



# CRITICAL ILLNESS QUESTIONNAIRE Q4A

Last name \_\_\_\_\_ First name \_\_\_\_\_ Date of birth \_\_\_\_\_ File number \_\_\_\_\_  
Y M D

Agent (Name) \_\_\_\_\_ Code \_\_\_\_\_ S.U. \_\_\_\_\_ Agency (Name) \_\_\_\_\_ Agency (Code) \_\_\_\_\_

## CRITICAL ILLNESS PRE-SCREENING QUESTIONNAIRE

**1. Do you suffer or have you ever suffered from one of the illnesses or conditions listed below?**

	Yes	No
a) Angina, angioplasty, coronary artery bypass, heart attack, stroke (CVA), transient ischemic attack (TIA) or other cerebrovascular disease.	<input type="checkbox"/>	<input type="checkbox"/>
b) Heart valve defect.	<input type="checkbox"/>	<input type="checkbox"/>
c) The following congenital heart diseases: aortic stenosis, atresia of any heart valve, atrial septal defect, coarctation of the aorta, discrete subvalvular aortic stenosis, double inlet ventricle, double outlet left ventricle, Ebstein's anomaly, Eisenmenger syndrome, hypoplastic left heart syndrome, hypoplastic right ventricle, pulmonary stenosis, single ventricle, tetralogy of Fallot, total anomalous pulmonary venous connection, transposition of the great vessels, truncus arteriosus, ventricular septal defect.	<input type="checkbox"/>	<input type="checkbox"/>
d) Cystic fibrosis, pulmonary fibrosis, emphysema.	<input type="checkbox"/>	<input type="checkbox"/>
e) Alzheimer's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Parkinson's disease, Huntington's chorea, muscular dystrophy, motor neuron disease, cerebral palsy, Down's syndrome, Rett's syndrome, autism or any other neurological disorders.	<input type="checkbox"/>	<input type="checkbox"/>
f) Type 1 diabetes (insulin-dependent).	<input type="checkbox"/>	<input type="checkbox"/>
g) Kidney failure, polycystic kidney disease.	<input type="checkbox"/>	<input type="checkbox"/>
h) Transplant of the heart, lungs, liver, kidneys, bone marrow, pancreas.	<input type="checkbox"/>	<input type="checkbox"/>
i) Benign brain tumor.	<input type="checkbox"/>	<input type="checkbox"/>
j) Sickle cell disease, aplastic anemia.	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, YOU ARE NOT ELIGIBLE FOR CRITICAL ILLNESS COVERAGE.**

## SUPPLEMENTARY QUESTIONNAIRE

	Yes	No
<b>2.</b> Do you or have you ever had cancer, a tumor, a cyst, a nodule, a lump or a growth, colon polyps, skin or lymph gland disorders? If yes, give details: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b> a) Currently, are you under medical investigation or have you been advised to undergo a diagnostic test or surgery that has not yet been carried out? b) Have you noticed any symptoms or had health problems for which you have not yet consulted a doctor, such as: abnormality, lump or mass of the breasts, shortness of breath, chest pain, dizziness, loss of balance, numbness, rectal bleeding, prostate, developmental delay (neurological or psychomotor) or other problems?	<input type="checkbox"/>	<input type="checkbox"/>
<b>4.</b> Within the past two years, have you taken part in boxing, wrestling or horse racing? If yes, give details: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Family history</b> Has any family member (father, mother, brother(s), sister(s), or grandparents if the insured is age 20 and under) suffered from, or is suffering from cancer, heart disease, cerebrovascular disease, intracranial aneurysm, diabetes, chronic kidney disease, Alzheimer's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Parkinson's disease, Huntington's chorea, muscular dystrophy, motor neuron disease, or any other neurological disorders, familial adenomatous polyposis, retinitis pigmentosa? If yes, complete the following table:	<input type="checkbox"/>	<input type="checkbox"/>

	Disease*	Age at diagnosis	Actual age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparents					

\* Indicate type of cancer, heart disease or neurological disorders: \_\_\_\_\_

**6. If the proposed insured is a minor age child, specify the amount of critical illness insurance covering each of the following persons:**

Father	Mother	Brother(s): Number:	Sister(s): Number:

If applicable, specify the reasons for which one of these individuals is not covered by critical illness: \_\_\_\_\_

## SIGNATURE

I hereby declare that the above answers form an integral part of my application to Industrial Alliance Insurance and Financial Services Inc., that they are written correctly and that they are complete and true, and that no circumstance which might affect the risk of insurance on my life has been concealed.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

Proposed insured's signature