PARA MED+

Extended Health, Travel and Dental coverage

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NOTE TO FINANCIAL ADVISOR — Give this notice to the owner

NOTICE

In order to proceed with the analysis of your insurance application, it is possible that we should obtain additional information.

INVESTIGATION

A representative from an investigation company may contact you in order to get more personal and financial information.

MEDICAL EXAMINATION

A physician or a nurse from a paramedical organization may ask you to undergo a medical examination.

TESTS

A physician or a nurse from a paramedical organization or from a medical clinic may ask for blood or urine sample. The test will focus on the presence of many possible abnormalities like cholesterol, diabetes, liver problems, the presence of medication, drugs, nicotine and AIDS detection or other. In order to take a blood or urine sample, your written consent will be required.

NOTICE OF COMPLETION OF A FILE AND OF COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION TO INSUREDS AND OWNER(S)

In this section, the term “personal information” refers to information about you that allows you to be identified, directly or indirectly. Your personal information will be collected, used, disclosed and processed:

- For the reasons and purposes described in this policy contract;
- According to the means determined in this policy contract;
- As may be described before collecting, using or disclosing it; And
- As otherwise permitted by law.

WHY DOES UV INSURANCE COLLECT YOUR PERSONAL INFORMATION?

For UV Insurance, protecting your personal information is essential. This is why we inform you that we collect, use and communicate your personal information with your consent, unless the law authorizes us to do otherwise, and this, for the duration necessary for the purposes below:

- Identify you;
- Establish and update your profile, your needs and your objectives;
- Assess your requests and your eligibility for our products and services;
- Provide you with advice related to your situation;
- Administer your contracts as well as your products or services (e.g., pricing, risk selection, underwriting, handling of your claims, etc.);
- Comply with legal and regulatory requirements (e.g., to prevent, detect or repress offences, cyber threats, fraud, etc.);
- Obtain your opinion in relation to our products or services;
- Provide you with personalized offers and advice on our products or services (see your right to withdraw consent) according to your preferences and in accordance with the rules relating to electronic and telephone communications;
- Conduct studies and research including the design and application of statistical models, some of which may create or infer new information about you.

HOW DOES UV INSURANCE COLLECT YOUR PERSONAL INFORMATION?

We may collect your personal information over the phone, in person, and through our forms and digital interfaces.

TO WHOM DOES UV INSURANCE COMMUNICATE YOUR PERSONAL INFORMATION?

For the reasons mentioned earlier, and only as related to your products or services, we share your personal information with our affiliates and our distribution networks as well as third parties, some of whom may be located at outside Quebec and Canada. A third party is an external person who is not a party to the relationship between UV Insurance and you. These third parties may include:

- Your financial security advisor and his firm or general agent;
- Other financial institutions, such as yours, insurers or reinsurers;
- Any physician, health professional or other practitioner;
- Any hospital, laboratory, medical clinic or paramedical organization;
- Personal Information Officers;
- Your employer or former employer;
- Other organizations or entities holding information about you, among others, in insurance, fraud or compensation;
- Government departments and agencies or regulatory authorities;
- Agents and service providers (e.g., technology services, document printing and shipping services, etc.)
- Any person or organization to whom you have given your consent;
- Any person authorized by law.

NOTE THAT IN ALL CASES, WE ENSURE THAT THEY RESPECT THE PROTECTION OF YOUR PERSONAL INFORMATION.

Upon receipt of this document, i.e. your insurance application, you consent to UV Insurance opening a file where your personal information will be kept and treated confidentially.

UV Insurance will be able to access your file as well as said personal information from its head office and they will only be consulted by employees and authorized representatives of UV Insurance who need to have access to it in the course of their work. Your information may also be used, stored and accessed securely in other countries according to the laws applicable there. For example, information may be disclosed in response to requests from the governments, courts or law enforcement authorities of those countries.

It is possible that your banking information will be communicated to the financial institutions responsible for processing your pre-authorized debits (“PAD”). It is also possible that your personal information will be communicated to your beneficiaries in connection with a claim (for example, in the event of death).

WITHDRAWAL OF YOUR CONSENT

At any time, you can withdraw your consent to the communication or use of your personal information. Be aware that the withdrawal of your consent may lead to legal or contractual consequences in the context of your insurance application, such as the impossibility of offering you the financial product or the services requested. In such a case and at your request, the UV Insurance representative will make sure to explain these consequences to you.

