La Capitale
Insurance and Financial Services

EVIDENCE OF INSURABILITY
GROUP INSURANCE

RWAM Insurance Administrators Inc.
49 Industrial Drive
Elmira, Ontario N3B 3B1

Underwritten by La Capitale Insurance and Financial Services

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

A- PARTICIPANT'S NAME (Maiden name, if applicable) FIRST NAME

ADDRESS NO. STREET APT. CITY PROVINCE POSTAL CODE

PHONE NO.
HOME: ( ) OFFICE: ( )

CURRENT POSITION (employment)

B-

	SURNAME (Maiden name if applicable)	GIVEN NAME	DATE OF BIRTH Year/Month/Day	HEIGHT Ft. in./cm	CURRENT WEIGHT Lbs/Kilo	WEIGHT ONE YEAR AGO Lbs/Kilo
PARTICIPANT						
DEPENDENT'S PARTICIPATION (FAMILY OR SINGLE-PARENT PLAN)						
SPOUSE						
CHILD						
CHILD						
CHILD						

C- MEDICAL QUESTIONNAIRE

IMPORTANT: ANSWER ALL QUESTIONS AND PROVIDE DETAILS REQUESTED UNDER SECTION "D" ON REVERSE SIDE, IF NECESSARY.

HAVE ANY OF THE PERSONS TO BE INSURED	PARTICIPANT YES	PARTICIPANT NO	SPOUSE YES	SPOUSE NO	CHILDREN YES	CHILDREN NO	FIRST NAME
1) OVER THE LAST 3 YEARS BEEN ABSENT FROM THEIR ORDINARY OCCUPATIONS OWING TO DISABILITY, ILLNESS OR INJURY? DATE: _____ REASON: _____	☐	☐	☐	☐	☐	☐	_____
2) EVER HAD AN APPLICATION FOR INSURANCE DECLINED, MODIFIED OR ACCEPTED WITH AN EXTRA INSURANCE PREMIUM? DATE: _____ CO.: _____ REASON: _____	☐	☐	☐	☐	☐	☐	_____
3) ENGAGED IN OR INTENDING ON ENGAGING IN A PROFESSIONAL SPORT OR A SPORT OR LEISURE ACTIVITY WHICH MIGHT REASONABLY RESULT IN INJURY? PLEASE EXPLAIN: _____	☐	☐	☐	☐	☐	☐	_____
4) CURRENTLY BEEN TAKING MEDICATION OR HOMEOPATHIC MEDICINE? NAME: _____ QTY/DAY: _____ REASON: _____	☐	☐	☐	☐	☐	☐	_____
5) CURRENTLY OR EVER TAKEN ILLEGAL DRUGS INCLUDING NARCOTICS? TYPE: _____ DATE OF THE LAST CONSUMPTION: _____	☐	☐	☐	☐	☐	☐	_____
6) SUFFERING FROM ANY SIGNS OR SYMPTOMS OF ANY PHYSICAL OR MENTAL ILLNESSES OR PHYSICAL OR MENTAL MANIFESTATIONS FROM ACCIDENT OR INJURY? PLEASE EXPLAIN: _____	☐	☐	☐	☐	☐	☐	_____
7) EVER SUFFERED FROM AN ILLNESS OR HAD ANY SIGN OR SYMPTOM OF A HEALTH PROBLEM? DATE: _____ PLEASE EXPLAIN: _____	☐	☐	☐	☐	☐	☐	_____
8) CONSULTING OR PLANNING ON CONSULTING A PHYSICIAN, UNDERGOING AN OPERATION OR HAVE BEEN ADVISED TO DO SO? PLEASE EXPLAIN: _____	☐	☐	☐	☐	☐	☐	_____
9) BEEN CONSULTING OR ARE PLANNING ON CONSULTING SOME OTHER HEALTH CARE PROFESSIONAL OR A THERAPIST, INCLUDING IN ALTERNATE MEDICINES? PLEASE EXPLAIN: _____	☐	☐	☐	☐	☐	☐	_____
10) OVER THE PAST 5 YEARS CONSULTED A PHYSICIAN, THERAPIST OR OTHER HEALTH PROFESSIONAL, INCLUDING IN ALTERNATE MEDICINES, OR BEEN ADMITTED TO A HOSPITAL OR OTHER HEALTH CARE INSTITUTION? IF SO, REFER TO SECTION "D"	☐	☐	☐	☐	☐	☐	_____
11) UNDERGONE OR BEEN ADVISED TO TAKE A TEST FOR DETECTING HIV/AIDS? DATE: _____ REASON: _____ RESULT: _____	☐	☐	☐	☐	☐	☐	_____

NOTE: THE DECLARATION AND AUTHORIZATION ON THE REAR SIDE ALSO APPLY TO THIS DECLARATION OF INSURABILITY.

