Desjardins Insurance | LIFE · HEALTH · RETIREMENT

PRINT RESET

UNDERWRITING MEDICAL PRE-ASSESSMENT

Complete all applicable sections. The more details you provide, the more accurate the pre-assessment.

Lock-in number	Application(s) number(s)	
Representative's name	Phone number	Fax number

A - INFORMATION ON THE PROPOSED INSURED

Date of birth (YYYY/MM/DD)	Sex ☐ Female ☐ Male	☐ Smoker ☐ Non-smoker	Occupation
Arrival date in Canada (if less than 2 years ago) (YYYY/MM/DD)	Country of origin		Status

Has the proposed insured ever submitted an application (or a reinstatement request) for life, disability, critical illness or long-term care insurance that was declined, deferred, or approved with an exclusion or extra premium? ☐ No ☐ Yes
If **"Yes"**, please complete the table below, indicating the reason the application was declined or approved with an exclusion or extra premium.

Name of insurance company	Date (YYYY/MM/DD)	Reason

B - INSURANCE

☐ Death ☐ Critical Illness ☐ Healthcare ☐ SOLO / SELECT ☐ Disability – income benefit/monthly expenses

C - FAMILY HISTORY

Family relationship	Illness	Age diagnosed	Family relationship	Illness	Age diagnosed
Father			**Brother(s)**		
Mother			**Sister(s)**		

D - GENERAL MEDICAL HISTORY

Height cm | in	Weight (current) kg | lb	Weight (1 year ago) kg | lb	If difference of 4.5 kg (10 lb) or more in past year, specify reason:
Diagnosis			Date of diagnosis (YYYY/MM/DD)

Medications (including dosage and reason):	Hospitalization: ☐ No ☐ Yes If **"Yes"**, date (YYYY/MM/DD):	Leave from work: ☐ No ☐ Yes If **"Yes"**, date (YYYY/MM/DD):
Surgery: ☐ No ☐ Yes	Reason:	Reason:
If **"Yes"**, date (YYYY/MM/DD):	Duration:	Duration:
Type of surgery:	Number of hospitalizations:	Number of episodes:

Date of last episode (YYYY/MM/DD): Number of episodes:

If there are any residuals or functional limitations, please specify:

Is the proposed insured awaiting any tests or test results? ☐ No ☐ Yes If **"Yes"**, please specify:

E - SPECIFIC MEDICAL CONDITIONS (provide additional details as required)

CANCER	PSYCHOLOGICAL	DIABETES	CARDIOVASCULAR
Type - location:	☐ Anxiety ☐ Attention deficit disorder ☐ Bipolar disorder ☐ Burnout ☐ Major depression ☐ Reactive or situational depression	☐ Type 1 ☐ Type 2	Angina attack ☐ 1 ☐ 2 or more Heart attack ☐ 1 ☐ 2 or more Stroke ☐ 1 ☐ 2 or more
Stage at diagnosis:	Suicide attempt or suicidal ideation: ☐ No ☐ Yes If **"Yes"**, number of attempts:	Date of last blood sugar or glycosylated hemoglobin (HbA1c) test (YYYY/MM/DD):	Vessels/arteries affected: ☐ 1 ☐ 2 or more
Recurrence: ☐ No ☐ Yes If **"Yes"**, date (YYYY/MM/DD):	Date of last suicide attempt (YYYY/MM/DD):	Results :	Date of last cardiology assessment **including stress test and results of tests** (YYYY/MM/DD):
Surgery: ☐ No ☐ Yes If **"Yes"**, date (YYYY/MM/DD):	Alcohol use: ☐ No ☐ Yes If **"Yes"**, specify:	Related disorders: ☐ Kidneys ☐ Vision	☐ Bypass - specify date (YYYY/MM/DD):
Chemotherapy or radiation therapy: ☐ No ☐ Yes If **"Yes"**, treatment end date (YYYY/MM/DD):	Drug use: ☐ No ☐ Yes If **"Yes"**, specify:	☐ Heart/stroke ☐ Neuropathy	☐ Angioplasty - specify date (YYYY/MM/DD):

Comments:

F - FOR UNDERWRITING USE ONLY

Preliminary tentative assessment: ☐ Standard ☐ Extra premium or exclusion ☐ Decline or postpone

Details:

By: (underwriting dep't) Date (YYYY/MM/DD):

Note: This document is not an insurance application, offer or policy. Preliminary assessment results are only an opinion based on information disclosed by the applicant. A final decision will only be made upon receipt of a duly completed application and basic information about the applicant's age, the amount of insurance, and any other requirements deemed necessary by Desjardins Insurance's underwriting department.