ACCESS TO YOUR FILE AND CORRECTION OF YOUR PERSONAL INFORMATION

Upon request, you can also be informed of the categories of persons who have access to your information within UV Insurance and the retention period of this information. You may have access to your file and your information collected to verify its accuracy and have information rectified if you demonstrate that it is inaccurate, incomplete, ambiguous, outdated or unnecessary. To access your file, have your information corrected, be informed of the retention period of your information, withdraw your consent or simply have your questions answered, you must make a written request to the attention of Privacy Officer of UV Insurance at the following coordinates:

PRIVACY OFFICER

1990 rue Jean-Berchmans-Michaud
Drummondville (QC) J2C 7G7
ResponsiblePRP@uvassurance.ca

To view our privacy policy, visit our website at https://uvinsurance.ca/privacy-policy/.

Extended Health, Travel and Dental coverage

APPLICATION

☐ New enrolment ☐ Addition or Modification to existing contract ☐ Reinstatement **Contract No.:**

	Agent information	Code	%
Name of firm:	Name of agent 1 (administrator):		
	Name of agent 2:		

1. INSURED INFORMATION

Employer/Agency:	Occupation:
First Name:	Last Name:
Date of Birth: ____________ DD / MM / YYYY	Gender: ☐ M ☐ F Language preference: ☐ French ☐ English

Address: ____
P.O. Box No. & Street Apt City Province Postal Code

Telephone: ____________ ____________ ____________
Home Office Cell

E-mail:

2. CHOICE OF COVERAGE

☐ Single ☐ Family ☐ Couple ☐ Single parent	Premium: ☐ Levelled ☐ Attained age	Monthly Premium $
Extended Health Insurance Travel Insurance included in EHC	Plan: ☐ Basic ☐ Basic Ultra Please complete all sections of this application, except for section 5	
	Plan: ☐ Select ☐ Deluxe ☐ Optimum Please complete all sections of this application	
Drug Plan (Complement to the RAMQ or a group insurance)	Option: ☐ $1,250 ☐ $2,500	
Home Care Assistance	Option: ☐ $25,000	
Dental insurance	Plan: ☐ Basic ☐ Deluxe	
Other		
	Total monthly premium	
	Total annual premium = (Total monthly premium x 12)	

Does the coverage you are applying for replace a group insurance policy that is currently in force or that ended within the last 60 days? If yes, please specify the contract and the name of the company. ☐ Yes ☐ No

Contract: ____________ Company: ____________

Do you currently have an individual or group insurance policy that covers you for dental care? ☐ Yes ☐ No
If yes, please indicate the contract number and the name of the company.

Contract: ____________ Company: ____________

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3. SPOUSE AND DEPENDENT CHILD* INFORMATION

Please note that the information of the persons to be insured must be indicated below. You must have the authorization to communicate information about your spouse and dependent children.				Date of Birth		
	First Name	Last Name	Gender	Date	Month	Year
Spouse[1]			☐ M ☐ F			
Dependent Child			☐ M ☐ F			
Dependent Child			☐ M ☐ F			
Dependent Child			☐ M ☐ F			
Dependent Child			☐ M ☐ F			
Dependent Child			☐ M ☐ F			

[1] If common-law spouse, please specify the date cohabitation began (DD/MM/YYYY)______/______/______.

*Dependent child means an unmarried child of the insured (whether a natural child, a stepchild or an adopted child), of his or her spouse, or of both of them, who depends on the insured for his or her support and who:

1) Is older than 24 hours and younger than 21 years of age and does not work more than 20 hours a week, unless he or she is a full- time student;
2) Is 21 years of age or older but less than 26 if he or she is a regular full-time day student in a recognized academic institution; or
3) Regardless of age, has a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability must have begun while the child was considered a dependent as defined previously and be of such nature that the dependent is totally incapable of pursuing a gainful occupation.

**If the dependent child is over 21 years of age and a full-time student in a recognized academic institution please fill out the application for over-age dependency coverage.

