

Armstrong

— Financial Services —

Confidential Client Questionnaire

Applicant: _____

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

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: _____

3. Travel History

Do you plan to (or have you) travel outside of the US/Canada within 12 months? ☐ Yes | ☐ No

Destination	Date	Duration	Travel Reason	Notes
				<input type="checkbox"/> Non-Urban
				<input type="checkbox"/> Non-Urban
				<input type="checkbox"/> Non-Urban
				<input type="checkbox"/> Non-Urban

How many days do you spend travelling within the US on average each year? _____ days

Do you own a home or property in the US? ☐ Yes | ☐ No

Address: _____

Owner(s): _____ Owned Since: _____ Value: _____

4. Existing Insurance Coverage

Do you have any life insurance policies or pending life insurance policy applications? ☐ Yes | ☐ No

Carrier	Coverage	Year	Type	Notes
				<input type="checkbox"/> Rated <input type="checkbox"/> Replace <input type="checkbox"/> Pending
				<input type="checkbox"/> Rated <input type="checkbox"/> Replace <input type="checkbox"/> Pending
				<input type="checkbox"/> Rated <input type="checkbox"/> Replace <input type="checkbox"/> Pending
				<input type="checkbox"/> Rated <input type="checkbox"/> Replace <input type="checkbox"/> Pending

5. Personal Needs Analysis

What is your total active annual income? _____

What is your other passive annual income? _____

How many years of future income is anticipated? _____

What is your net worth (assets minus liabilities)? _____

Have you ever been charged with any criminal offences? ☐ Yes | ☐ No

In the past 5 years, have you been involved in a bankruptcy? ☐ Yes | ☐ No

Have you, or a relative, ever been involved in political activity? ☐ Yes | ☐ No

Will a third party obtain a legal interest in the applied-for policy? ☐ Yes | ☐ No

Details: _____

6. Corporate Information

Will a corporation or entity be the owner of your life insurance policy? ☐ Yes | ☐ No

Corporation Name: _____ Federal BN: _____

Your corporate title: _____ Are you a signing officer? ☐ Yes | ☐ No

Please specify the beneficial business owners and their respective ownership share:

Name: _____ / _____ % Name: _____ / _____ %

Name: _____ / _____ % Name: _____ / _____ %

	This Year	Last Year
Corporate book value (net worth):	_____	_____
Corporate fair market value:	_____	_____
Corporate gross annual revenue:	_____	_____
Corporate net (after-tax) annual revenue:	_____	_____

Do you authorize any third party (comptroller, assistant, accountant ...) to act as an intermediary for any information or document requests or any other inquiries we may have? ☐ Yes | ☐ No

Name: _____ Role: _____

Email: _____ Phone: _____

Additional Notes:

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal grey lines across its entire width, providing a guide for writing. The paper itself is a clean, off-white color. There are no margins, text, or other markings present on the page.

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

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

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

- | | |
|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> cystic fibrosis |
| <input type="checkbox"/> chronic bronchitis | <input type="checkbox"/> emphysema |
| <input type="checkbox"/> sarcoidosis or tuberculosis | <input type="checkbox"/> chronic obstructive pulmonary disease |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> other |

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

- | | |
|--|---|
| <input type="checkbox"/> celiac disease | <input type="checkbox"/> hepatitis (active or carrier state) |
| <input type="checkbox"/> cirrhosis | <input type="checkbox"/> hiatus hernia |
| <input type="checkbox"/> colitis | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> liver disease or pancreatitis |
| <input type="checkbox"/> gastrointestinal bleeding | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> gastrointestinal reflux | <input type="checkbox"/> other |

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

- | | |
|---|---|
| <input type="checkbox"/> abnormal Pap test | <input type="checkbox"/> protein in the urine |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> sugar or blood in the urine |
| <input type="checkbox"/> kidney stone | <input type="checkbox"/> urinary tract infection (UTI) |
| <input type="checkbox"/> nephritis | <input type="checkbox"/> uterine fibroids |
| <input type="checkbox"/> polycystic kidney disease | <input type="checkbox"/> other kidney or bladder disorders |
| <input type="checkbox"/> prostatitis or other prostate disorder | <input type="checkbox"/> other reproductive disorder or STD |

e. Your breasts, such as: ☐ No to all

- | | |
|---|---|
| <input type="checkbox"/> abnormal mammogram or biopsy | <input type="checkbox"/> lumps |
| <input type="checkbox"/> cysts | <input type="checkbox"/> other physical changes |