C- MEDICAL QUESTIONNAIRE (Cont'd)

IMPORTANT: ANSWER ALL QUESTIONS AND PROVIDE DETAILS REQUESTED UNDER SECTION "D" ON REVERSE SIDE, IF NECESSARY.

HAVE ANY OF THE PERSONS TO BE INSURED	PARTICIPANT YES	PARTICIPANT NO	SPOUSE YES	SPOUSE NO	CHILDREN YES	CHILDREN NO	FIRST NAME
12) SMOKED CIGARETTES, CIGARILLOS, CIGARS OR A PIPE, OR USED CHEWING TOBACCO, MARIJUANA, SMOKING CESSATION AIDS OR NICOTINE SUBSTITUTES?	☐	☐	☐	☐	☐	☐	
IF YES, FOR HOW LONG?	_____ year(s)		_____ year(s)		_____ year(s)		
PRODUCT(S):							
DATE OF LAST USE (year/month):							
13) OVER THE PAST 3 YEARS HAD THEIR DRIVER'S LICENCE SUSPENDED OR REVOKED? DATE: _____ REASON: _____	☐	☐	☐	☐	☐	☐	
14) UNDERGONE A DETOXIFICATION TREATMENT OR BEEN ADVISED TO DO SO? DATE: _____ NAME OF PHYSICIAN OR CLINIC: _____	☐	☐	☐	☐	☐	☐	

15) CURRENTLY BEEN CONSUMING OR PREVIOUSLY CONSUMED ALCOHOLIC BEVERAGES?

	WEEKLY QUANTITY					
	BEER		WINE		STRONG ALCOHOLIC LIQUORS	
	CURRENTLY	ONE YEAR AGO	CURRENTLY	ONE YEAR AGO	CURRENTLY	ONE YEAR AGO
PARTICIPANT						
SPOUSE						
CHILD						

D- EXPLANATION OF POSITIVE ANSWERS TO QUESTIONS 1 TO 14

QUEST. NO.	FIRST NAME	DIAGNOSIS – OPERATION – ACCIDENT REASON FOR CONSULTATION – NAME OF ILLNESS		BLOOD TESTS, X-RAYS, ECG, OTHER TESTS			PHYSICIAN CONSULTED OR HOSPITAL			
		DATE	DETAILS	NAME THEM	DATE	RESULTS	NAME	ADDRESS	DATE	DURATION

DECLARATION

"I hereby certify that the aforementioned answers are complete and true, and I acknowledge that in the event the application is accepted, it will be governed by the conditions of the contract applied for. In addition, I acknowledge that the insurance entered into this agreement will only come into force for any of the aforementioned persons on the day when La Capitale Insurance and Financial Services Inc. accepts it and contacts the applicant in writing regarding the acceptance." This application is considered to be refused if the head office of La Capitale Insurance and Financial Services Inc. has not accepted it within one hundred and twenty (120) days following the date on which it was completed. Furthermore, I acknowledge that any misrepresentation may cause the cancellation of the insurance.

Signed at _____, on this _____ 20____.

_____
Participant

AUTHORIZATION

If you participate to the family or single-parent plan, we also require the consent of your spouse and your dependent(s) age 18 or over.

AUTHORIZATION

"I hereby authorize any physician, any other professional and provider in the field of health and rehabilitation, as well as any public or private health care or social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that has received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any other person holding files or personal information, especially medical information pertaining to me and to my dependents, if applicable, to provide to La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) or to its agents, any information that it holds, needed for the processing of my file.

I also authorize La Capitale to forward this information to the aforementioned persons when necessary, within the scope of their activities and the processing of my file.

This consent is valid for purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same effect as the original.

_____ _____ _____ _____
Participant's signature or if under age, of his or her legal representative | Date | Spouse's signature | Date

_____ _____ _____ _____
Signature of dependent age 18 or over | Date | Signature of dependent age 18 or over | Date