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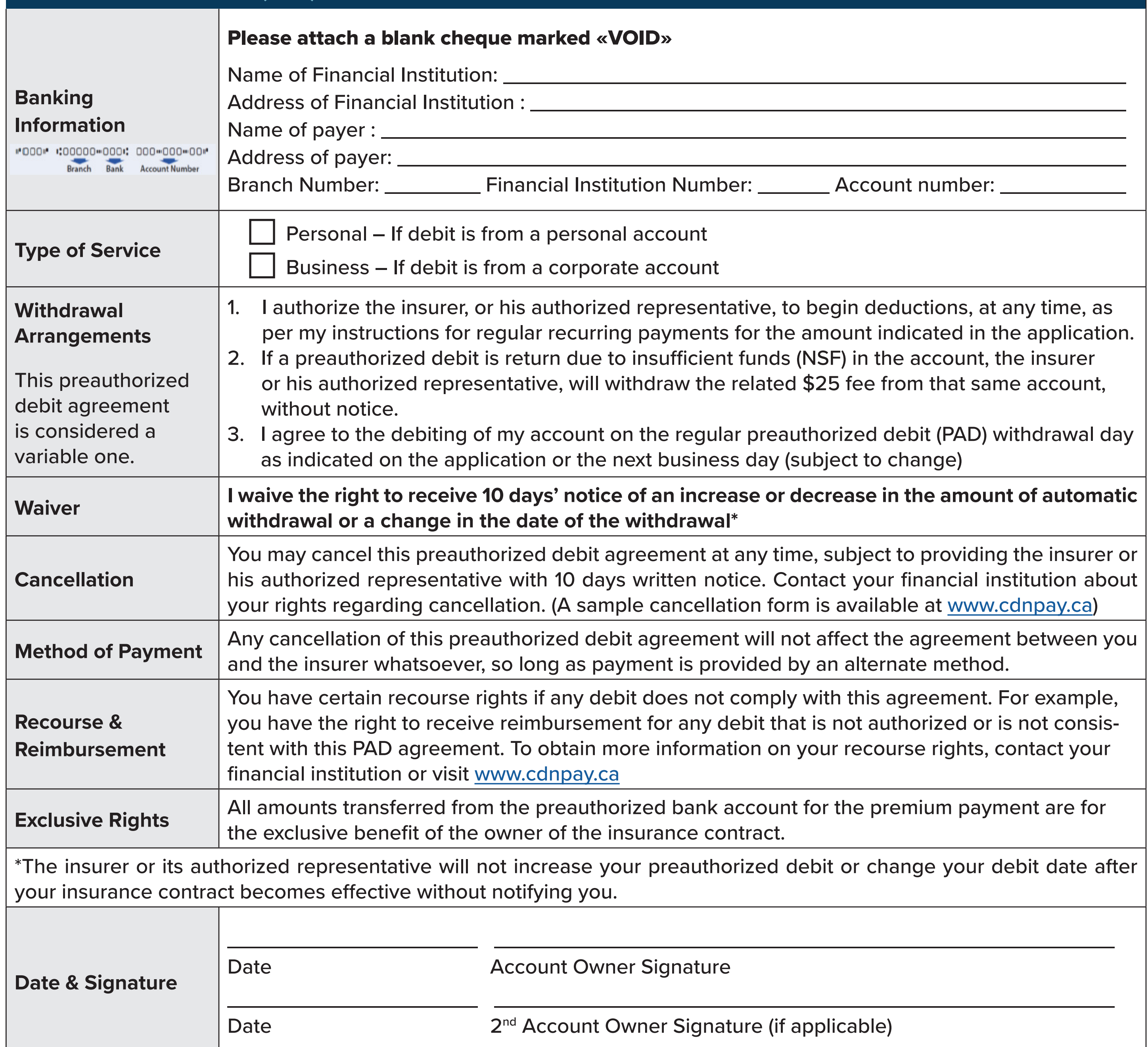

4. PREMIUMS AND METHOD OF PAYMENT

☐ Monthly preauthorized debit $ ________________ (See preauthorized debit section)

☐ Annual preauthorized debit $ ________________ (See preauthorized debit section)

A first withdrawal will be taken on the approval date. Thereafter, the withdrawal date will be the same as the issue date (except if the 29th, 30th and 31st, withdrawal date will be the 1st of the month)

☐ Annual $ ________________

Make cheque payable to: «Odyssey Insurance in Trust», third party administrator on behalf of the insurer.

