Complete this questionnaire for the riders that meet the following conditions:

Child Rider (Life Insurance) — Sections A and B

- As a rider on all term and permanent life insurance products for any type of simplified issue or regular underwriting
- For children | 14 days to age 17

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

If you answered **YES** to one of the questions in **Section B**, your application will go under review. A decision will be sent to you shortly.

Waiver of Premium (WPD and WPDD) — Sections C and D

- As a rider on all term and permanent life insurance products for any type of simplified issue or regular underwriting and on the AdapCI
- For the owner or the payer of the Basic Coverage | Ages 18 to 55

If you answered **NO** to **ALL** questions in **Section D**, you are eligible for this additional coverage.

If you answered **YES** to one of the questions in **Section D**, your application will go under review. A decision will be sent to you shortly.

Waiver of Premium in the Event of Loss of Employment (WPLE) — Sections E and F

- As a rider on all term and permanent life insurance products for any type of simplified issue or regular underwriting and on the AdapCI
- For the insured, owner or payer of the Basic coverage | Ages 18 to 50

If you answered **NO** to **ALL** questions in **Section F,** you are eligible for this additional coverage.

If you answered **YES** to one or many of the questions in **Section F**, you are not eligible for this additional coverage.

For all other products or insurance amounts, please refer to the **regular underwriting requirements** or other forms in the **Advisor Resource Center**.

UV INSURANCE

Eligibility Questionnaire
Simplified Issue | Additional Coverages

EQC093

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

Section A — 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
			ft. in.	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 B — 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, check "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?	☐	☐	☐	☐	☐	☐	☐	☐

If you are applying for the Child Rider (Life Insurance) only and meet all the criteria listed on page 1, you may submit a PDF or paper application found in the Advisor Resource Centre on uvinsurance.ca with this completed questionnaire including **Section G – Signatures**. If you are also applying for the Waiver of Premium (WPD and WPDD), please complete **Sections C and D**. If you are also applying for the Waiver of Premium in the Event of Loss of Employment (WPLE), please complete **Sections E and F**.

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

Section C — 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 D — 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	☐	☐
▸ Osteoarthritis	☐	☐
▸ Gout	☐	☐
▸ Osteoporosis	☐	☐
▸ Fibromyalgia	☐	☐
▸ Chronic pain syndrome	☐	☐
▸ Amputation	☐	☐
▸ Myasthenia gravis	☐	☐
▸ Post-polio syndrome	☐	☐
▸ Other musculoskeletal disorders 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?	☐	☐

	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

	Yes	No
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:

	Yes	No
Was the decrease in dosage recommended by the physician due to poor control of the medical condition or side effect(s)?	☐	☐
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?	☐	☐

If you are applying for the Waiver of Premium (WPD and WPDD) only and meet all the criteria listed on page 1, you may submit a PDF or paper application found in the Advisor Resource Centre on uvinsurance.ca with this completed questionnaire including **Section G – Signatures**. If you are also applying for the Waiver of Premium in the Event of Loss of Employment (WPLE), complete **Sections E and F**.

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

Section E — 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 F — 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?	☐	☐

If you are applying for the Waiver of Premium in the Event of Loss of Employment (WPLE) only and meet all the criteria listed on page 1, you may submit a PDF or paper application found in the Advisor Resource Centre on uvinsurance.ca with this completed questionnaire including **Section G – Signatures**.

Section G – 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 ______________________________
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 D – Waiver of Premium (WPD and WPDD)** and/or **Section F – Waiver of Premium in the Event of Loss of Employment (WPLE)**

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**.

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ▪ Phone: 819 478-1315 ▪ Toll free: 1 800 567-0988 ▪ Fax: 819 474-1990

UV Insurance is a registered trademark of The Union Life Mutual Assurance Company.