SSQ Financial Group

DECLARATION OF INSURABILITY

BBD

BC Office
500 – 2755 Lougheed Hwy
Port Coquitlam, BC V3B 5Y9
1-800-668-2295

Ontario Office
107 – 6 Cataraqui Street
Kingston, ON K7K 1Z7
1-888-272-0413

Name of Employer			
Name of Employee		Occupation	
Employee's Address			
Home Telephone	Work Telephone	Best Time to Contact ☐ Home ☐ Work ☐ a.m. ☐ p.m. ☐ evening	
Name of Applicant		☐ Employee ☐ Spouse ☐ Child	
1. Height: _____ ft _____ in or _____ cm Weight: _____ lb or _____ kg		Date of Birth Y M D	☐ Male ☐ Female

2. 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? _____

For each affirmative answer, 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	**Details**
a)	Eye, ear, nose or throat disorders;	☐	☐	
b)	Dizziness, fainting, convulsions, epilepsy, headaches, paralysis, neurological condition, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease, degenerative disease;	☐	☐	
c)	Shortness of breath, persistent hoarseness or cough, coughing up blood, chronic 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 ECG, stroke (CVA), transient ischemic attack (TIA), cardiac arrhythmia, peripheral vascular disease, phlebitis or any other disorders of the heart or blood vessels;	☐	☐	
e)	Hepatitis, carrier of hepatitis, cirrhosis, jaundice, intestinal bleeding, ulcer, colitis, ulcerative colitis, Crohn's disease, ileitis, diverticulitis, or other disorders of the esophagus, stomach, intestine, liver or pancreas;	☐	☐	
f)	Sugar, blood, pus or protein in urine, stones or other disorders of the kidneys, bladder, prostate, testicles or reproductive organs, sexually transmitted disease, breast disorder including lumps, cysts, other physical changes or abnormal mammogram findings or biopsy;	☐	☐	
g)	Diabetes, thyroid, high cholesterol or other endocrine disorders;	☐	☐	
h)	Anxiety, depression, burnout or other psychiatric, psychological or nervous disorders, chronic fatigue syndrome, mental retardation or other mental disorders;	☐	☐	
i)	Lupus, neuritis, arthritis, rheumatism, gout, or other disorders of the bones or muscles, including the spine, back and joints;	☐	☐	
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)	AIDS, positive HIV screening test or AIDS-related complex (ARC), or positive result for a hepatitis B or C sceening test;	☐	☐	
n)	Any mental or physical disorder not mentioned above.	☐	☐	
4.	Within the past 5 years, have you: a) consulted a chiropractor, a physiotherapist, psychologist, acupuncturist, audiologist, speech therapist, osteopath or podiatrist?	☐	☐	
	b) had an electrocardiogram (resting or stress), echocardiogram, X-Ray, MRI, blood test, biopsy or any other test?	☐	☐	
	c) been a patient in a hospital or a clinic?	☐	☐	
5.	Do you take any medication other than that mentioned previously?	☐	☐	
6.	Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done, which was not completed?	☐	☐	
7.	Do you have any signs or symptoms for which you have not sought treatment or consulted a doctor?	☐	☐	
8.	Within the past 5 years, have you been absent from work or had to stop your ordinary activities for a period of 7 days or more due to illness(es) or injury(ies)?	☐	☐	
9.	Do you have any physical or mental condition that limits your ability to perform your daily activities?	☐	☐	

Do not answer questions 10 to 18 for children under age 18

Yes No

10. a) Do you consume alcoholic beverages? If yes, quantity per week: Beer: _____ bottle(s), Wine: _____ glass(es), Hard liquor: _____ ounce(s) ☐ ☐

b) Has your level of consumption been higher in the past? If yes, state when and why you changed your consumption habits: ☐ ☐

Date: Y M Reason: _____

Previous quantity per week: Beer: _____ bottle(s), Wine: _____ glass(es), Hard liquor: _____ ounce(s)

c) Have you ever used marijuana, hashish or cannabis? ☐ ☐

If yes, quantity: _____ frequency: _____ duration: from Y M to Y M

d) Have you ever used cocaine, LSD, heroine or other narcotic drugs? ☐ ☐

If yes, type: _____ quantity: _____ frequency: _____ duration: from Y M to Y M

e) Have you ever undergone detoxification treatment or been advised to do so? ☐ ☐

If yes, date: Y M Name of Institution: _____

11. Within the past 12 months, have you used tobacco products such as cigarette, cigar, cigarillo or pipe or smoked drugs? ☐ ☐

12. Do you intend to travel or live outside Canada or the United States? ☐ ☐

If yes, date: Y M Destination: _____ Duration of trip: _____

13. Within the past 5 years, has your driver's licence been suspended or taken away from you? ☐ ☐

If yes, date: Y M Reason: _____

14. Have you ever been convicted of a criminal offence or are there any charges pending against you ? ☐ ☐

If yes, date: Y M Type of criminal offence: _____ Sentence: _____

15. Within the past 5 years, have you practised a high-risk activity such as mountain climbing, parachuting, motor vehicle racing, hang-gliding, scuba diving, or flying in an ultra-light or privately owned aircraft or other? ☐ ☐

If yes, activity: _____ Date of most recent participation: Y M

Do you still intend to practice this activity? ☐ ☐

16. Has any application for insurance filed by you been refused or been modified or accepted with an extra premium or exclusion? ☐ ☐

If yes, date: Y M Reason: _____ Insurer: _____

17. Family history Do any of the 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? ☐ ☐

If yes, provide details:

Family history	Age at onset	Age if alive	Age at death	State of health or cause of death	Family history	Age at onset	Age if alive	Age at death	State of health or cause of death
Father					Brother(s)				
Mother					Sister(s)				

18. For women only:

a) Are you currently pregnant? Yes ☐ No ☐ If yes, expected due date: Y M

b) Are you experiencing any complications with the pregnancy? Yes ☐ No ☐ If yes, provide details: _____

c) Is the delivery anticipated to be normal? Yes ☐ No ☐ If no, provide details: _____

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, 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number 416-597-0590.

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, Quebec 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.

DECLARATION AND AUTHORIZATION TO OBTAIN AND TO DISCLOSE PERSONAL INFORMATION TO OTHERS

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 understand that these answers shall form the basis of the insurance contract. I also understand that any misrepresentation or concealment on my part may lead to insurance being cancelled. I acknowledge that I have kept a complete and duly signed copy of this form.

I have read both notices above regarding personal information protection and the Medical Information Bureau and I concur with the contents thereof.

I hereby authorize SSQ, Life Insurance Company Inc. (SSQ), its mandataries, the group plan administrator, its service providers and its reinsurers, 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; and

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 individual or organization.

I authorize SSQ, the group plan administrator, or their representatives and/or agents to request I undergo any medical or paramedical examination(s) or evaluation(s) as may be required for the purposes mentioned above. I understand that my refusal or withdrawal of consent may result in the delay or denial of my application.

A copy 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.

Date : Y M D

Signature of Applicant: _____

(Parent or guardian if for a child under age 18)