



11204

Delta III Building  
2875 Laurier Blvd, Suite 400  
P.O. Box 1500  
Quebec QC G1K 8X9  
E-mail:

Tel.: 418 644-4200  
1 800 463-4856  
Fax: 418 646-1313  
adm.collectif@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

**A- PARTICIPANT'S LAST NAME (MAIDEN NAME IF APPLICABLE)** FIRST NAME

NO. STREET APT. CITY PROVINCE POSTAL CODE  
ADDRESS

TELEPHONE CURRENT DUTIES (employment)  
HOME: ( ) - WORK: ( ) -

**B- PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH OF THE PROPOSED INSURED:**

	LAST NAME (MAIDEN NAME IF APPLICABLE)	FIRST NAME	DATE OF BIRTH YEAR / MONTH / DAY	HEIGHT FT. IN/CM	CURRENT WEIGHT LB/KG	WEIGHT A YEAR AGO LB/KG
PARTICIPANT						
<b>DEPENDENTS (FAMILY OR SINGLE-PARENT COVERAGE)</b>						
SPOUSE						
CHILD						
CHILD						
CHILD						

**C- MEDICAL QUESTIONNAIRE**

**IMPORTANT: ANSWER ALL QUESTIONS AND EXPLAIN ANY ANSWERS UNDER SECTION D ON THE REVERSE, IF NECESSARY**

PLEASE SPECIFY WHETHER ANY OF THE PROPOSED INSURED:

	PARTICIPANT		SPOUSE		CHILDREN		FIRST NAME
	YES	NO	YES	NO	YES	NO	
1) IS CURRENTLY, <b>OR HAS BEEN WITHIN THE LAST 3 YEARS</b> , ABSENT FROM HIS OR HER REGULAR DUTIES DUE TO CONVALESCENCE, ILLNESS OR INJURY? DATE: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) HAS EVER SUBMITTED AN APPLICATION FOR INSURANCE THAT WAS DECLINED, DEFERRED OR APPROVED WITH A HIGHER PREMIUM? DATE: _____ CO.: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) PRACTISES OR PLANS TO PRACTISE A PROFESSIONAL SPORT OR A HAZARDOUS LEISURE ACTIVITY? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) IS TAKING ANY PRESCRIPTION DRUGS OR HOMEOPATHIC MEDICINES? NAME: _____ QTY/DAY: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) TAKES, OR HAS EVER TAKEN DRUGS OR NARCOTICS? TYPE: _____ DATE LAST USED: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) SUFFERS FROM ANY PHYSICAL OR MENTAL ABNORMALITY, DISABILITY OR ANY AFTER-EFFECTS OF AN ACCIDENT? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) SUFFERS OR HAS EVER SUFFERED FROM AN ILLNESS, OR HAS EVER HAD A HEALTH PROBLEM? DATE: _____ PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8) IS CONSULTING, PLANS TO CONSULT OR HAS BEEN ADVISED TO CONSULT A <b>PHYSICIAN</b> OR HAS BEEN TOLD HE OR SHE NEEDS TO HAVE AN OPERATION? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9) IS CONSULTING OR PLANS TO CONSULT <b>ANOTHER HEALTH CARE PROFESSIONAL</b> , INCLUDING ALTERNATIVE MEDICINE? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) <b>WITHIN THE LAST 5 YEARS</b> , HAS CONSULTED A PHYSICIAN, THERAPIST OR OTHER HEALTH CARE PROFESSIONAL, INCLUDING ALTERNATIVE MEDICINE, OR BEEN ADMITTED TO A HOSPITAL OR OTHER MEDICAL ESTABLISHMENT? IF YES, EXPLAIN UNDER SECTION D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11) HAS UNDERGONE, IS DUE TO UNDERGO, OR HAS EVER BEEN ADVISED TO UNDERGO A HIV (AIDS) TEST? DATE: _____ REASON: _____ RESULT: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



