




3 steps to follow after completing this questionnaire:

-  Make a complete copy for your records
-  Attach a copy of your insurance application to the questionnaire
-  Mail this questionnaire with the copy of your insurance application to the following address: Desjardins Insurance
C.P. 3000, Lévis (Québec) G6V 9X8

Contract number

Account number

Certificate number

A. Member

First name, last name and address of member



Telephone numbers

Home (Area code + No.):

Work (Area code + No.):

 This information is
required to process
your application.

Occupation:

Place of birth (province, state, country)

Are you presently working?

 Yes No

If so, number of hours worked each week – If you are not working, state reason

B. Employer

Name and address of employer

C. Proposed insureds

Member				Spouse			
First name		Last name		First name		Last name	
Sex	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth		Sex	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth	
Height	<input type="checkbox"/> ft in <input type="checkbox"/> cm	Weight	<input type="checkbox"/> lb <input type="checkbox"/> kg	Weight one year ago	<input type="checkbox"/> lb <input type="checkbox"/> kg	Height	<input type="checkbox"/> ft in <input type="checkbox"/> cm
Reason for change in weight (if applicable)				Reason for change in weight (if applicable)			
Child 1		Child 2		Child 3			
First name		Last name		First name		Last name	
Sex	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth		Sex	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth	
Height	<input type="checkbox"/> ft in <input type="checkbox"/> cm	Weight	<input type="checkbox"/> lb <input type="checkbox"/> kg	Weight one year ago	<input type="checkbox"/> lb <input type="checkbox"/> kg	Height	<input type="checkbox"/> ft in <input type="checkbox"/> cm
Reason for change in weight (if applicable)				Reason for change in weight (if applicable)			

D. Health questionnaire		Member		Spouse	
		Yes	No	Yes	No
1.	Are you currently being treated by a physician or another health care professional or taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you intending to consult a physician or another health care professional, or to undergo surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever suffered from an infirmity, a deformity or any other physical, nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever undergone an electrocardiogram, an X-ray, a mammography, a colonoscopy, a blood test or any other examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever undergone or been advised to undergo laboratory tests for the detection of the AIDS virus or antibodies to the virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever been prescribed a diet, medication, treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever been treated in a hospital, clinic or rehabilitation centre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever claimed or received benefits or been absent from work for more than 10 consecutive days because of an illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever received abnormal diagnostic test results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever experienced symptoms for which you have not yet consulted a health care professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever consulted a physician or another health care professional for any physical or mental disorder not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have any of the children to be insured ever suffered from heart, lung, neurological or mental problems, cancer or diabetes or had an application for insurance rejected, rated, modified or deferred?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Complete the table below for each question to which you answered yes. Use an additional sheet if needed.

No.	First name	Nature of illnesses, surgery, accidents, consultations, examinations, treatments, medication, results	Date	Length of illness/ disability	Length of hospitalization (if applicable)	Name and address of physicians or hospitals
				<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	
				<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	
				<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	
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				<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	
				<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> years	

E. Lifestyle questionnaire		Member		Spouse	
		Yes	No	Yes	No
1.	In the last 10 years, have you had an application for insurance declined or modified, or approved with an exclusion or extra premium? If yes, indicate the reason and the dates:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	In the last 5 years, have you had your driver's license suspended or revoked? If yes, indicate the reason and the dates:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	In the last 12 months, have you used any form of tobacco, including e-cigarettes or other tobacco substitutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been treated for alcohol or substance abuse or been advised to decrease consumption of alcohol or drugs? If yes, indicate the reason and the dates:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	What is your weekly consumption or use of:	Member		Spouse	
	tobacco, e-cigarettes or other tobacco substitutes				
	alcoholic beverages				
	narcotics or drugs				

F. History –  Complete for each proposed insured

Is there any history in your family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron diseases or other hereditary diseases?

Yes No If yes, please complete the table below. For cancer, indicate the type.

Check the family member					Illness(es) (if cancer: type)	Age at onset of the illness	Age if alive	Age at death
Member	Father	Mother	Brother	Sister				
Member	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				
Spouse	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				
Children	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				

G. Statement and authorization regarding your personal information

I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB, Inc. and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance.

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original. If the Desjardins Financial Security Life Assurance Company medical director deems appropriate, I authorize him to send the information that he obtained to analyze my application or that supports the Company's decision to the following physician:

Name and address of physician: _____



Signature of member

Date (yyyy - mm - dd)

Remember your signature and the date!

Signature of spouse

Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

H. Authorization regarding your personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.



Signature of member

Date (yyyy - mm - dd)

Remember your signature and the date!

Signature of spouse

Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)