Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com/planmember
Tel.: 1-800-263-1810

GROUP INSURANCE

HEALTH AND LIFESTYLE QUESTIONNAIRE

EVIDENCE OF INSURABILITY

Completing the questionnaire

- Answer all questions.
- Provide information only for the proposed insured person(s).
- The proposed insured person(s) must read, physically sign and date the questionnaire.

After completing the questionnaire

- Keep a copy for your records.
- Attach a copy of your insurance application.
- Send the questionnaire and your insurance application to: Desjardins Insurance, C. P. 3000, Lévis (Québec) G6V 9X8

You must report any changes to your health or lifestyle that could influence Desjardins Insurance's decision that occur **between the time you fill out this questionnaire and when your application is approved.**

A REQUEST

- ☐ Late application
- ☐ Request for amount of insurance in excess of the non-evidence maximum (see your booklet)
- ☐ Request for mandatory benefit requiring evidence
- ☐ Addition of dependent without a life event
- ☐ Request for optional benefit (evidence required)
- ☐ Other:

B IDENTIFICATION OF MEMBER

This information is required to process your application.

Last name and first name

Contract number	Division number	Certificate number
00054969		

Address – No., street, apt. | City | Province | Postal code

Telephone numbers

Home (Area code + No.): Work (Area code + No.):

Occupation:

Place of birth (province, state, country)

Are you presently working? ☐ Yes ☐ No

If so, number of hours worked – If not, state reason:

C IDENTIFICATION OF EMPLOYER

Name

ONTARIO PHARMACISTS ASSOC

Address – No., street, office | City | Province | Postal code

D IDENTIFICATION OF PROPOSED INSUREDS

	Last name and first name	Sex	Date of birth (YYYY MM DD)	Height	Weight	Weight one year ago
MEMBER		☐ M ☐ F		☐ ft in ☐ m	☐ lb ☐ kg	☐ lb ☐ kg
	Reason for change in weight (if applicable):					
SPOUSE		☐ M ☐ F		☐ ft in ☐ m	☐ lb ☐ kg	☐ lb ☐ kg
	Reason for change in weight (if applicable):					
1 **CHILD**		☐ M ☐ F		☐ ft in ☐ m	☐ lb ☐ kg	☐ lb ☐ kg
	Reason for change in weight (if applicable):					
2 **CHILD**		☐ M ☐ F		☐ ft in ☐ m	☐ lb ☐ kg	☐ lb ☐ kg
	Reason for change in weight (if applicable):					
3 **CHILD**		☐ M ☐ F		☐ ft in ☐ m	☐ lb ☐ kg	☐ lb ☐ kg
	Reason for change in weight (if applicable):					

E HEALTH QUESTIONNAIRE ⚠ COMPLETE FOR EACH PROPOSED INSURED.