PREAUTHORIZED DEBIT (PAD) AGREEMENT

Banking Information Branch / Bank / Account Number	**Please attach a blank cheque marked «VOID»** Name of Financial Institution: ________________ Address of Financial Institution : ________________ Name of payer : ________________ Address of payer: ________________ Branch Number: ________ Financial Institution Number: ______ Account number: __________
Type of Service	☐ Personal – If debit is from a personal account ☐ Business – If debit is from a corporate account
Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.	1. I authorize the insurer, or his authorized representative, to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. 2. If a preauthorized debit is return due to insufficient funds (NSF) in the account, the insurer or his authorized representative, will withdraw the related $25 fee from that same account, without notice. 3. I agree to the debiting of my account on the regular preauthorized debit (PAD) withdrawal day as indicated on the application or the next business day (subject to change)
Waiver	**I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal***
Cancellation	You may cancel this preauthorized debit agreement at any time, subject to providing the insurer or his authorized representative with 10 days written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca)
Method of Payment	Any cancellation of this preauthorized debit agreement will not affect the agreement between you and the insurer whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca
Exclusive Rights	All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance contract.

*The insurer or its authorized representative will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.

Date & Signature	____________ Date	____________________ Account Owner Signature
	____________ Date	____________________ 2nd Account Owner Signature (if applicable)

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5. HEALTH QUESTIONS - FOR EXTENDED HEALTH SELECT, DELUXE AND OPTIMUM

Any reference to test results, excludes genetic tests. Genetic test means a test that analyses DNA, RNA, or Chromosomes for purposes such as prediction of disease or vertical transmission risks. Do not provide any information about genetic tests in this application, other questionnaires or forms. However, you must answer all other questions truthfully including information about all other types of medical tests.

A) Pre-underwriting questionnaire

Have you or your spouse or dependent child listed ever received care, been diagnosed or experienced symptoms relating to the following disorders:

- AIDS, AIDS-related complex or HIV infection
- Alzheimer's disease
- amyotrophic lateral sclerosis (ALS disease)
- angina
- cancer (except basal cell carcinoma)
- chronic fatigue
- autism spectrum disorders
- chronic pancreatitis
- chronic renal failure
- cirrhosis of the liver
- cystic fibrosis
- diabetes (type 1)
- heart attack
- hepatitis B or C
- fibromyalgia
- dementia
- multiple sclerosis
- organ transplant (except corneal)
- Parkinson's disease
- rheumatoid arthritis
- stroke
- systemic lupus erythematosus?

☐ Yes ☐ No

If any proposed insured answered YES to the above pre-underwriting questionnaire, he/she is not eligible for this underwritten product.

B) Underwriting questionnaire
(Only complete the following questionnaire for each proposed insured that have answered no to the pre-underwriting questionnaire).

1.

First Name/Last Name	Name of family physician	Date of last consultation, reason, results and treatment	Height	Weight
Proposed insured		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____
Spouse		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____

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First Name/Last Name	Name of family physician	Date of last consultation, reason, results and treatment	Height	Weight
Dependent child		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____
Dependent child		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____
Dependent child		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____
Dependent child		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____
Dependent child		Date: Reason: **Results/treatment:**	cm ☐ ____ in ☐ ____	kg ☐ ____ lbs ☐ ____

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2. In the **past five (5) years**, have you or your spouse or dependent child listed ever received care, been diagnosed or experienced symptoms relating to the following disorders:

	YES	NO
a) **Cardiovascular system:** arrhythmia, heart murmur, high blood pressure, high cholesterol, or any other cardiac, circulatory or blood vessels disorder?	☐	☐
b) **Digestive system:** ulcer, ulcerative colitis, Crohn's disease, polyps, disorder of the stomach, pancreas, intestines, liver, or any other gastrointestinal disorder?	☐	☐
c) **Endocrine or blood system:** diabetes, anemia, leukemia, thyroid disorder, gout, or any other endocrine or blood disorder?	☐	☐
d) **Genito-urinary system:** chronic bladder infections, kidney stones, disorder of the kidneys, prostate, uterus, cervix, breast, urinary tract or any other genital or urinary disorder?	☐	☐
e) **Immune system:** Lyme disease, AIDS or AIDS-related complex, or other immune disorder or deficiency?	☐	☐
f) **Musculoskeletal system:** back or neck disorders (including low back pain), muscle, bone or ligament disorders, arthritis, or any bone or joint disorder?	☐	☐
g) **Neurological system:** transient ischemic attack (TIA), chronic headaches, migraines, dizziness, vertigo, seizure, epilepsy, paralysis or any other neurological or brain disorder?	☐	☐
h) **Nervous system:** anxiety, depression, anorexia or any other eating disorder, attention deficit disorder (with or without hyperactivity), or any other mental, nervous or emotional disorder?	☐	☐
i) **Respiratory system:** asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, or any other respiratory or lung disorder?	☐	☐
j) **Other conditions or diseases:** tumor, eye, ear or skin disorder (including acne)?	☐	☐

