



Complete this questionnaire for any term or permanent life insurance application that meets the following conditions:

- ▶ The insurance amount requested is less than or equal to \$150,000.

The insured is aged:

- ▶ 16 to 75 | Whole Life High Value and Adaptable
- ▶ 18 to 80 | Whole Life Pay to 100
- ▶ 18 to 65 | T-10, T-15 and T-20
- ▶ 18 to 60 | T-25
- ▶ 18 to 55 | T-30



If you answered **NO** to **ALL** questions, you are eligible for less than or equal to \$150,000.

If you answered **YES**

- ▶ to **question 1** in **Section B**, you are eligible and the smoking rate will apply to the contract.
- ▶ to **questions 7-A, 7-B, or 7-C** in **Section B**, you must answer **NO** to the sub-questions to qualify.
- ▶ to **question 9** in **Section B**, you must answer **NO** to the sub-questions to qualify.



If you answered **YES** to any other question, you are **NOT** eligible for Express.



A basic coverage and a temporary coverage rider can be applied for using the Express questionnaire, provided the total amount of insurance is less than or equal to \$150,000.

Term and permanent life insurance

If your request does not meet the above criteria, please refer to the other two simplified issue questionnaires:

Express Questionnaire for Children

15 days to age 15 | \$10,000 to \$150,000

Immediate Questionnaire

Ages 18 to 45 | \$150,001 to \$499,999

Ages 46 to 55 | \$150,001 to \$350,000

Ages 56 to 65 | \$150,001 to \$250,000

For all other insurance amounts, please refer to the regular underwriting requirements:

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

Section A – 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
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Section B – Life Insurance – Express

	Yes	No
1. In the last twelve (12) months, have you used cigarettes, cigarillos, electronic cigarettes (with or without nicotine), little cigars, pipes, chewing tobacco, shisha, betel nut, nicotine patches, smoking cessation products or tobacco in any other form?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently hospitalized or residing in a nursing home or center for persons with loss of autonomy, or do you use a wheelchair or need help or assistance with two or more of the following activities of daily living: bathing, dressing, toileting, continence, mobility, feeding?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been treated for, consulted, or diagnosed with Acquired Immunodeficiency Syndrome (AIDS), an AIDS-related condition, or had an investigation indicating the presence of the human immunodeficiency virus (HIV) or HIV antibodies?	<input type="checkbox"/>	<input type="checkbox"/>
4. During the last sixty (60) days:		
a) Have you been hospitalized (excluding pregnancy-related hospitalizations) or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been informed of any abnormal test results?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you been advised by a health care professional to have any kind of test, medical investigation or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any symptoms or have you received any abnormal results for which:		
a) You have not yet consulted a health care professional?	<input type="checkbox"/>	<input type="checkbox"/>
b) You are currently under investigation or awaiting a diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>
c) You have been advised by a health care professional to have any tests and/or surgery that has not yet been done?	<input type="checkbox"/>	<input type="checkbox"/>
d) A doctor or medical specialist has recommended that you have more frequent medical follow-ups than usual?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last ten (10) years, have you consulted, received care, been treated, been diagnosed, had symptoms, or are currently being treated for the following conditions:		
a) A cancer with metastasis and/or involved lymph node(s), two (2) different types of cancer or a recurrence of a cancer (excluding basal cell carcinoma)?	<input type="checkbox"/>	<input type="checkbox"/>
b) Cystic fibrosis or a chronic respiratory disease that requires daily oxygen administration (excluding sleep apnea), chronic kidney disease or polycystic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
c) Dementia, Alzheimer's disease, muscular dystrophy, Huntington's disease, amyotrophic lateral sclerosis (ALS) or Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>
d) Chronic heart failure, cardiomyopathy or heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>
e) Have you been on a waiting list for organ or bone marrow donation or have you received an organ or bone marrow donation (excluding corneal transplants)?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
7. Have you ever consulted, received care, been treated, diagnosed or had symptoms for the following conditions:		
a) A cerebrovascular accident (CVA), transient ischemic attack (TIA), aneurysm or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer questions i and ii		
i. Before the age of 40?	<input type="checkbox"/>	<input type="checkbox"/>
ii. In the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
b) Coronary artery bypass surgery, angioplasty, stent insertion, a pacemaker or chronic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer questions i and ii		
i. Before the age of 40?	<input type="checkbox"/>	<input type="checkbox"/>
ii. In the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
c) Angina or heart attack (myocardial infarction)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer questions i and ii		
i. Before the age of 40?	<input type="checkbox"/>	<input type="checkbox"/>
ii. In the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last five (5) years, have you consulted, received care, been treated, been diagnosed, had symptoms or are currently being treated for the following disorders:		
a) Chronic liver disease (including but not limited to cirrhosis, fibrosis, hepatitis B or C)?	<input type="checkbox"/>	<input type="checkbox"/>
b) Peripheral arterial disease or peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
c) Leukemia, lymphoma of any type, malignant melanoma, breast, ovarian, cervix, lung or colorectal cancer?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have diabetes that requires insulin?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer questions a) and b)		
a) Were you diagnosed with any type of diabetes more than 20 years ago?	<input type="checkbox"/>	<input type="checkbox"/>
b) In the last six (6) months, has your diabetes-related medication been adjusted or changed (adding or replacing a medication, increasing or decreasing the prescribed dosage)?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the last twenty-four (24) months, have you consulted, received care, been treated, been diagnosed, had symptoms or are you currently undergoing treatment for bipolar disorder, schizophrenia, psychosis, borderline personality disorder, or have you attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the last twelve (12) months, excluding an intentional diet, a change in lifestyle, a bariatric surgery or a pregnancy, has your weight decreased by 10% or more?	<input type="checkbox"/>	<input type="checkbox"/>
12. In the last six (6) months, did you have a bariatric surgery?	<input type="checkbox"/>	<input type="checkbox"/>
13. In the next twelve (12) months, do you plan to travel outside of North America, the Caribbean (excluding Haiti), the United Kingdom or the European Union for a total of more than twelve (12) weeks?	<input type="checkbox"/>	<input type="checkbox"/>
14. In the last three (3) years, have you been convicted of a criminal offence or a criminal act (including impaired driving) or have charges of a criminal offence or a criminal act (including impaired driving) been filed against you?	<input type="checkbox"/>	<input type="checkbox"/>
15. In the last twenty-four (24) months:		
a) Have you used barbiturates, narcotics or opioids that are not prescribed by a health care professional, heroin, cocaine, amphetamines, hallucinogens, steroids, or other illegal drugs or similar narcotics?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been advised by a health care professional to reduce your use of any drugs (including cannabis) and/or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you stayed in a residence for the treatment of drug and/or alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>



