



DISABILITY INSURANCE QUESTIONNAIRE **Q6A** COMPLEMENTARY TO THE APPLICATION

INSURANCE AND FINANCIAL SERVICES INC.

Last name	First name	Date of birth Y M D	File number
Agent (name)	Code	S.U.	Agency (name) Agency (code)

PRE-SCREENING QUESTIONNAIRE

	Yes	No
Nervous Disorders (nervous disorders not included on this questionnaire must be declared in the application):		
1.1 In the last 5 years , have you suffered from bouts of depression that required you to stop working for more than 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
1.2 In the last 2 years , have you suffered from nervous or emotional disorders, including stress, fatigue, anxiety, overwork or burn-out, that required you to stop working for more than 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Currently , are you undergoing psychotherapy treatments in relation to any of the above-mentioned medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal Disorders:		
1.4 In the last 5 years , have you suffered from osteoarthritis or any other types of arthritis?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the questions above, you are not eligible for Disability Insurance coverage.

IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS ABOVE, PLEASE COMPLETE THE FOLLOWING SECTION.

SUPPLEMENTARY QUESTIONNAIRE

	Yes	No
Musculoskeletal Disorders:		
1.5 Over the last 5 years , have you suffered from vertebra related disorders, slipped disks, musculoskeletal disorders, including neck or back pain, shoulder, elbow or knee pain, or pain in any other joint that required you to stop working for more than 2 weeks? If so, answer question a) below.	<input type="checkbox"/>	<input type="checkbox"/>
a) Did you undergo chiropractic therapy, physiotherapy, massage therapy, osteopathic therapy, orthopedic therapy, ergotherapy or any other forms of treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Nature of the problem (diagnosis): _____		
Type of treatment: _____		
Date of first treatment: _____		
Date of last treatment: _____		
Frequency: _____		
Complete recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
1.6 Over the last 12 months , did you undergo any chiropractic therapy, physiotherapy, massage therapy, osteopathic therapy, orthopedic therapy, ergotherapy or any other forms of treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Type of treatment: _____		
Reason: <input type="checkbox"/> Relieve pain <input type="checkbox"/> Conditioning <input type="checkbox"/> Prevention <input type="checkbox"/> Other _____		
Frequency: _____/week _____/month _____/year		

If you answered "Yes" to any of the questions above, certain exclusions may apply to your Disability Insurance coverage.

SIGNATURE

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

Signed at _____ this _____ day of _____

Signature of the proposed insured

Signature of witness