



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

The insurance amount requested is:

- ▶ \$150,001 to \$499,999 for ages 18 to 45
- ▶ \$150,001 to \$350,000 for ages 46 to 55
- ▶ \$150,001 to \$250,000 for ages 56 to 65

The insured is aged:

- ▶ 18 to 65 | T-10, T-15 and T-20
 - ▶ 18 to 60 | T-25
 - ▶ 18 to 55 | T-30
- ▶ If the basic coverage is a permanent life insurance of \$150,000 or less and the total insurance amount including the term insurance rider do not exceed the above limits.



If you answered **NO** to **ALL** questions in **Section B and Section C**, you are eligible for Immediate.

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 **questions 16 or 17** in **Section C**, the sub-questions will determine if you are eligible for an adjusted premium. If you answered **YES** to **question 22-A** in **Section C**, the sub-questions will determine if you are eligible for a standard premium. For an immediate decision, please use the questionnaire available within the electronic application from your My Universe portal. Read the document: [The Secrets of Immediate](#)



A basic coverage and a temporary coverage rider can be applied for using the Immediate questionnaire within the above mentioned limits. If the basic coverage is a permanent life insurance, it must be less than or equal to \$150,000. All applications for permanent life insurance of \$150,001 or more will be subject to regular underwriting.



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

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 15 years | \$10,000 to \$150,000

[Express Questionnaire](#)

Ages 16 to 80 | \$10,000 to \$150,000

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"/>

Section C – Life Insurance – Immediate

16. In the last five (5) years, have you consulted, received care, been treated, diagnosed with or had symptoms of the following conditions?

a)

	Angina pectoris		Heart attack (myocardial infarction)	
	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer these questions:				
When was the last episode?	<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	Yes	No	Yes	No
Did you have more than one episode?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently suffering from diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b)

	Cerebrovascular accident (CVA)		Transient ischemic attack (TIA)		Aneurysm		Coronary artery disease	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
When was the last episode?	<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Did you have more than one episode?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently suffering from diabetes?	<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)

	Coronary artery bypass surgery		Angioplasty		Insertion of a stent	
	Yes	No	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer these questions:						
When was the last surgical intervention?	<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years		<input type="checkbox"/> 0 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
How many vessels have been affected?	<input type="checkbox"/> 1		<input type="checkbox"/> 1		<input type="checkbox"/> 1	
	<input type="checkbox"/> 2		<input type="checkbox"/> 2		<input type="checkbox"/> 2	
	<input type="checkbox"/> 3 or more		<input type="checkbox"/> 3 or more		<input type="checkbox"/> 3 or more	
	Yes	No	Yes	No	Yes	No
Have you received a pacemaker due to coronary artery bypass surgery, angioplasty, stent insertion (STENT), or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently suffering from diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d)	Pacemaker or implantable defibrillator	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, answer these questions:		
When was the last surgical intervention?	<input type="checkbox"/> 0 - 3 years	
	<input type="checkbox"/> 4 - 5 years	
	Yes	No
Have you received a pacemaker or an implantable defibrillator due to coronary artery bypass surgery, angioplasty, stent insertion (STENT), or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
17. In the last five (5) years, have you 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"/>
If yes, answer questions a) and b)		
a) Was it Thyroid cancer?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer these questions:		
▶ Have you received chemotherapy or radiotherapy treatments?	<input type="checkbox"/>	<input type="checkbox"/>
▶ Have you had one or many affected lymph node(s) and/or metastases?	<input type="checkbox"/>	<input type="checkbox"/>
b) Was it Prostatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer these questions:		
▶ Has the Prostate Specific Antigen (PSA) returned to normal values?	<input type="checkbox"/>	<input type="checkbox"/>
▶ Have you received chemotherapy or radiotherapy treatments?	<input type="checkbox"/>	<input type="checkbox"/>
▶ Have you had one or many affected lymph node(s) and/or metastases?	<input type="checkbox"/>	<input type="checkbox"/>
18. If you are 30 years old or younger, have you been diagnosed with diabetes (excluding gestational diabetes) or has your healthcare professional recommended regular blood glucose monitoring?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have diabetes associated with any of the following: coronary artery disease (including but not limited to angina), heart attack (myocardial infarction), coronary artery bypass, angioplasty, stent insertion, peripheral vascular disease, amputation, neuropathy, retinopathy, stroke (CVA) or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
20. In the last three (3) years, have you had an amputation as a result of an illness?	<input type="checkbox"/>	<input type="checkbox"/>
21. In the last three (3) months:		
a) Has any new medication been added or prescribed or has any existing medication been modified, removed or replaced (including increase or decrease in prescribed dosage) on the advice of a health care professional or have you stopped taking any medication without the advice of a health care professional?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been on anticoagulant therapy?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you have a family history of any of the following conditions?		
a) Polycystic Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer the question:		
▶ Have you undergone an investigation for this disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer the question:		
▶ Have you been diagnosed with polycystic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) Huntington's disease?	<input type="checkbox"/>	<input type="checkbox"/>
23. In the last twenty-four (24) months, has your driver's licence been suspended, revoked, or in the last twelve (12) months, have you committed more than three (3) traffic violations?	<input type="checkbox"/>	<input type="checkbox"/>

