UV INSURANCE

DECLARATION OF INSURABILITY

(USE ONE FORM FOR EACH INSURED)

POLICY NUMBER : _____

PART I

❒ Reinstatement ❒ Policy Change ❒ Change to non smoker

(Urine sample required for all amounts) Order no. _____

Policy Number _____

Name of the insured at birth _____ Date of Birth _____

Address _____ Postal Code _____ Tel. (_____)_____

Occupation _____ Employer _____

Is the insured working 12 months per year? Yes ❒ No ❒ If no, why? _____

Since the policy was issued, has the insured:

			Yes	No	Please detail each of the answers where you checked yes:
1.		Submitted an insurance application to another insurance company or to UL Mutual? **If yes, provide amount of insurance, company and issue date:** _____	❒	❒	
2.		Been declined, changed or postponed any application for life insurance, critical illness, disability or reinstatement? **Details …**	❒	❒	
3.	a)	Engaged or intends to make aeronautical flights other than a passenger of commercial lines? **If yes, complete the Aviation Questionnaire**.	❒	❒	
	b)	Practiced or intends to practice sports with particular risks such as: scuba diving, parachuting, car racing, hang gliding, motorcycle, etc.? **If yes, complete the appropriate form(s).**	❒	❒	
	c)	Had or intends to travel or reside outside North America? **If yes, complete the Foreign Travelling Questionnaire.**	❒	❒	
4.	a)	Ever used alcoholic drinks? **Details …**	❒	❒	
	b)	Ever used drugs (marijuana, cocaine, speed, or others)? **If yes, complete the Drug Questionnaire.**	❒	❒	
5.		Consulted a doctor or another health professional? **If yes, provide date, reason, result, name of doctor and address.**	❒	❒	
6.		Taken or is taking medication? **If yes, give reason, name of the medication and dosage.**	❒	❒	
7.		Had a test or an exam or is in medical investigation for a weakness, pain or other health disorder? **If yes, provide date, reason, test, treatment, name of the doctor or hospital.**	❒	❒	
8.		Suffer or suffered from the Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or other immunological disorder, or had a positive test for exposure to the AIDS virus or the HIV antibody? **Details …**	❒	❒	
9.	a)	Made use of tobacco or product produced from tobacco (nicorettes, nicotine patch) under any form, or cannabis, marijuana or other within the last 12 months? **Details …**	❒	❒	
	b)	When did you quit using tobacco or tobacco products if any? _____/_____/_____	❒	❒	
10.	a)	Had its driver's license revoked? **Details…**	❒	❒	
	b)	Lost any demerit points on his/her driving record? **Details…**	❒	❒	

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PART I (CONTINUED FROM PAGE 1)

11. Height: _____ ft. _____in. _____ m _____ cm Weight: _____ lbs _____ kg

Has your weight changed in the last year? Yes ❒ No ❒ **Details:** _____

12. Family History (complete the entire table for each family members even if they are in good health)

Family Member	Condition (illnesses)	Age at the beginning of illness, If applicable	Current Age	Age at Death, If applicable	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

➔ **If the plan is not ADAPCI+ (critical illness), go directly to page 4 for signatures.**

PART II (TO COMPLETE ONLY FOR ADAPCI+ CRITICAL ILLNESS)

1) Since the policy was issued, has the insured consulted, been diagnosed, or suffered one or more of the following disorders:

