UV INSURANCE

Complementary to the
Individual Insurance Application

CREDIT INSURANCE RIDER

Insured's Last Name
First Name
Contract or Application No.

1. Coverage requested:

a) Amount: $ _____ /month

(min. $300, max. 1.5% of life insurance amount requested without exceeding $3,500)

b) Coverage option:

☐ 2 years ☐ 5 years ☐ to age 65

c) Table of loans to be insured:

LOAN TO INSURE	BALANCE	MONTHLY PAYMENT	LOAN ALREADY INSURED		TO REPLACE		NAME OF INSURER
			YES	NO	YES	NO	
Mortgage loan	$	$	☐	☐	☐	☐	
Mortgage line of credit	$	$	☐	☐	☐	☐	
Personal line of credit	$	$	☐	☐	☐	☐	
Personal loan	$	$	☐	☐	☐	☐	
Motorized vehicle loan	$	$	☐	☐	☐	☐	
Student loan	$	$	☐	☐	☐	☐	
Commercial loan	$	$	☐	☐	☐	☐	
Lease	$	$	☐	☐	☐	☐	
	$	$	☐	☐	☐	☐	
	$	$	☐	☐	☐	☐	

2. What is your current status? ☐ Salaried employee ☐ Self employed ☐ Stay at home spouse ☐ Parental leave

3. What is your occupation? _____

4. What is your annual gross income? $ _____

5. Name and address of your employer or your business:

Name _____

Address _____ City _____ Postal Code _____

6. Nature of the business (sector of activity): _____

7. If you are self employed, what is the percentage of your shares in the business? _____ %

8. Number of years at your employer or self employed: _____ year(s)

9. Number of hours worked per week: _____ hour(s)

10. Number of weeks worked per year: _____ week(s)

11. Number of years in a similar business: _____ year(s)

12. Briefly describe your tasks: _____

13. What percentage of your work is considered manual? _____ %

14. Do you work from home? ☐ Yes ☐ No

If yes, confirm the number of hours worked from home per week: _____ hour(s)

15. Do you have income replacement insurance with your employer? ☐ Yes ☐ No

If yes, name of insurer: _____

_____ % of income ☐ In force ☐ Pending

This document must be duly completed and signed to be valid.

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Contract or Application No.

Page 12, Section D, **Question 1 i)** must read:

Have you ever received care, consulted, been diagnosed or experienced symptoms relating to the following disorders: (to encircle if it is necessary)

Disorder of muscle, bone, joint, back, neck or ligament, sprains, tendinitis, synovitis, fracture, rheumatism, arthritis, gout, osteoporosis, osteoarthritis, fibromyalgia, chronic pain syndrome, amputation, degenerative disc disease, myasthenia gravis, post-polio syndrome or other musculoskeletal disorders? ☐ Yes ☐ No

For all affirmative answers, please complete the following table:

Date	Reason	Details: Tests, Results, Treatment, Duration, Recovery Date, Sequela, Name of Doctor and Hospitals Consulted

Page 12, Section D, **Question 8** (women only)

a) Have you already had complications during pregnancy (current or past)? ☐ Yes ☐ No ☐ Not applicable

If yes, please give details:

_____

_____

_____

b) Are you currently pregnant? ☐ Yes ☐ No

If yes:

1. Expected date of birth: _____
2. Name of attending physician or healthcare worker: _____

   Address: _____
3. What was your weight before pregnancy? _____ lbs _____ kg

Signed at _____ prov. _____ this _____ day of _____ 20 ____

X _____
Signature of person to be insured

X _____
Owner's signature (if a company, duly appointed representative)

X _____
Signature of Financial Advisor/Witness

X _____
Advisor/Witness
(capital letters)

EN-22-UV-2019-04-ANNEX

This document must be duly completed and signed to be valid.