever been diagnosed before age 60 with one or more of the following conditions: Heart disease, cerebrovascular accident, cancer (specify the type) or diabetes? Don’t indicate family history of high blood pressure or high levels of cholesterol. If so, please indicate: ☐ Yes ☐ No

	Condition(s)	Age at diagnosis	Age if living	Age at death		Condition(s)	Age at diagnosis	Age if living	Age at death
Father					Brother(s)				
Mother					Sister(s)				

Children under the age of 14 do not have to answer questions 10 to 18.

Question	Yes	No
10. a) Do you consume alcoholic beverages (one serving equals 341 ml or 12 oz. of beer, 150 ml or 5 oz. of wine or 45 ml or 1.5 oz. of spirits)? If so, indicate the number of servings per week: Beer: ______ Wine: ______ Spirits: ______	☐	☐
b) Was your level of consumption higher in the past? If so, indicate your past consumption, the date and the reason your habits have changed: Past number of servings per week: Beer: ______ Wine: ______ Spirits: ______ Date: YYYYMMDD Reason: ______	☐	☐
c) Do you use cannabis products for recreational or medicinal purposes (include all forms of cannabis, marijuana and hash)? If so, please indicate:	☐	☐

Type	Quantity	Frequency	Usage date	Type of usage
Joints	Number of joints: ______	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD to YYYYMMDD	☐ Recreational ☐ Medicinal*
☐ Edible product ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD to YYYYMMDD	☐ Recreational ☐ Medicinal*

*If you were using it for medicinal purposes, please fill out the following chart:

For what condition	Prescribed	Prescribing physician (name and contact information)
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Question	Yes	No
d) Was your level of consumption higher in the last two (2) years? If so, indicate past consumption, the date and the reason your habits have changed: Form: ______ Quantity: ______ Frequency: ______ Date: YYYYMMDD Reason: ______	☐	☐
e) In the last ten (10) years, have you used drugs or narcotics that were not prescribed by a physician (e.g. cocaine, ecstasy, LSD, magic mushrooms, heroin, fentanyl, anabolic steroids, etc.)? If so, please indicate:	☐	☐

Type	Quantity	Frequency	Usage date
______	______	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD to YYYYMMDD

Question	Yes	No
f) With regard to your consumption of alcohol, cannabis or other drugs, have you been advised to reduce or cease your consumption, consulted a healthcare professional, had therapy or treatment or attended support group meetings? If so, date: YYYYMMDD Details: ______	☐	☐
11. In the last five (5) years, have you used tobacco or consumed any product containing nicotine such as cigars, cigarillos, cigarettes, marijuana/ cannabis with tobacco, e-cigarettes, vaping products, pipes, nicotine gum or patches? If so, what types: ______ Quantity per day: ______ Last used: YYYYMMDD	☐	☐
12. a) In the last twelve (12) months, have you travelled or lived outside of Canada or the United States? If so, date: YYYYMMDD Destination: ______ For how long: ______ Reason: ______	☐	☐
b) In the next twelve (12) months, do you intend to travel or live outside of Canada or the United States? If so, date: YYYYMMDD Destination: ______ For how long: ______ Reason: ______	☐	☐
13. In the last three (3) years, have you been found guilty of two or more violations of the Highway Safety Code? If so, please indicate the dates, types of infractions and km per hour over the speed limit:	☐	☐
14. In the last ten (10) years: a) Have you ever been charged with or found guilty of impaired driving or has your driver's licence been suspended? If so, date of the infraction: YYYYMMDD Grounds: ______ Date the driver's licence was reinstated: YYYYMMDD	☐	☐
b) Have you ever been charged with or found guilty of any criminal offence or fraudulent transactions? If so, date: YYYYMMDD Grounds: ______ Charge(s): ______ Sentence: ______	☐	☐

	Yes	No
15. Are you currently being investigated by or are you temporarily or permanently suspended from a professional association in Canada or the United States? If so, please explain: ______	☐	☐
16. In the last twelve (12) months, have you participated in activities such as motorized vehicle races, scuba diving, skydiving, flying ultralights, private flights, hang gliding, mountain or rock climbing, bungee jumping, off-trail skiing (heliskiing, catskiing, etc.), combat sports or any other hazardous sport? If so, specify what sports: ______ Last participated: Y Y Y Y M M D D	☐	☐
Do you intend to practise any of these sports in the next 12 months? If so, specify what sports: ______	☐	☐
17. Have any of your applications for insurance ever been declined, modified or accepted with an extra premium or exclusion? If so, date: Y Y Y Y M M D D Reason: ______ Insurer: ______	☐	☐

18. For women only:

Are you currently pregnant? ☐ Yes ☐ No If so, complete:

a) What is the due date? Y Y Y Y M M D D b) Weight before pregnancy: ______

c) Are you having or have you had complications during pregnancy or childbirth (e.g. gestational diabetes, caesarean section, preeclampsia, ectopic pregnancy, premature labour, miscarriage, etc.)?

If so, date: Y Y Y Y M M D D Details of complications: ______

d) Is the delivery anticipated to be normal? ☐ Yes ☐ No If not, provide details: ______

Notice to proposed insured persons

MIB, LLC notices

Certain information must be collected when an insurer receives an application for insurance and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insured persons, most insurance companies, including Beneva Inc., work with an organization called MIB, LLC (MIB).