		Yes	No
a)	Ears, eyes, nose or throat disorder?	❒	❒
b)	Lungs, asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), blood spitting, sleep apnea, sarcoidosis, or other respiratory or pulmonary disorder?	❒	❒
c)	Nervous system disorder, epilepsy, dizziness, tremors, convulsions, multiple sclerosis: optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance, loss of sensation, or other neurological or brain disorder?	❒	❒
d)	Mental, nervous or emotional disorder, attention deficit disorder, hyperactivity, burn-out, depression, panic attack, anxiety, suicide idea or attempt, or other psychiatric, emotional or mental disorder?	❒	❒
e)	Heart or blood vessel disorder: chest pain, palpitations, hypertension, rheumatic fever, heart murmur, heart attack, stroke, high cholesterol, transient ischemic attack (TIA) angina, valve, incompetence, bypass, thrombophlebitis or other heart diseases, or cardiac surgery?	❒	❒
f)	Abdominal organ disorder: bleeding, ulcerative colitis, Crohn's disease, hepatitis all type, hepatitis carrier, steatosis, polyp, diverculitis or other disorder of the stomach, intestines, liver, or pancreas?	❒	❒
g)	Kidney, bladder or genital organs diseases: sugar, blood or proteins in the urine, stone or any other kidney diseases, hypertrophy of the prostate, kidney failure, hysterectomy, precancerous cells in the cervix or other disorder of the kidney, bladder, or genital organ?	❒	❒
h)	Blood or glands disorder: diabetes, thyroid glands disorder, lymphatic gland disorder, pituitary gland disorder, coagulation disorder, hemochromatosis, skin disorder, lupus or other disorder of glands, blood, or skin?	❒	❒
i)	Muscular-skeletal disorder: paralysis, muscle, bones, joints, tendons, ligament, rheumatism, arthritis, osteo-arthritis, gout, osteoporosis, fibromyalgia, back pains, or other musculoskeletal disorder?	❒	❒
j)	Benign or malignant tumour, cyst, beauty mark, cancer, tumour, mass, skin lesion, nodule, lump, naevus, mole, or has undergone radiotherapy or chemotherapy?	❒	❒
k)	Genetic condition, incurable disease or physical or mental handicap including intellectual deficiency?	❒	❒
l)	Does he/she suffer from an illness, syndrome, or disorder not mentioned previously?	❒	❒

PLEASE COMPLETE THE TABLE BELOW FOR EACH ANSWER WHERE YOU CHECKED YES.

Quest. No.	Date	Reason	Details: tests, results, treatment, recovery date, after effect, name of the consulted doctors or hospitals

PART II (CONTINUED FROM PAGE 2)

2) Has the insured applied for a disability claim or received benefits, disability income or compensation or requested additional financial help as a result of an injury, illness or handicap?

Yes ❒ No ❒ If yes, details: _____

_____

3) Was the insured aware of any symptom or weakness for which he/she did not consult a physician or receive treatment?

Yes ❒ No ❒ If yes, details: _____

_____

4) Please write the date, reason, and result of the insured's last medical consultation (include name and address of the doctor):

Date:_____ Reason:_____ Result:_____

Name of the doctor and address: _____

_____

QUESTIONNAIRE REGARDING ADAPCI+ HYBRID+ OPTION MUST BE COMPLETED IF THIS OPTION IS REQUESTED.

KEEP THIS PORTION

Notice and Authorisation of Personal Information Disclosure Receipt

Policy Number: _____

One of the main purposes of UV Insurance, Insurance Company is to provide insurance at a modest cost. The study (evaluation) of the risks is necessary not only to conserve the lowness of this cost but also for each insured to contribute its just part of the cost. For the study of your request, we must obtain information coming from different sources. This information is given to us by your medical exam, if required, and by reports that we can receive from your doctors who treated you and hospitals where you stayed, and by reports containing information of personal nature or relative to your solvency**.**

All information relating to your insurability is treated confidentially; however we may transmit a brief report to Medical Information Bureau, a non-profit organism which carries out an information exchange on behalf of its member life insurance companies. If you submit a life or critical illness insurance request or you submit a claim request to a member company, the Medical Information Bureau (MIB) will provide that company, at its request, with the information it has on you.

