Armstrong
Financial Services

Confidential Client Questionnaire

1. Personal Information

Name: _____ Email: _____

Cell Phone: _____ Date of Birth: (mm/dd/yyyy) _____ / _____ / _____

Gender: (Male, Female) _____ Place of Birth: _____

Home Address: _____ No. of Years: _____

Resident Status: (Citizen, Resident, Visa) _____ US tax resident? □ Yes | □ No

Driver's License No.: _____ Place of Issue: _____

Issued: (mm/dd/yyyy) _____ / _____ / _____ Expires: (mm/dd/yyyy) _____ / _____ / _____

Marital Status: (Married, Common-law, Divorced, Single, Other) _____

Spouse Name: _____ Date of Birth: (mm/dd/yyyy) _____ / _____ / _____

Occupation: _____ Employer: _____ No. of Years: _____

Employer Address: _____

Height: (ft/in) _____ Weight (lbs) _____ Change of ±10 lbs in last 12 months? □ Yes | □ No

Details: _____

Primary Physician: _____ Date of Last Visit: _____

Clinic Name: _____ Clinic Location: _____

Details of last visit: _____

_____

_____

Medications: _____

_____

Do you have, or have you been treated for, any of the following conditions: High blood pressure, High cholesterol, Cancer, tumours, leukemia, polyps or skin lesions, Diabetes, coronary or vascular issues, Depression or Anxiety, gastrointestinal issues such as Chrons or Colitis? □ Yes | □ No

_____

_____

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Other Physician: _____ Date of Last Visit: _____

Clinic Name: _____ Clinic Location: _____

Details: _____

_____

_____

Other Physician: _____ Date of Last Visit: _____

Clinic Name: _____ Clinic Location: _____

Details: _____

_____

_____

Other Physician: _____ Date of Last Visit: _____

Clinic Name: _____ Clinic Location: _____

Details: _____

_____

_____

Has any parent or any sibling ever been diagnosed with heart disease, stroke, cancer, Huntington's chorea, kidney disease, Parkinson's, multiple sclerosis, Alzheimer's, ALS or Lou Gehrig's or other motor neuron disease, diabetes, hepatitis, kidney disorders or retinitis pigmentosa? □ Yes | □ No

Relation: _____ Diagnosis: _____

Age of Onset: _____ Current Age: _____ / Age at Death: _____ Cause: _____

Details: _____

_____

_____

Relation: _____ Diagnosis: _____

Age of Onset: _____ Current Age: _____ / Age at Death: _____ Cause: _____

Details: _____

_____

_____

2. Lifestyle Information

In the past 15 years, have you consumed any alcoholic beverages? □ Yes | □ No

- ☐ Wine _____ Glasses / Month
- ☐ Beer _____ Bottles / Month
- ☐ Liquor _____ Ounces / Month

In the past 15 years, have you consumed any nicotine products (Including Cigarettes, Cigars, Cigarillo, Vapes, E-Cigarette, Patch/Gum, Pipe, or Other)? □ Yes | □ No

Date of last use: _____ Details: _____

In the past 15 years, have you consumed any marijuana products? □ Yes | □ No

Date of last use: _____ Details: _____

In the past 15 years, have you used drugs or had counselling for drug/alcohol use? □ Yes | □ No

Date of last use: _____ Details: _____

In the past 5 years, have you participated in a hazardous activity, or do you expect to participate in a hazardous sport or activity, such as backcountry skiing, snowboarding or snowmobiling, ballooning, hang gliding, heli-skiing, mountain climbing, racing of any kind, scuba or skin diving, skydiving, ultralight flying, flying in an aircraft as a pilot? □ Yes | □ No

Date of last activity: _____ Details: _____

In the past 2 years, have you had driving or speeding violations? □ Yes | □ No
In the past 5 years, have you had your driver's license suspended? □ Yes | □ No
In the past 10 years, have you ever been subject to a DUI offence? □ Yes | □ No

Details: _____

Medical Questionnaire Addendum

Please complete the following medical questionnaire. After completing the questionnaire, utilize the space provided at the end to elaborate on any selected responses. When providing these details, ensure to reference the related question number.

Note: references to "tests" or "test results" in this questionnaire do not include genetic tests.

1. Have you ever had or been investigated or treated for conditions involving any of the following:

a. Your heart and blood vessels, such as: ☐ No to all

- ☐ angina
- ☐ blood clots
- ☐ bypass or angioplasty
- ☐ cerebrovascular disease (CVA)
- ☐ chest pain or shortness of breath
- ☐ claudication
- ☐ heart attack (myocardial infarction)
- ☐ heart disease or heart murmur
- ☐ palpitations or irregular pulse
- ☐ peripheral vascular/artery disease
- ☐ poor circulation
- ☐ stroke or transient ischemic attack
- ☐ swollen ankles (not due to pregnancy)
- ☐ other

b. Your nose, throat or lungs, such as: ☐ No to all

- ☐ asthma
- ☐ chronic bronchitis
- ☐ sarcoidosis or tuberculosis
- ☐ sleep apnea
- ☐ cystic fibrosis
- ☐ emphysema
- ☐ chronic obstructive pulmonary disease
- ☐ other

c. Your abdominal organs, such as: ☐ No to all

- ☐ celiac disease
- ☐ cirrhosis
- ☐ colitis
- ☐ Crohn's disease
- ☐ diverticulitis
- ☐ gastrointestinal bleeding
- ☐ gastrointestinal reflux
- ☐ hepatitis (active or carrier state)
- ☐ hiatus hernia
- ☐ jaundice
- ☐ irritable bowel syndrome
- ☐ liver disease or pancreatitis
- ☐ ulcer
- ☐ other