		MEMBER		SPOUSE		CHILDREN	
		Yes	No	Yes	No	Yes	No
1	In the **last 2 years**, has the proposed insured taken medication (not including contraceptives, vitamins and natural products) prescribed by a doctor for **more than 4 consecutive weeks**?	☐	☐	☐	☐	☐	☐
2	Has the proposed insured had or do they currently have discomfort, signs or symptoms for which:						
	• They have not yet consulted a doctor?	☐	☐	☐	☐	☐	☐
	• They are waiting to see a specialist?	☐	☐	☐	☐	☐	☐
	• They have consulted a doctor or other health professional and been advised to take medication, or undergo tests or surgery that has yet to happen or for which they are currently awaiting results?	☐	☐	☐	☐	☐	☐
3	In the **last 5 years**, has the proposed insured spent **more than 72 hours**:						
	• In a hospital, clinic or rehabilitation facility for care not related to pregnancy or childbirth?	☐	☐	☐	☐	☐	☐
	• In an alcohol, drug or gambling addiction treatment centre?	☐	☐	☐	☐	☐	☐
4	In the **last 5 years**, has the proposed insured been absent from work for health reasons other than maternity leave for **more than 4 consecutive weeks**?	☐	☐	☐	☐	☐	☐
5	**In the last 10 years**, has the proposed insured consulted a health professional, been diagnosed, received treatment or undergone surgery for any of the following:						
	• Abnormality of the immune system, including AIDS or a positive HIV test or other immunological infection or disorder	☐	☐	☐	☐	☐	☐
	• Cancer, tumor, polyp or other malignant disease	☐	☐	☐	☐	☐	☐
	• Endocrine system disorders, including diabetes, thyroid disease or other endocrine problems	☐	☐	☐	☐	☐	☐
	• Lung disorders, including asthma, emphysema, pulmonary fibrosis, tuberculosis, sleep apnea or other chronic lung or respiratory problems	☐	☐	☐	☐	☐	☐
	• Cystic fibrosis	☐	☐	☐	☐	☐	☐
	• Physical disorder, malformation or infirmity	☐	☐	☐	☐	☐	☐
	• Heart disease or problems with the circulatory system, including hypertension, infarct, angina, stroke, transient ischemic attack (TIA) or other heart, blood vessel or circulatory problems	☐	☐	☐	☐	☐	☐
	• Gastrointestinal disorders, including Crohn's disease and ulcerative colitis, hepatitis, hidden hepatitis, cirrhosis or other liver, pancreas, stomach or intestinal problems	☐	☐	☐	☐	☐	☐
	• Blood disorders, including anemia, leukemia, hemophilia or other blood problems	☐	☐	☐	☐	☐	☐
	• Cerebral, neurological or psychological disorders, including epilepsy, convulsions, dizziness, loss of consciousness, coma, depression, anxiety, eating disorders, job-related burnout, paralysis, multiple sclerosis, motor neuron disorders, Alzheimer's disease, Parkinson's disease or other cerebral, nervous or psychological problems	☐	☐	☐	☐	☐	☐
	• Neurological impairment, including autism spectrum disorder, Rett syndrome, cerebral palsy, muscular dystrophy, hyperactivity, attention deficit disorder, delayed maturation, intellectual disability	☐	☐	☐	☐	☐	☐
	• Problems with kidneys, urinary tract, bladder, prostate, breasts (including abnormal mammogram or ultrasound) or genitals (including abnormal PAP test) or presence of sugar, blood or protein in the urine	☐	☐	☐	☐	☐	☐
	• Muscle, joint and bone conditions, including chronic fatigue, fibromyalgia, arthritis, all forms of lupus, back or neck pain, or other musculoskeletal problems	☐	☐	☐	☐	☐	☐
	• Ear, nose and throat conditions (not including otitis) or eye problems (not including myopia, presbyopia, hyperopia and astigmatism)	☐	☐	☐	☐	☐	☐
	• Other illnesses or medical problems not listed above	☐	☐	☐	☐	☐	☐

Complete the table below for each question to which the proposed insured answered yes. Use an additional sheet if needed.

No.	First name	Nature of illnesses, surgery, accidents, consultations, examinations, treatments, medication, results	Date YYYY MM DD	Length of illness/ disability	Lenght of hospitalization (if applicable)	Name and address of physicians or hospitals
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	

F LIFESTYLE QUESTIONNAIRE ⚠ COMPLETE FOR EACH PROPOSED INSURED.

