

Eligibility Questionnaire 3 – Additional Coverages

Important: Fill out in block letters and answer each section as accurately as possible.

Section 1 – Information on the proposed insured

Application N° _____

| Child | Last name, first name | Date of birth | Height | | Weight | | Gender | Level of education | Relationship with the contract owner |
|-------|-----------------------|-------------------------------|---------|-------|--------|----|---|--------------------|--------------------------------------|
| | | | in. ft. | m. cm | lb | kg | | | |
| 1 | | Y Y Y Y M M D D | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 2 | | Y Y Y Y M M D D | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 3 | | Y Y Y Y M M D D | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 4 | | Y Y Y Y M M D D | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |

Section 2 – Child Rider (Life Insurance)

| | Child n° 1 | | Child n° 2 | | Child n° 3 | | Child n° 4 | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1. Has an application for this child to be insured already been declined, postponed or changed in any way? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If the child to be insured is under 12 months old, was the birth premature by more than four (4) weeks? (If the child is 12 months or older, enter no) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the child to be insured suffer from: Cystic fibrosis, cerebral palsy, muscular dystrophy, intellectual disability, autism, Asperger's syndrome, pervasive developmental disorder (PDD) or trisomy 21? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the child to be insured suffer from a disease requiring daily or weekly treatment and/or regular medical follow-ups, other than: attention deficit disorders with or without hyperactivity (ADD/ADHD), asthma, otitis, cold, flu or benign skin conditions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last six (6) months: | | | | | | | | |
| a) Has the child to be insured been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Did a physician mention abnormal results following a diagnostic test on the child to be insured? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Did a physician advise the child to be insured to undergo a diagnostic test, a special test, or any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Did a physician advise the child to be insured to consult another physician, a specialist, or to undergo a medical investigation that has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

No

If you answered NO to ALL questions, the child or children might be accepted if the height and weight are within normal growth curves for the age.

Please submit the application with **Section 7 – Signatures.**

Yes

If you answered YES to one of these questions, your application will go under review. A decision will be sent to you shortly.

Please submit the application with **Section 7 – Signatures.**

Important: Fill out in block letters and answer each section as accurately as possible.

Section 3 – Information on the proposed insured

1. Application N° _____
2. First name _____ Last name _____
3. Date of birth

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

Section 4 – Waiver of Premium (WPD and WPDD)

Yes No

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. In the last five (5) years, have you received care, consulted, been treated, been diagnosed, or had symptoms related to the following disorders : | | |
| a) Anxiety, depression, adjustment disorder, chronic fatigue, distress, attention deficit disorder with or without hyperactivity, post-traumatic stress disorder, burnout, panic disorder, eating disorder (anorexia, bulimia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Schizophrenia, psychosis, suicidal ideation or attempted suicide or any other nervous or psychiatric disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Back disorders: | | |
| ▶ Back disorders (cervical, dorsal, lumbar and lumbosacral spine) | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Degenerative disc disease | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Sprain | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Herniated disc | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Whiplash | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Vertebral fracture | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Vertebral misalignment | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Other back disorder Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Musculoskeletal disorders : | | |
| ▶ Muscle disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Bone disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Joint disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Fracture | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Ligament | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Osteo-arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Chronic pain syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Amputation | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Myasthenia gravis | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Post-polio syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Other musculoskeletal disorder Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Type 1 or type 2 diabetes, ulcerative colitis, Crohn's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD), epilepsy, paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Coagulation disorder and/or anticoagulant medication? | <input type="checkbox"/> | <input type="checkbox"/> |

No

If you answered NO to ALL questions from this section, you are eligible for this additional coverage.

Please submit the application with **Section 7 – Signatures.**

Yes

If you answered YES to one of these questions, your application will go under review. A decision will be sent to you shortly.

Please submit the application with **Section 7 – Signatures.**

| | Yes | No |
|---|--------------------------|---|
| 2. Have you ever made a claim or received a pension, income replacement benefit, compensation following injury, sickness or a handicap? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, answer the questions a) and b) | | |
| a) When did this occur? | | |
| <input type="checkbox"/> 0 - 12 months <input type="checkbox"/> 13 - 24 months <input type="checkbox"/> 25 - 36 months <input type="checkbox"/> More than 36 months | | |
| b) Duration of disability? | | |
| <input type="checkbox"/> 0 - 30 days <input type="checkbox"/> 31 - 90 days <input type="checkbox"/> 91 - 120 days <input type="checkbox"/> More than 120 days | | |
| 3. In the last six (6) months: | | |
| a) Has one or more prescription drugs been modified (addition or replacement, increase or decrease in dosage)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, answer the question: | | |
| ▶ Please indicate the change(s): | | |
| <input type="checkbox"/> Addition of prescription drug | <input type="checkbox"/> | <input type="checkbox"/> Replacement of prescription drug |
| <input type="checkbox"/> Increase in dosage | <input type="checkbox"/> | <input type="checkbox"/> Decrease in dosage |
| If decrease in dosage, answer the questions: | | |
| ▶ Was the decrease in dosage recommended by the physician due to poor control of the medical condition or side effects? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ Was the decrease in dosage recommended by the physician due to excellent control of the medical condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you stopped taking one or more prescription drugs without being advised to do so by your physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Have you consulted or been hospitalized at a health-care facility? | <input type="checkbox"/> | <input type="checkbox"/> |

Important: Fill out in block letters and answer each section as accurately as possible.

Section 5 – Information on the proposed insured

- Application N° _____
- First name _____ Last name _____
- Date of birth

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

Section 6 – Waiver of Premium in the Event of Loss of Employment (WPLE)

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you been in your current job for less than 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is your occupation a seasonal or part-time job? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you working for a company that you own or are you working for your spouse or a family member? | <input type="checkbox"/> | <input type="checkbox"/> |


No

If you answered NO to ALL questions from this section, you are eligible for this additional coverage.

Please submit the application with **Section 7 – Signatures.**

Yes

If you answered YES to one or many of these questions, you are not eligible for this additional coverage.

 This questionnaire must be dated on the day it was completed and be received at the UV Insurance head office within **14 days following the date of signature**.

Section 7 – Signatures

I certify that answers contained in this questionnaire are complete and true and they are an integral part of the insurance application with UV Insurance and cannot be separated.

Signed in _____ | Y | Y | Y | Y | M | M | D | D |

X _____ **X** _____
Signature of proposed insured (if 14 years old or more) Signature of owner 1* (if legal entity, authorized signatory)

X _____ **X** _____
Signature of proposed insured (if 14 years old or more) Signature of owner 2* (if legal entity, authorized signatory)

X _____ **X** _____
Signature of the father, mother or legal tutor (if the proposed insured is a minor) Signature of advisor

* Signature required for **Section 4 – Waiver of Premium** and/or **Section 5 – Waiver of Premium in the Event of Loss of Employment**