d. Your kidneys, bladder or reproductive organs, such as: ☐ No to all

- ☐ abnormal Pap test
- ☐ bladder infection
- ☐ kidney stone
- ☐ nephritis
- ☐ polycystic kidney disease
- ☐ prostatitis or other prostate disorder
- ☐ protein in the urine
- ☐ sugar or blood in the urine
- ☐ urinary tract infection (UTI)
- ☐ uterine fibroids
- ☐ other kidney or bladder disorders
- ☐ other reproductive disorder or STD

e. Your breasts, such as: ☐ No to all

- ☐ abnormal mammogram or biopsy
- ☐ cysts
- ☐ lumps
- ☐ other physical changes

f. Your nervous system, such as: ☐ No to all

- ☐ ALS or other motor neuron disease
- ☐ Alzheimer's disease
- ☐ bacterial meningitis
- ☐ cerebral palsy
- ☐ cognitive impairment
- ☐ coma
- ☐ dementia
- ☐ developmental delay
- ☐ dizziness
- ☐ epilepsy
- ☐ other
- ☐ fainting or syncope
- ☐ loss of speech
- ☐ mental impairment
- ☐ migraine headaches
- ☐ multiple sclerosis
- ☐ paralysis
- ☐ Parkinson's disease
- ☐ post-concussion syndrome
- ☐ seizures or convulsions
- ☐ tremor
- ☐ vertigo

g. Your skin, such as: ☐ No to all

- ☐ basal cell carcinoma
- ☐ dermatitis
- ☐ dysplastic nevus syndrome
- ☐ dysplastic nevus
- ☐ nevus or nevi
- ☐ psoriasis
- ☐ lesions, freckles or moles
- ☐ other

h. Your eyes or ears, such as: ☐ No to all

- ☐ blindness
- ☐ blurred or double vision
- ☐ deafness
- ☐ glaucoma
- ☐ tinnitus
- ☐ impaired hearing
- ☐ impaired sight
- ☐ labyrinthitis
- ☐ optic neuritis
- ☐ other

i. Your mental health, such as: ☐ No to all

- ☐ anxiety
- ☐ attempted suicide
- ☐ burnout
- ☐ chronic fatigue
- ☐ depression
- ☐ schizophrenia
- ☐ eating disorder or other psychological, behavioral or emotional disorder

j. Your glands or blood, such as: ☐ No to all

- ☐ abnormal blood sugar
- ☐ Anemia or hemophilia
- ☐ bleeding tendency
- ☐ gout
- ☐ lymph glands
- ☐ thyroid disorders
- ☐ endocrine disorders
- ☐ other

k. Your muscles or bones, such as: ☐ No to all

- ☐ any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions
- ☐ rheumatoid arthritis or osteoarthritis
- ☐ lupus
- ☐ chronic pain syndrome
- ☐ fibromyalgia
- ☐ muscular dystrophy
- ☐ scleroderma
- ☐ other

l. Your immune system, such as: ☐ No to all

- ☐ AIDS or HIV
- ☐ other

2. In the past 5 years, have you had any:

   a. Medical tests such as ECG's, X-rays, CT scans, Pap, MRI, or blood tests? □ Yes | □ No

   b. Surgery, hospital care, treatment, medical examination, diagnostic test, or counselling are not already mentioned or have been recommended but have yet to take place? □ Yes | □ No

   c. used any recommended medication not already mentioned in this application on a daily basis for more than three weeks (including prescription and nonprescription)? □ Yes | □ No

   d. consulted a counsellor, health care worker, physician or therapist? □ Yes | □ No

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3. In the last year, have you missed more than 15 consecutive days of work or school because of illness or injury? □ Yes | □ No

4. Are you taking any prescribed medication or herbal treatment, or are you under observation for anything other than what you have disclosed? □ Yes | □ No

5. Are you currently unable to perform your regular occupation or activities? □ Yes | □ No

6. Are you aware of any symptoms for which you have not consulted a doctor? □ Yes | □ No

7. Do you wear any device that helps you monitor health or a specific condition? □ Yes | □ No

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Financial Services

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Additional Notes: _____

Armstrong Financial Services info@ArmstrongLife.com Tel. (833) 603-5500 / Fax. (514) 447-1804

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Authorization for Release of Health-Related Information

This Authorization complies with the HIPAA Privacy Rules

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize (Armstrong Financial Services, Armstrong Financial USA, IDC-WIN, ASG Life) (the "Representative"), and its affiliated agencies to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA-protected health information do not apply for purposes of this authorization, and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing the privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement or the evaluation or underwriting for the possible procurement of life, health, long-term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies at the bottom of this page and their re-insurers, the Representative, its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that another law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services or my eligibility for health care benefits; provided, however, that if a health care service (e.g., a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Armstrong Financial	Guardian Hooper	Nationwide	Sagicor / SBLI	Canada life
Accordia Life	John Hancock	New York Life	SSQ / Beneva	BMO Insurance
ASG Life	LIBRA Insurance	Pacific Life	Security Mutual	Manulife
American General	Lincoln Life & Annuity	Pan American Life	Symetra	Sun Life
ANICO / Banner Life	Lincoln Financial Group	Principal Life Insurance	Transamerica Life	Industrial Alliance
ExamOne / Dynacare	MassMutual	Principal National Life	Transamerica Financial	Empire Life
William Penn	Metropolitan Life	Protective Life	Equitable Life	RBC Life
Zurich American Life	Mutual of Omaha	Prudential Financial	Desjardins	_____

Agent/Witness: _____ Date: _____

Client Name: _____ Date: _____

Client Signature: _____ Sign Here