If you make a request, the Bureau will provide any information it has on you. If you doubt the accuracy of the information that the Bureau has on you, you may ask for rectification. The address of the Bureau is: Medical Information Bureau: 330, Ave. University, Suite 501, Toronto (Ontario) M5G 1R7 – Tel.: (416) 597-0590. Web site : www.mib.com

We can also transmit on request this information to life insurance companies to which you submitted a life insurance or a critical illness, disability or a claim request. The Bureau aims at avoiding to its members and to their carriers of policy of the additional expenses caused by a small number of persons hiding facts relative to their insurability. This information provided by the Bureau may take the insurance company to request an extensive investigation, but the regulations of this one forbid to make the evaluation of a risk on the basis of the information which it supplies. The Bureau is neither a trustee of hospital reports, or doctors, and the information which it possesses does not indicate if a life insurance application was approved at normal rate or with extra premiums, or if it was declined.

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AGREEMENT IN RELATIONS TO ESTABLISH A PERSONAL FILE

To ensure the confidentiality of your personal information including social insurance number, UV Insurance will establish a file for the purpose of providing you with different financial and insurance services, pension and other additional services it offers. Only UV Insurance authorised employees in the performance of their duties will have access to this file.

You are entitled to access the personal information and rectify the information if proven to be inexact, incomplete, ambiguous, outdated or unnecessary. To do so, a written request must be sent to the attention of the Information Access Manager at UV Insurance C.P. 696, Drummondville (Quebec) J2B 6W9.

AGREEMENT FOR INFORMATION GATHERING AND COMMUNICATING PERSONAL INFORMATION TO A THIRD PARTY

In order to establish insurability, maintain our file and claims assessment, we authorize any person or institutions holding personal information about us including any health information, medical history, or eligibility for claims, to transmit such information to UV Insurance or its reinsurers upon request. This includes doctors or other practitioners, hospital, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, the Medical Information Bureau, personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, Commission de santé et sécurité du travail du Québec or other Workmen's Compensation Board, Canada or Quebec Pension Plan, Société de l'assurance automobile du Québec or other Department of Motor Vehicles, la Régie de l'assurance médicaments du Québec or other provincial Health Department, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Likewise, we authorise UV Insurance to transmit to a third party as well as its reinsurers the information. In the same purpose and to gather the same type of information, we also authorise that UV Insurance or its reinsurers may request an investigative report about us and use information in their possession in other files.

This agreement is as good as gathering, utilise and transmit of personal information concerning minor children. No modification or alteration of this agreement will affect its content nor bind the insurer. This agreement may also be used when a request for additional insurance or a contract modification.

DECLARATION

We, as proposed insured and the policy owner, declare having examined all the questions included in the declaration. All answers given were correctly reproduced and are complete and true. Also, we authorise that they be used as the basis for the insurance contract requested and we recognize that all false declaration or omission may void the insurance contract issued as a result of this declaration of insurability.

We acknowledge that the insurance will take effect upon acceptance of the declaration by the Company as long as it was accepted without modification, and the premiums have been paid and no change occurred in the insurability of the insured since the signature of this declaration.

We acknowledge to have examined the agreement in relations to establish a personal file.

A photocopy of this agreement shall be as valid as the original.

Signed at _____ this _____ day of _____ 20_____

X _____
SIGNATURE OF THE PERSON TO BE INSURED
(If 14 years or older)

X _____
SIGNATURE OF THE POLICY OWNER
(If company, authorized signatory)

X _____
SIGNATURE OF THE WITNESS

X _____
SIGNATURE OF FATHER, MOTHER, OR GUARDIAN
(If the person to be insured is minor)

RESERVED TO HEAD OFFICE

Following the submission of proofs of insurability of the insured, the spouse and/or the policy owner and for the payment of all the premiums in arrears and not paid this day, The Union Life, Mutual Insurance Company, certifies that the previously mentioned policy is reinstated.

Approved in Drummondville, this _____ day of _____ 20 _____

X _____
COMPANY'S AUTHORIZED SIGNATORY