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

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

g. Your skin, such as: ☐ No to all

- | | |
|--|---|
| <input type="checkbox"/> basal cell carcinoma | <input type="checkbox"/> nevus or nevi |
| <input type="checkbox"/> dermatitis | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> dysplastic nevus syndrome | <input type="checkbox"/> lesions, freckles or moles |
| <input type="checkbox"/> dysplastic nevus | <input type="checkbox"/> other |

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

- | | |
|---|---|
| <input type="checkbox"/> blindness | <input type="checkbox"/> impaired hearing |
| <input type="checkbox"/> blurred or double vision | <input type="checkbox"/> impaired sight |
| <input type="checkbox"/> deafness | <input type="checkbox"/> labyrinthitis |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> optic neuritis |
| <input type="checkbox"/> tinnitus | <input type="checkbox"/> other |

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

- | | |
|--|---|
| <input type="checkbox"/> anxiety | <input type="checkbox"/> depression |
| <input type="checkbox"/> attempted suicide | <input type="checkbox"/> schizophrenia |
| <input type="checkbox"/> burnout | <input type="checkbox"/> eating disorder or other psychological, behavioral or emotional disorder |
| <input type="checkbox"/> chronic fatigue | |

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

- | | |
|---|--|
| <input type="checkbox"/> abnormal blood sugar | <input type="checkbox"/> lymph glands |
| <input type="checkbox"/> Anemia or hemophilia | <input type="checkbox"/> thyroid disorders |
| <input type="checkbox"/> bleeding tendency | <input type="checkbox"/> endocrine disorders |
| <input type="checkbox"/> gout | <input type="checkbox"/> other |

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

- | | |
|---|--|
| <input type="checkbox"/> any injury or disorder of the muscles, bones, joints or spine causing any physical limitations or restrictions | <input type="checkbox"/> chronic pain syndrome |
| <input type="checkbox"/> rheumatoid arthritis or osteoarthritis | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> lupus | <input type="checkbox"/> muscular dystrophy |
| | <input type="checkbox"/> scleroderma |
| | <input type="checkbox"/> other |

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

- | | |
|--------------------------------------|--------------------------------|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> 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
-

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

Question #: _____ Details: _____

Question #: _____ Details: _____

Question #: _____ Details: _____

Question #: _____ Details: _____

Question #: _____ Details: _____

Question #: _____ Details: _____

Advisor Disclosure & Privacy Statement

Licenses & Jurisdictions

I am licensed as a life and health insurance agent in Quebec & Ontario. I represent several insurers, but I place most of my business with BMO Insurance, Canada Life, Sun Life & Manulife. No insurer holds an ownership interest in my business. I don't hold a significant interest in any insurance company.

Compensation

I am compensated by a sales commission on policies I sell, and I may also receive a renewal (or service) commission on policies that remain active. Commissions are paid by the company that provides the product you purchased. If my sales reach a certain level, I may be eligible for additional compensation, such as a bonus, and other benefits, such as conferences.

Conflict of interest

I take the potential of a conflict of interest seriously. I confirm that I have no conflict of interest. If I become aware of a potential conflict, I will tell you. If you need information about my qualifications or business relationships, please contact me.

Client Authorization

I acknowledge that my independent financial security advisor will create and maintain a client file for me. This file will contain personal information related to me, which will be gathered to assess my financial situation, offer me products and services that may be of interest and benefit to me, and assist me with ongoing services, changes, and claims. This personal information may include records of meetings and phone calls, as well as instructions that I give regarding the products and services that I have purchased or wish to purchase or consider. I authorize and direct my advisor to hold additional personal information or documents (originals or copies) containing my personal information provided by me or with my authorization. Examples of personal information and documents are insurance policies, insurance applications in whole or in part, including medical and lifestyle information, wills, testaments, powers of attorney, marriage or birth certificates, income tax returns or notices of assessment, corporate financial statements, and mortgage and real estate ownership papers.

