

Please contact your LS Mutual agent for more details:

Ray Battiston, BA, CAIB, CIP, Insurance Broker
151 Osprey Cres, Callander, ON Canada P0H 1H0
Business Toll Free: 1 800 526.7420 • Business Local: 705 752.1723
Local Fax: 705 752.5198 • Toll Free Fax: 1 888 751.5124
raybattiston@on.aibn.com • http://www.lscoldnorth.com



MEDICAL QUESTIONNAIRE



3050, boul. St-Jean, suite 200
Trois-Rivières (Québec)
G9B 2M9
Tel: 819 377-1777
Toll free: 1 800 268-9633
Fax: 819 377-6069

(TO BE COMPLETE BY THE CLIENT AND/OR PHYSICIAN IF NECESSARY) YOU MUST ANSWER ALL QUESTIONS.

Policy Number: A W

Name: _____ Age: _____ Height: _____ Weight: _____

Smoker: YES No. of years: _____ NO Date quit (m/y): _____ Always nonsmoker

1) Have you ever consulted a physician and/or have been diagnosed and/or have been treated and/or taken prescribed medication (including ASA) and/or have been hospitalized for any of the following conditions?

A : CARDIAC AND VASCULAR

YES NO

If yes, specify below:

- Infarct (heart attack) Date (m/y): _____ Date (m/y): _____
- Angina (chest pain) Functionnal class I II III IV
Nitroglycerine use: patch specify dosage: 2mg 4mg 6mg 8mg
Spray Specify the use: _____
- Arterial blockage(s) (heart) Degree: _____% Surgically treated : YES NO Degree: _____% Surgically treated : YES NO
- Bypass (es) Number: _____ Date (m/y): _____ Number : _____ Date (m/y) : _____
- Dilatation(s) (angioplasty) Number: _____ Date (m/y): _____ Number : _____ Date (m/y) : _____
- Cardiac murmur
- Heart Failure (CHF) Ejection fraction: _____ %
- Irregular heart beat (arythmia) Type: _____
- Pacemaker Date of installation (m/y): _____
- Defibrillator Date of installation (m/y): _____
- Cardiac surgery Date (m/y) : _____ Type of surgery : _____
- Lower Limb stenosis (Legs) Limp : YES NO
- Aneurysm Localisation : _____ Size _____ Surgically treated : YES NO
- Carotid stenosis (neck) Right Degree : _____ % Surgically treated : YES NO Left Degree : _____ % Surgically treated : YES NO

B : NEUROLOGICAL

YES NO

If yes, specify below :

- CVA (stroke) Date (m/y) : _____ Date (m/y) : _____ Sequel(s) : _____
- Tia (mini- stroke) Date (m/y) : _____ Date (m/y) : _____

C : RESPIRATORY/PULMONARY

YES NO

If yes, specify below :

- Chronic Bronchitis COPD Emphysema Asthma
Number of prescribed puffers : _____
Specify the use (Be specific : do not write « when needed ») : per day per week per month per year
 less than 1 1 2 3 4 more than 4 times
- Pulmonary embolism Date (m/y) : _____ Date (m/y) : _____ Date (m/y) : _____
- Pneumonia with hospitalisation : Date (m/y) : _____ Date (m/y) : _____ Date (m/y) : _____
- Bronchitis with hospitalisation : Date (m/y) : _____ Date (m/y) : _____ Date (m/y) : _____

D : CANCER

YES NO

If yes, specify below :

- Type of cancer 1 : _____ Date of diagnostic (m/y) : _____ Stage : _____
- Radiotherapy Chemotherapy Cancer eliminated (remission) If yes, specify since when (m/y) : _____
- Type of cancer 2 : _____ Date of diagnostic (m/a) : _____ Stage : _____
- Radiotherapy Chemotherapy Cancer eliminated (remission) If yes, specify since when (m/y) : _____

2) Are there any other **conditions not mentioned** in this questionnaire or in the application for which you wish to be covered?

YES NO If yes, specify : _____

3) **SURGERIES AND/OR HOSPITALIZATIONS AND/OR HOSPITAL ER VISITS:** Please provide all surgeries or hospitalizations or hospital ER visits in the past 3 years. (Attach an additional page if necessary)

CONDITIONS	DURATION AND NUMBER OF TIMES	DATES (m/y)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4) **VISITS WITH A SPECIALIST:** Please indicate all visits with a specialist in the last 24 months :

SPECIALITY	NUMBER OF TIMES	DATE OF THE LAST VISIT(m/y)
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) **VISITS WITH YOUR ATTENDING PHYSICIAN:** Please indicate all the visits with your attending physician en the last 18 months :

DATE (m/y)	REASON
_____	_____
_____	_____
_____	_____

6) **FUTUR TREATMENT:**

Have any tests, treatment or surgeries been ordered and not completed yet? YES NO

If yes, specify : _____

7) **LIST OF YOUR PRESCRIBED MEDICATIONS, DOSAGE AND DATES OF LAST MODIFICATION OF DOSAGE :** including « as needed », puffers, patch and insulin. (Attach an additional page if necessary)

_____ Name et mg (m/y)	_____ Name et mg (m/y)	_____ Name et mg (m/y)
_____ Name et mg (m/y)	_____ Name et mg (m/y)	_____ Name et mg (m/y)
_____ Name et mg (m/y)	_____ Name et mg (m/y)	_____ Name et mg (m/y)
_____ Name et mg (m/y)	_____ Name et mg (m/y)	_____ Name et mg (m/y)

8) **RECENT TEST RESULTS:** Be precise, do not write "Normal"

Date (m/y) : _____

Blood pressure reading _____ / _____ Glycemia : _____ Glucosylated Hemoglobin (HbA1c) : _____

➔ **ATTACH COPIES OF ANY TESTS DONE WITHIN THE LAST TWELVE MONTHS.**

IF COMPLETED BY AN ATTENDING PHYSICIAN:

Name : _____ License No: _____

Physician's signature: _____ Date: _____

DECLARATION

I declare that all information contained herein is accurate and complete. I understand that if at the time of a claim an answer in this questionnaire is proven to be untrue, inaccurate or incomplete, the claim will not be paid. In addition, my policy will be null and void and all premiums paid will be reimbursed. I agree to advise my insurer immediately of any change in my medical condition or medication between the date of application and the date of departure or the effective date of the insurance, add on or extension. Should I fail to do so, any major change in my medical condition or medication that could affect the decision to accept my application may result in a change in my coverage or render my coverage null and void.

Me, my spouse or any member of my family making a claim on my behalf are required to release all information on my past or present medical conditions including any prescribed medication I am currently taking. In the case of uncertainty concerning my past or present conditions or medical treatments, I must request assistance from my physician before signing and submitting this questionnaire.

Applicant's Signature: _____ Date (d/m/y): _____