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report on this subject to MIB, which operates an information exchange on behalf of member insurance companies of the MIB Inc. Group. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply this company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in its files. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866 692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set out in the federal *Fair Credit Reporting Act*. The address of the MIB's information bureau is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Personal Information Protection Notice

Beneva[1] believes that protecting your personal information is essential. That is why, unless legislation authorizes us to do otherwise, we inform you that we are collecting, using and communicating your personal information, with your consent, for the length of time to required for the following purposes

- Identifying you
- Determining and updating your profile, needs and objectives
- Analyzing your applications and eligibility for our products and services
- Communicating advice based on your situation
- Administering your contracts, products and services (e.g. pricing, underwriting, processing your claims, etc.)
- Complying with legal and regulatory requirements (e.g. preventing, detecting or quashing infractions, cyberthreats, fraud, etc.)
- Obtaining your opinion about our products and services
- Providing you with offers and personalized advice on our products and services in line with your preferences and in compliance with the rules on electronic and telephone communications (See your right to withdraw your consent)
- Conducting studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

1. The term "Beneva" refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. The term "Affiliates of Beneva Inc." designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L'Unique General Insurance Inc. and Unica Insurance Inc.

What methods does Beneva use to collect your personal information?

We collect your personal information by telephone, in person, with our forms and our digital interfaces.

To whom does Beneva communicate your personal information?

For the reasons mentioned above, and only when related to your products or services, we communicate your personal information to our affiliates and our distribution networks, as well as third parties, some of which may be located outside Quebec and Canada.

These third parties may include:

- Other financial institutions, such as insurers and reinsurers
- Other organizations or entities that hold information about you such as insurance, fraud or claims information
- Intermediaries
- Credit rating agencies
- Government ministries and agencies or regulatory authorities
- Employers
- Claims' services providers such as healthcare professionals and car repair establishments
- Other agents and service providers (technological services, printing and document shipping services, etc.)

Note that we ensure that your personal information always remains confidential.

What access and rectification rights do you have?

You can access your personal information and request that incomplete or inaccurate information be corrected. Send your request to the following address:

Chief Privacy Officer

Beneva
625 rue Jacques-Parizeau
Québec QC G1R 2G5
ResponsablePRP@beneva.ca

To find out more about our protection of personal information practices, see our Privacy Statement at www.beneva.ca

Your consent for collecting, using and communicating your personal information is required for providing you with a product or service that you have been offered or for which you have applied. You have the right to withdraw your consent, but this means that Beneva cannot provide you with its products or services.

Declarations

The undersigned:

1. Agrees that all information they disclosed during a telephone interview **recorded** by a paramedical company or any other person authorized to represent Beneva Inc. or acting on its behalf, including but not limited to medical history and health status, is deemed to be part of this application and this information can be used to issue the contract underwritten by Beneva Inc. The undersigned agrees also that any recording, transcription or other reproduction of this information by Beneva Inc. or on its behalf will be considered as accurate, complete and binding as a written document.
2. Agrees that if the recorded information is found to be inaccurate or incomplete (including, but not limited to, information provided to support non-smoking rates for an insured person in accordance with the terms of the contract they have applied for), the contract is null and void for that insured person.
3. Declares having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applications. This is the case for the electronic application, which allows for assessing a person's risk profile in order to provide the best possible premium. The undersigned agrees that submitting an application activates this process.
4. Declares having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.
5. Declares that the preceding statements are true, complete and correctly entered and are part of the application for insurance from Beneva Inc. Any misrepresentations or omissions by proposed insured persons concerning circumstances known to them that may significantly influence a reasonable insurer in determining the premium, assessing the risk or deciding to accept the risk could result in the contract being declared null and void, upon the insurer's request, even with regard to claims that are not related to risks that have been misrepresented or omitted.
6. Declares having been made aware of the personal information protection notice as well as all other notices to the insured person.

______________________ this ____________ day of ____________ the year ____________

Signed at (city and province) Date

X ______________________

Insured's signature

X ______________________

Signature of the father, mother or legal guardian of a minor insured
(child's insurance)

Authorizations

In order that we may provide you with and administer your products and services, the following authorizations are required.

1. I authorize any professional and any intervening party in the field of health, any healthcare service provider, any public or private health or social services institution, any insurance or reinsurance company, the MIB, LLC, any investigation agency as well as any natural person or entity that may hold personal information concerning my state of health, medical history or lifestyle habits required for the reasons mentioned above in the notice on protecting personal information to communicate it to Beneva Inc. or its reinsurers. This authorization is only valid for the time period required for achieving the purposes for which it was requested.
2. I authorize Beneva Inc. and its reinsurers to collect, use and communicate the personal information required for the reasons mentioned in the notice concerning the protection of personal information to any professional and any intervening party in the field of health, any healthcare service provider, any public or private health or social services institution, any insurance or reinsurance company, any investigation agency, any natural person or entity that may hold personal information concerning my state of health, medical history or lifestyle habits as well as to MIB, LLC. This authorization is only valid for the time period required for achieving the purposes for which it was requested.
3. I authorize Beneva Inc. and its reinsurers to gather, use and communicate personal information held by a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is only valid for the time period required for achieving the purposes for which it was requested.
4. I authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and authorizations required for assessing the death benefit claim and obtaining the necessary supporting documents.

Insured person

I acknowledge that I have read the four authorizations above and I consent to them.

	X	Y Y Y Y M M D D
Name of insured (please print)	Insured's signature	Date
	X	Y Y Y Y M M D D
In the case of a minor: The name of the mother, father or legal guardian (please print)	In the case of a minor: Signature of the mother, father or legal guardian (indicate the relationship with the insured)	Date

The proposed insured person must make a complete copy of this form for reference purposes.