If you are applying for life insurance only and meet all the criteria listed on page 1, you may submit a PDF or paper application available on uvinsurance.ca with this completed questionnaire including **Section D**.

If you are also applying for a Credit Insurance Rider, please continue to the next questionnaire.

Complete this questionnaire only if you are applying for a Credit Insurance Rider (disability):



If you answered **NO** to **ALL** questions, you are eligible for the Express Credit Insurance Rider.



If you answered **YES** to any of the following questions and based on the answers to the sub-questions, the Credit Insurance Rider may be transferred to underwriting and we may ask for additional details: **6-A, 6-B and 7-A (if decrease in dosage)**. Two decisions will then be possible: accepted or declined, after a brief analysis. In Express, there is never any exclusion. To find out if a question answered **YES** will be transferred to underwriting, please use the questionnaire available within the electronic application from your My Universe portal.



If you answered **YES** to any other question, you are **NOT** eligible for the Express Credit Insurance Rider.

Section C – Credit Insurance Rider

	Yes	No
1. Are you currently working less than 20 hours per week and 9 months per year? To be eligible to the Credit Insurance Rider, you must be employed or self-employed and working full time (or at least 20 hours per week and 9 months per year) or in parental leave from this same work.	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you practising an ineligible occupation?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever consulted, received care, been diagnosed, had symptoms or are you currently being treated for the following disorders: Angina pectoris, heart attack (myocardial infarction), stroke (CVA), transient ischemic attack (TIA), aneurysm, coronary heart disease, coronary artery bypass surgery, angioplasty, insertion of a stent or pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever consulted, received care, been treated, been diagnosed, had symptoms or are you currently being treated for any type of cancer (excluding basal cell carcinoma)?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the last five (5) years, have you consulted, received care, been treated, been diagnosed, had symptoms or are you currently being treated for 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 disorders Precise _____	<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"/>