		MEMBER		SPOUSE		CHILDREN	
		Yes	No	Yes	No	Yes	No
1	In the **last 10 years**, has the proposed insured had an application for insurance declined or modified, or approved with an exclusion or extra premium? If yes, indicate the reason and the dates:	☐	☐	☐	☐	☐	☐
2	In the **last 5 years**, has the proposed insured had their driver's license suspended or revoked?	☐	☐	☐	☐	☐	☐
3	Has the proposed insured been accused or found guilty of a criminal act within the **last 5 years**?	☐	☐	☐	☐	☐	☐
4	In the **last 12 months**, has the proposed insured used any form of tobacco, including e-cigarettes or other tobacco substitutes?	☐	☐	☐	☐	☐	☐
5	Has the proposed insured received treatment for drug or alcohol addiction, or has a health professional recommended that they reduce their drug or alcohol consumption?	☐	☐	☐	☐	☐	☐
6	How much of the following does the proposed insured consume? *If none, indicate 0.* For alcoholic beverages, 1 serving = 1 bottle of beer (8 ounces) 1 glass of wine (4 ounces) 2 ounces of spirits						
	Tobacco? *Number of cigarettes per day*						
	E-cigarettes? *Uses per day*						
	Tobacco substitute? *Uses per day*						
	Alcoholic beverages? *Number of servings per week*						
	Drugs or narcotics (including marijuana)? *Number of grams per week and product used*						

G HISTORY ⚠ COMPLETE FOR EACH PROPOSED INSURED.

Is there any history in the family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron diseases or other hereditary diseases?

☐ Yes ☐ No If yes, please complete the table below. For cancer, indicate the type.

Check the family member		Illness(es) (if cancer: type)	Age at onset of the illness	Age if alive	Age at death
MEMBER	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				
SPOUSE	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				
CHILDREN	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				

H STATEMENT AND AUTHORIZATION REGARDING YOUR PERSONAL INFORMATION

I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB, Inc. and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance. I agree to notify Desjardins Insurance of any changes that occur to the health or lifestyle of the proposed insureds until such time as this application is approved. "Change to health or lifestyle" refers to any situation that could influence Desjardins Insurance's decision, such as a change in health status, occupation, lifestyle, smoking habits or tobacco use; an accident; a consultation, examination or treatment by any health care professional; a recommendation to have a medical appointment or consultation with a health care professional that has not yet taken place; a medical test or a recommendation to have a medical test that has not yet been completed; a violation of the Highway Safety Code or other similar laws; a Criminal Code offence; foreign travels or participation in hazardous sports.

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original. If the Desjardins Insurance medical director deems appropriate, I authorize the medical director to send the information that they obtained to analyze my application or that supports the Company's decision to the following physician:

Name and address of physician: _____

Remember your signature and the date!

Signature of member _____ **Date (YYYY - MM - DD)** _____

Signature of spouse _____ **Signature of dependent children aged 18 and over to be insured (aged 14 and over for Québec)** _____

I PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance. Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, it is possible that some of your personal information may be transferred to another country and be subject to the laws of that country. For information about Desjardins Insurance's policies and practices in terms of transferring personal information outside of Canada, visit the Desjardins Insurance website at www.desjardinslifeinsurance.com, or write to the Desjardins Insurance Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions you may have about the transfer of personal information to service providers located outside of Canada.

J NOTICE APPLICABLE TO MIB, INC.

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Insurance, its reinsurers and MIB, Inc., a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you submit an application for life or health insurance coverage for an individual or a benefit claim for an insured to another MIB, Inc. member company, upon request, MIB, Inc. will supply such company with the information it has on file about this person.

MIB, Inc. receives personal information for which the collection, use and disclosure is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Accordingly, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to Desjardins Insurance's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, Inc. is also bound by U.S. laws regarding the disclosure of personal information. To review MIB, Inc.'s Consumer Privacy Policy, please visit www.mib.com/privacy_policy.html.

Upon request, MIB, Inc. will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, Inc. by emailing canadadisclosure@mib.com or calling 1-866-692-6901. Insureds who dispute the accuracy of the information MIB, Inc. has on record for them can seek a correction in accordance with the procedures set forth on MIB, Inc.'s website at www.mib.com. They can also write to MIB, Inc.'s information office at 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Desjardins Insurance and its reinsurers can also release information from their files to other insurance companies to which an application for life or health insurance or a benefit claim has been submitted. Consumers can obtain additional information about MIB, Inc. at www.mib.com.