24. During the last five (5) years

- | | | |
|---|--------------------------|--------------------------|
| 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 stayed in a residence for the treatment of drug and/or alcohol abuse or been advised by a healthcare professional to reduce your consumption of drugs and/or alcohol, including cannabis? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Have you been convicted of a criminal offence or a criminal act (including impaired driving), or have charges of a criminal offence or criminal act (including impaired driving) been laid against you? | <input type="checkbox"/> | <input type="checkbox"/> |

25. Please indicated your height and weight (in/cm and lb/kg)

Height _____ ft.in cm Weight _____ lb kg

Table of constitution for question 10 of the Immediate (minimum/maximum weight according to height)

Height	Feet/inches	4' 8" – 4' 10"	4' 11" – 5' 1"	5' 2" – 5' 4"	5' 5" – 5' 7"	5' 8" – 5' 10"	5' 11" – 6' 1"	6' 2" – 6' 4"	6' 5" – 6' 7"
	Meters	1,42 – 1,49	1,50 – 1,56	1,57 – 1,64	1,65 – 1,72	1,73 – 1,79	1,80 – 1,87	1,88 – 1,95	1,96 – 2,01
Weight	Pounds	79 – 190	87 – 200	94 – 220	104 – 240	115 – 260	125 – 282	136 – 305	147 – 333
	Kg	36 – 86	39 – 91	43 – 100	47 – 109	52 – 118	57 – 128	61 – 138	66 – 151



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 found in the Advisor Centre on uvinsurance.ca with this completed questionnaire including **Section E**.

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 Immediate 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: **4-A, 4-B, 4-D, 5-A, 6-A, 6-B, 7, 8-A, 8-B, and 9-A (if decrease in dosage)**. Three decisions will then be possible: accepted, accepted with exclusion, or declined, after a brief analysis. 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 of the following questions, you are **NOT** eligible for the Immediate Credit Insurance Rider: **1, 2, 3, 4-C, 5-B, 6-C, 6-D, 9-B, 9-C, 10-A, 10-B and 10-C**.

Section D – Credit Insurance Rider (disability)

	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"/>
If yes, answer questions a), b), c) and d)		
a) Date of diagnosis <input type="checkbox"/> 0 - 5 years <input type="checkbox"/> 6 - 10 years <input type="checkbox"/> more than 10 years		
b) Specify the type of cancer: _____		
c) Have you had metastases and/or affected lymph node(s), two different types of cancer or a recurrence of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you received chemotherapy or radiotherapy treatments?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the last ten (10) years, have you consulted, received care, been treated, been diagnosed, had symptoms or are you currently being treated for any of the following disorders:	<input type="checkbox"/>	<input type="checkbox"/>
a) Anxiety, depression, adjustment disorder, chronic fatigue, distress, attention deficit disorder with or without hyperactivity, post-traumatic stress disorder, burnout, panic disorder, eating disorder (including but not limited to anorexia, bulimia)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, answer the question:		
▶ How many episodes have you had? <input type="checkbox"/> Only one (1) <input type="checkbox"/> 2 - 3 <input type="checkbox"/> More than three (3)		
▶ Are you still currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If not, answer the question:		
▶ How long ago did you stop your treatment? <input type="checkbox"/> 0 - 5 years <input type="checkbox"/> 6 - 10 years		
b) Schizophrenia, psychosis, suicidal ideation or attempted suicide or any other nervous or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>

6. In the last seven (7) years, have you consulted, received care, been treated, been diagnosed, had symptoms or are you currently being treated for any of the following disorders:

a) Back disorder

	Back disorder (cervical, dorsal, lumbar or lumbosacral spine)		Degenerative discopathy		Sprain		Herniated disc	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date of diagnosis?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing treatment (including but not limited to medication, physiotherapy, massage therapy (other than for wellness), osteopathy, chiropractic, physiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Whiplash		Fracture		Vertebral misalignment		Other back disorders Specify: <input type="text"/>	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date of diagnosis?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing treatment (including but not limited to medication, physiotherapy, massage therapy (other than for wellness), osteopathy, chiropractic, physiotherapy)?	<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) Musculoskeletal disorders

