Evidence of Insurability Form

Section 1 Employee Information

Please print clearly

Name of Employer	Client No.
Employer's Address	
Name of Employee	Occupation
Employee's Address	
Home Telephone	Work Telephone

❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Place of Birth (City and Country)	Height (ft./in.)	Weight (lbs.)

Regular Physician or Family Doctor Name and Address

Date and Reason Doctor Last Seen and Results

Section 2 Applicant Questions

Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

	Yes	No
1. Have you had any indication of or been treated for:		
a. any disease or disorder of the eyes, ears, nose, mouth or throat, or any allergies including any job-site environmental sensitivity?	❑	❑
b. lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other respiratory disorder?	❑	❑
c. dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, multiple sclerosis, chronic anxiety, burnout, fatigue, depression or eating disorder?	❑	❑
d. chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	❑	❑
e. hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorders of the stomach, intestine, liver or gall bladder?	❑	❑
f. sugar, albumin, protein, blood and/or pus in the urine, sexually transmitted disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	❑	❑
g. any hereditary disorders or diabetes, thyroid or other endocrine disorders?	❑	❑
h. gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	❑	❑
i. disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	❑	❑
j. anemia or other disorder of the blood, or have you ever received a blood transfusion or blood products?	❑	❑
2. Are you currently taking any medication, receiving treatment(s) or following a special diet?	❑	❑
3. Have you ever used or dealt in barbiturates, narcotics, or other drugs or hallucinogens, including marijuana and cocaine, except as prescribed by a physician, or received, been advised to receive or are you currently receiving treatment or counseling for the use of drugs?	❑	❑
4. Have you used any form of tobacco or cannabis in the last 12 months?	❑	❑
5. Do you consume alcoholic beverages? If yes, quantity per week: bottles of beer glasses of wine ounces of liquor	❑	❑
6. Have you ever been advised to drink less alcohol, received treatment or joined an organization because of alcohol? If yes, please provide details:	❑	❑
7. Within the past 5 years, has your driver's licence been suspended or taken away from you? If yes, date and reason:	❑	❑
8. Have you ever tested positive for, been diagnosed with or been told you have Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) disease?	❑	❑
9. Do you participate in organized contact sports or hazardous activities (e.g., mountain climbing, hang-gliding, scuba-diving, parachuting, flying (pilot/crew member), motorized racing)?	❑	❑
10. Do you contemplate a trip or taking up residence outside Canada or the USA? (Specify location and duration below)	❑	❑

Continued on the back

Section 2 Applicant Questions (continued)

Please print clearly

Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

	Yes	No
11. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	❑	❑
12. Are you currently unable to work, whether inside or outside the home? How many work days have you lost due to disability/illness in the last two years?	❑	❑
13. Other than above, have you within the last five years:		
a. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	❑	❑
b. received medical or surgical attention due to illness or injury?	❑	❑
c. been a patient in a hospital, clinic, sanitarium or other medical facility?	❑	❑
d. had an electrocardiogram, x-ray or other diagnostic tests with abnormal findings or indicating any health problems?	❑	❑
e. sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care, etc.?	❑	❑
f. requested or received a pension, benefits or payment because of an injury, sickness or disability?	❑	❑
14. Are you currently pregnant? If so, due date:	❑	❑

Section 3 For every "Yes" answer given above, please provide full details

Question No.	Nature of disorder	Date of first occurrence	Current status and treatment

Section 4 Important Notices

Medical Information Bureau

Information regarding your insurability will be treated as confidential. SSQ, Life Insurance Company Inc., or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau will, upon request, supply such company with information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction.

The Bureau's address is: Medical Information Bureau, 501 – 330 University Avenue, Toronto, Ontario M5G 1R7.

SSQ, Life Insurance Company Inc., or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Personal Information Protection

To safeguard the confidentiality of your personal information, SSQ, Life Insurance Company Inc. opens an insurance file to hold information about your application for insurance and any claims you make.

Access to your file is restricted to those employees and agents of SSQ who must consult your file for underwriting, claims adjudication and claims audit purposes, and any other person you may authorize.

Your file is kept at SSQ's offices. You may consult the personal information contained in your file, and have any errors or inaccuracies rectified, by making a request in writing to the following address: Personal Information Protection Officer, SSQ, Life Insurance Company Inc., 2525 Laurier Blvd, P.O. Box 10500, Station Sainte-Foy, Quebec, PQ G1V 4H6.

SSQ, Life Insurance Company Inc. has a strict Personal Information Protection Policy. To obtain a brochure outlining this policy, you may send a request in writing to SSQ's Personal Information Protection Officer at the address provided above or visit their website at www.ssq.ca.

Section 5 Declaration and Authorization

I hereby declare that I have read this statement and I certify that the answers recorded above are full, complete, true and consistent with the statements I have made. I have kept a duly completed and signed copy of this form. I understand that these answers shall be part of my application for insurance. I also understand that any misrepresentation or concealment on my part may void any coverage issued as a result of this application.

I have read the notices in Section 4 regarding personal information protection and the Medical Information Bureau and I concur with the contents thereof.

I hereby authorize SSQ, Life Insurance Company Inc., its mandatories and reinsurers, and ENCON Group Inc., as required for determining insurability and for insurance management, including claim settlement purposes:

a) to obtain information, solely to the extent required for processing my file, from any individual or corporation, or any public or parapublic organization which has personal information about me or about my dependents, according to the terms of the contract, including any physician or health care professional, any medical or paramedical facility, the Medical Information Bureau and any other insurer;
b) to only disclose the personal information that they may have about me or about my dependents, according to the terms of the contract, to the extent required, to such individual or organization; and
c) to use the necessary personal information contained in any other file already held by them which has been completed.

A photocopy of this authorization shall be as valid as the original. This authorization shall be valid only for the period necessary to effect the purposes stated herein.

Please sign here

Signature

Date (yyyy/mm/dd)