Privacy

This consent also allows for the sharing of information with any persons, financial institutions, businesses, or other parties with whom we deal. This may include service providers in jurisdictions outside of Canada and would, therefore, be subject to the laws of those jurisdictions. You may withdraw your consent at any time (subject to legal or contractual obligations and on providing us reasonable notice) by contacting our Privacy Officer. Please advise us if you do not agree to share your personal information, including financial and medical information, so we may provide you with financial services that best meet your needs. By signing below, you consent to collecting your personal information for your file.

You acknowledge that you have read and understood the information enclosed and agree to proceed.

Agent/Witness: _____ Date: _____

Client Name: _____ Date: _____

Client Signature: _____



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
Accordia Life
ASG Life
American General
ANICO / Banner Life
ExamOne / Dynacare
William Penn
Zurich American Life

Guardian Hooper
John Hancock
LIBRA Insurance
Lincoln Life & Annuity
Lincoln Financial Group
MassMutual
Metropolitan Life
Mutual of Omaha

Nationwide
New York Life
Pacific Life
Pan American Life
Principal Life Insurance
Principal National Life
Protective Life
Prudential Financial

Sagikor / SBLI
SSQ / Beneva
Security Mutual
Symetra
Transamerica Life
Transamerica Financial
Equitable Life
Desjardins

Canada life
BMO Insurance
Manulife
Sun Life
Industrial Alliance
Empire Life
RBC Life

Agent/Witness: _____ Date: _____

Client Name: _____ Date: _____

Client Signature: _____



Notice to the applicant and to the intermediary

This form must be sent together with the [Driving Record Search](#) (4941A).

Information entered on this form must not have been modified, crossed out or erased. Otherwise, the application may be refused.

[Consult the fees required for each record.](#)

To help us better process your application, please complete this form on-screen before printing.

INFORMATION ON APPLICANT

Company, organization or other (print) Dynacare Insurance Solutions			
Last name and first name of the person authorized to act on behalf of the applicant (print)			
Address (Street number, street name, apt.) 10945, boul. Louis-H.-Lafontaine, bureau 201			
Municipality/Province Montréal/Québec	Postal code H1J 2E8	Telephone	Ext.

INFORMATION ON INTERMEDIARY

Intermediary company or organization (print) Conseillers en systèmes d'information et en gestion CGI Inc.			
Last name and first name of authorized person (print) Responsable du Centre d'assistance technique			
Address (Street number, street name, apt.) 1350, Boul. René-Lévesque Ouest			
Municipality/Province Montréal/Québec	Postal code H3G 1T4	Telephone	Ext.

Note: The intermediary agrees to use this information only to transmit it to the applicant.

AUTHORIZATION OF DRIVER'S LICENCE HOLDER

Driver's licence number <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <small>Fill all 13 spaces</small>									
Last name and first name of driver's licence holder <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
Date of birth <table border="1" style="width: 100%;"> <tr> <td style="width: 33%;">Year</td> <td style="width: 33%;">Month</td> <td style="width: 33%;">Day</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>		Year	Month	Day				Telephone (home) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
Year	Month	Day							
		Telephone (work) <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right; font-size: small;">Ext.</div>							
<p>I, the undersigned, authorize the Société de l'assurance automobile du Québec to disclose to the applicant indicated above the content of my driving record, including, in particular, suspensions, revocations, demerit points, offences, as well as accidents in which I was involved while driving a heavy vehicle. This authorization is valid for twelve (12) months as of the date of signature.</p>									
Year-Month-Day <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>							
Date		Signature of licence holder							

Protection of Personal Information

All information gathered by authorized Société de l'assurance automobile du Québec personnel is handled confidentially. The Société requires this personal information to apply the *Automobile Insurance Act*, the *Act respecting the Société de l'assurance automobile du Québec* and the *Highway Safety Code*. Under the *Act respecting Access to documents held by public bodies and the Protection of personal information*, it may be conveyed to Government departments or agencies, or used for statistical, survey, study, audit or investigative purposes. Failure to provide information can result in a refusal of service on the Société's part. You may consult, correct or obtain a copy of any personal information concerning you.

For more information, consult the Policy on Privacy on the Société's Web site at saaq.gouv.qc.ca or contact the Société's call centre.

For information, call 418 528-3183 or 1 800 642-1865 (toll free)