	Disorders of muscles		Disorders of bones		Disorders of joints		Fracture	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date of diagnosis?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing treatment (including but not limited to medication, physiotherapy, massage therapy (other than for wellness), osteopathy, chiropractic, physiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Ligament		Rheumatism		Arthritis		Osteoarthritis	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date du diagnostic ?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Gout		Osteoporosis		Fibromyalgia		Chronic pain syndrome	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date of diagnosis?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing treatment (including but not limited to medication, physiotherapy, massage therapy (other than for wellness), osteopathy, chiropractic, physiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Amputation		Myasthenia gravis		Post-polio syndrome		Other musculoskeletal disorders Specify:	
	Yes	No	Yes	No	Yes	No	Yes	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"/>
If yes, answer these questions:								
Date of diagnoses?	<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year		<input type="checkbox"/> 0 - 1 year	
	<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years		<input type="checkbox"/> 2 - 3 years	
	<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years		<input type="checkbox"/> 4 - 5 years	
	<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years		<input type="checkbox"/> 6 - 7 years	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you have any limitations or sequelae?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a surgery been performed or is a surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently undergoing treatment (including but not limited to medication, physiotherapy, massage therapy (other than for wellness), osteopathy, chiropractic, physiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes **No**

6. In the last seven (7) years, have you consulted, received care, been treated, been diagnosed, had symptoms or are you currently being treated for any of the following disorders:

- c)** Type 1 or type 2 diabetes, ulcerative colitis, Crohn's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD), epilepsy, paralysis?
- d)** Coagulation disorder and/or anticoagulant medication?

7. During the last twelve (12) months, have you received any physiotherapy, massage therapy (other than for wellness), osteopathy, physiotherapy, chiropractic, or psychotherapy (other than for welfare purposes) or consulted a social worker?

If yes, answer the question:

▶ What was/were the condition(s)?

- | | |
|---|---|
| <input type="checkbox"/> Disorders of muscles | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Disorders of bones | <input type="checkbox"/> Vertebral misalignment |
| <input type="checkbox"/> Disorders of joints | <input type="checkbox"/> Any other musculoskeletal or spinal disorder |
| <input type="checkbox"/> Ligament | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Back disorders (cervical, dorsal, lumbar, lumbosacral spine) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Degenerative disc disease | <input type="checkbox"/> Burnout |
| <input type="checkbox"/> Sprain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Other emotional disorders |

8. Have you ever made a claim or received a pension, income replacement benefit, compensation following injury, sickness or a handicap?

If yes, answer 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 the disability?

- 0 - 30 days 31 - 90 days 91 - 120 days More than 120 days

9. In the last six (6) months:

a) Have one or more prescription drugs been modified (addition or replacement, increase or decrease in dosage)? Yes No

If yes answer the question:

▶ Please indicate the change(s):

- | | |
|--|---|
| <input type="checkbox"/> Addition of prescription drug | <input type="checkbox"/> Replacement on prescription drug |
| <input type="checkbox"/> Increase in dosage | <input type="checkbox"/> Decrease in dosage |

If decrease in dosage, answer these questions:

- | | | |
|---|------------------------------|-----------------------------|
| ▶ Was decrease in dosage recommended by a healthcare professional due to poor control of the medical condition or side effects? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▶ Was the decrease in dosage recommended by a healthcare professional due to fair control of the medical condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

b) Have you stopped taking one or more prescription drugs without being advised to do so by a healthcare professional? Yes No

c) Have you consulted or been hospitalized at a health-care facility? Yes No

10. In the last ten (10) years:

a) Have you used any barbiturates, narcotics or opioids not prescribed by a healthcare professional, heroin, cocaine, amphetamines, hallucinogens, steroids, or other illegal drugs or similar narcotics? Yes No

b) Have you stayed in a residence for the treatment of drug and/or alcohol abuse or been advised by a healthcare professional to reduce your consumption of drugs and/or alcohol, including cannabis? Yes No

c) Have you been convicted of a criminal offence or a criminal act (including impaired driving), or have charges of a criminal offence or criminal act (including impaired driving) been laid against you? Yes No

Section E – 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	X _____ Signature of owner 1 (if legal entity, authorized signatory)
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X _____ Signature of owner 2 (if legal entity, authorized signatory)	X _____ Signature of advisor
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 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**.