3. In the **past two (2) years**, have you or your spouse or dependent child listed:

	YES	NO
a) Consulted or been advised to consult or received treatment from any of the following health professionals: physiotherapist, massage therapist, podiatrist, chiropractor, acupuncturist, nutritionist, psychologist, speech therapist, homeopath, or naturopath?	☐	☐
b) Required, used, or been advised to use any of the following equipment, device, or medical accessories: artificial limbs, wheel chair, walker, orthopedic devices or arch supports, oxygen, CPAP machine, ostomy supplies, diabetic supplies or equipment?	☐	☐
c) Been treated for alcohol or drug dependency or been recommended to reduce your alcohol or drug consumption?	☐	☐
d) Been treated or followed for any congenital or physical impairment, deformity, or illness not covered above or been advised that you should be?	☐	☐

4. Provide details for each YES answer given in questions 2 and 3.

Person's Name	Question	Condition or disease/ Diagnosis	Treatment and cost	Date of treatments (dd/mm/yyyy)	Result of treatment/ extent of recovery
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	

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5. Have you or your spouse or dependent child listed been advised to undergo a diagnostic test, a test, an exam, be hospitalised or have surgery even if it has not been completed? ☐ Yes ☐ No
   If YES, specify :

6. Are you or your spouse or dependent child listed aware of any symptoms or health discomfort for which you have not yet consulted a physician, or received a diagnosis? ☐ Yes ☐ No
   If YES, specify:

7. In the past **twelve (12) months**, have you or your spouse or dependent child listed taken any prescribed medication?
   ☐ Yes ☐ No
   If YES, complete the following table:

Person's name	Name of prescribed drug	Reason for the prescription	Dosage	Frequency	Monthly cost	Date started & date stopped
						Date started _________ Date stopped _________ Ongoing ☐
						Date started _________ Date stopped _________ Ongoing ☐
						Date started _________ Date stopped _________ Ongoing ☐
						Date started _________ Date stopped _________ Ongoing ☐
						Date started _________ Date stopped _________ Ongoing ☐
						Date started _________ Date stopped _________ Ongoing ☐

____
Signature of the proposed insured

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DECLARATIONS

1. On the date of signing of this application, the proposed insured, in his personal capacity as well as in his capacity of authorized representative of any proposed insured, hereby declares the following that concerning himself/herself and each eligible proposed insured:
   a. We are currently working or if not, we are not disabled or receiving any type of disability benefits.
   b. We are not currently hospitalized or waiting to be hospitalized (including day surgery).
   c. We have not been diagnosed or received any treatment (including medication) for any type of cancer in the past five (5) years (except for basal cell carcinoma).
   d. We have not tested positive on the AIDS virus antibody test or been diagnosed with AIDS (acquired immune deficiency syndrome) or ARC (AIDS – related complex).

   Initials

2. We confirm that each eligible proposed insured holds a valid card from his/her provincial health government plan.
3. We attest to having received our dependent's consent (spouse and/or children) in order to enroll in this individual insurance plan in their name. (only applicable if you have requested coverage for your spouse and/or children)
4. We declare that we have read all the questions contained in this application and that the answers given have been faithfully reproduced and are complete and true. In addition, we agree that they serve as the basis for the insurance contract requested and acknowledge that any false declaration or omission may result in the termination of the insurance contract obtained as a result of this application.
5. We declare that we have been informed that the insurance comes into force upon acceptance of this policy contract provided that the latter has been accepted without modification, that the first premium has been paid and that no change has occurred in the insurability of the people to be insured since this application was signed.
6. We declare that we have been informed that the advisor is remunerated by commission in relation to the transaction described in the above-mentioned application.
7. We declare that we have read the above notices and we consent to the creation of a file as well as the collection, use and communication of personal information. We understand that any information disclosed in this application and any supplemental documents, if any, may be collected, used, retained or disclosed by or to other participants in the insurance application process and any potential assignee of the insurance policy.
8. We declare that we have been informed that UV Insurance may collect our personal information using technologies that include functions allowing identification, localization or profiling, which are necessary in order to assess our request. This is the case of the application in electronic, PDF and paper format, which enables us to establish our risk profile and obtain the best possible premium. We agree that submitting the application triggers the activation of these functions.
9. We declare that we have been informed that UV Insurance may use our personal information to make exclusively automated decisions, that is, without any human intervention. For example, when an electronic application is submitted, an automated decision may be made to speed up underwriting, including the calculation of the premium and the selection of risks.
10. We declare that we have been informed that the illnesses and conditions covered by this insurance are limited to those defined in the contract.
11. We declare that we informed the insurer about having other citizenship(s) than the Canadian citizenship.
12. We declare that we have been informed that the financial security advisor is independent of UV Insurance and that he is not its representative.
13. We declare that the answers and declarations contained in this application, if they have been completed, and in any paramedical questionnaire, telephone interview and all other questionnaires are complete and true and form an integral part of the application for life, Accident and sickness or Critical illness insurance and cannot be dissociated from it.

