Eligibility Questionnaire 4 – Additionnal Coverages

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

Section 1 – Information on the proposed insured

Application Nº _____

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					☐ M ☐ F		
2		Y Y Y Y M M D D					☐ M ☐ F		
3		Y Y Y Y M M D D					☐ M ☐ F		
4		Y Y Y Y M M D D					☐ M ☐ F		

Section 2 – Child Rider (Life Insurance)

	Child nº 1		Child nº 2		Child nº 3		Child nº 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?	☐	☐	☐	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐
5. In the last six (6) months:								
a) Has the child to be insured been hospitalized?	☐	☐	☐	☐	☐	☐	☐	☐
b) Did a physician mention abnormal results following a diagnostic test on the child to be insured?	☐	☐	☐	☐	☐	☐	☐	☐
c) Did a physician advise the child to be insured to undergo a diagnostic test, a special test, or any surgery?	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐

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.

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

Section 3 – Information on the proposed insured

1. Application Nº _____
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
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)?	☐	☐
b) Schizophrenia, psychosis, suicidal ideation or attempted suicide or any other nervous or psychiatric disorder?	☐	☐
c) Back disorders:		
▸ Back disorders (cervical, dorsal, lumbar and lumbosacral spine)	☐	☐
▸ Degenerative disc disease	☐	☐
▸ Sprain	☐	☐
▸ Herniated disc	☐	☐
▸ Whiplash	☐	☐
▸ Vertebral fracture	☐	☐
▸ Vertebral misalignment	☐	☐
▸ Other back disorder Specify _____	☐	☐
d) Musculoskeletal disorders :		
▸ Muscle disorders	☐	☐
▸ Bone disorders	☐	☐
▸ Joint disorders	☐	☐
▸ Fracture	☐	☐
▸ Ligament	☐	☐
▸ Rheumatism	☐	☐
▸ Arthritis	☐	☐
▸ Osteo-arthritis	☐	☐
▸ Gout	☐	☐
▸ Osteoporosis	☐	☐
▸ Fibromyalgia	☐	☐
▸ Chronic pain syndrome	☐	☐
▸ Amputation	☐	☐
▸ Myasthenia gravis	☐	☐
▸ Post-polio syndrome	☐	☐
▸ Other musculoskeletal disorder Specify _____	☐	☐
e) Type 1 or type 2 diabetes, ulcerative colitis, Crohn's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD), epilepsy, paralysis?	☐	☐
f) Coagulation disorder and/or anticoagulant medication?	☐	☐

No

If you answered NO to ALL questions from this section, you are eligible for this additionnal 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? **If yes,** answer the questions **a)** and **b)**	☐	☐
a) When did this occur? ☐ 0 - 12 months ☐ 13 - 24 months ☐ 25 - 36 months ☐ More than 36 months		
b) Duration of disability? ☐ 0 - 30 days ☐ 31 - 90 days ☐ 91 - 120 days ☐ 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)?	☐	☐
If yes, answer the question:		
▸ Please indicate the change(s): ☐ Addition of prescription drug ☐ Replacement of prescription drug ☐ Increase in dosage ☐ 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?	☐	☐
▸ Was the decrease in dosage recommended by the physician due to excellent control of the medical condition?	☐	☐
b) Have you stopped taking one or more prescription drugs without being advised to do so by your physician?	☐	☐
c) Have you consulted or been hospitalized at a health-care facility?	☐	☐

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

Section 5 – Information on the proposed insured

1. Application Nº _____
2. First name _____ Last name _____
3. 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?	☐	☐
2. Is your occupation a seasonal or part-time job?	☐	☐
3. Are you working for a company that you own or are you working for your spouse or a family member?	☐	☐

No
If you answered NO to ALL questions from this section, you are eligible for this additionnal 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 additionnal 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

Print

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 _____
Signature of proposed insured (if 14 years old or more)

X _____
Signature of owner 1* (if legal entity, authorized signatory)

X _____
Signature of proposed insured (if 14 years old or more)

X _____
Signature of owner 2* (if legal entity, authorized signatory)

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

X _____
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**

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