



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		
<input type="checkbox"/> Male	Date of Birth (yyyy/mm/dd)	Place of Birth (City and Country)	Height (ft./in.)	Weight (lbs.)
<input type="checkbox"/> Female				
Regular Physician or Family Doctor Name and Address				
Date and Reason Doctor Last Seen				

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?	<input type="checkbox"/>	<input type="checkbox"/>
b. lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, multiple sclerosis, chronic anxiety, burnout, fatigue, depression or eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e. hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorders of the stomach, intestine, liver or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
g. any hereditary disorders or diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
h. gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	<input type="checkbox"/>	<input type="checkbox"/>
i. disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
j. anemia or other disorder of the blood, or have you ever received a blood transfusion or blood products?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently taking any medication, receiving treatment(s) or following a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you used any form of tobacco or cannabis in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide details:		

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
7. Have you had any driving infractions within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you contemplate a trip or taking up residence outside Canada or the USA? (Specify location and duration below)	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. received medical or surgical attention due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
c. been a patient in a hospital, clinic, sanitarium or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. had an electrocardiogram, x-ray or other diagnostic tests with abnormal findings or indicating any health problems?	<input type="checkbox"/>	<input type="checkbox"/>
e. sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
f. requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you currently pregnant? If so, due date:	<input type="checkbox"/>	<input type="checkbox"/>

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 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 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:

- 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;
- 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
- 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.

Signature	Date (yyyy/mm/dd)

Please
sign here