AUTHORIZATIONS

Your authorizations are necessary to provide and administer your products or services offered by UV Insurance:

1. We authorize any professional and participant in the field of health, any health care provider, any public or private health or social services establishment, any insurer or reinsurer, any investigation agency as well as any natural or legal person likely to hold personal information related to our state of health, our medical history or our lifestyle habits necessary for the reasons mentioned in the notice of constitution of a file and the collection, use and communication of information personal, to communicate them to UV Insurance or its reinsurers. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.

2. We authorize UV Insurance, and its reinsurers to collect, use and communicate the personal information necessary for the reasons mentioned in the notice of constitution of a file and the collection, use and communication of personal information from any professional and intervener in the field of health, health care provider, public or private health or social services establishment, insurer or reinsurer, investigation agency, natural or legal person likely to hold personal information related to our state of health , our medical history or our lifestyle habits. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.

3. We authorize UV Insurance to communicate to the undersigned financial security advisor and owner, all personal information collected on the application or during the risk assessment process and which could have an impact on the premium or the issuance of the contract. This information includes, but is not limited to, the results of medical tests or laboratory tests, information provided during a telephone interview, a paramedical examination, a questionnaire or a declaration of insurability, medical history, criminal, work, alcohol or drug use, financial information or any other element considered during the evaluation of the application. The financial security advisor, thus informed, will be able to better guide us through the various insurance options available to us.

4. We authorize UV Insurance and its reinsurers to collect, use and disclose personal information held by any credit reporting agency for the purposes of pricing, risk selection, study, research and development, design and application of statistical models, regulatory and contractual compliance and prevention and detection of fraud, errors and misrepresentations. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.

5. We authorize, in the event of death, the beneficiary, the heir or the liquidator of their succession to communicate to UV Assurance and its reinsurers, when required by the latter(s), all the information and authorizations necessary to the study of the death claim and obtaining the required justifications.

6. Agree that any photocopy of these authorizations has the same value as the original.

7. I authorize the insurer or Odyssey Insurance (Groupe Financier Odyssée Inc) to use my personal information in order to send me information on other products and services that might interest me. If no, please check (√) the following:

☐ I do not authorize this use.

These authorizations may be canceled at any time by sending a written notice to UV Insurance.

By signing and submitting this application on my behalf, I consent to the collection, communication and use of my personal information as described above and elsewhere in this policy contract.

I acknowledge having read and agree to the thirteen (13) declarations and the seven (7) authorizations above.

Signed at ________________________ on this ______ day of ________________________ 20____
(Province)

______________________________ Signature of the proposed insured

______________________________ Signature of the Agent

______________________________ Signature of the spouse

Use of french: UV Insurance must ensure compliance with the *Charter of the French Language*. As an advisor, you must present the documentation in French to your English-speaking Québec client. As you are the one completing this electronic application, you must obtain his express wish to proceed in English after presenting him with the French documentation.

- ☐ My client is francophone
- ☐ My client doesn't reside in Quebec
- ☐ I certify that I have provided my client, who resides in Québec, with a copy of the **application in French** before its signature in English. After examining such version, my client requests that the contract herein and any other related documentation be presented in English. It is his express wish to be bound by the English version of this application only and for all related documents to be drafted in English only

Underwritten by:

UV Insurance P.O. Box 696, Drummondville (Quebec) J2B 6W9
Tel. 819 478-1315 Toll free 1-800 567-0988 Fax 819 474-1990