iA Financial Group

# MEDICAL QUESTIONNAIRE Q5A

| Last name | First name | Date of birth (Y M D) | File number |
|---|---|---|---|
| Parab | Archana | 1987 03 04 | |

| Agent (name) | Code | S.U. | Agency (name) | Agency (code) |
|---|---|---|---|---|
| | | | | |

## Questionnaires

Completing the appropriate questionnaire(s) will allow us to make a decision more rapidly.

- 1 **High blood pressure** -->
- 2 **Gastrointestinal disorders** -->
- 3 **Concussion, convulsions, dizziness, epilepsy, loss of consciousness** -->
- 4 **Urinary trouble** -->
- 5 **Nervous disorders** -->
- 6 **Respiratory disorders** -->
- 7 **Musculoskeletal trouble (including neck and back pain)** -->
- 8 **Chest pain** -->
- 9 **Arthritis, rheumatism, gout** -->
- 13 **Children's height and weight** -->
- 10 **Sleep apnea** -->
- 11 **Diagnostic tests** -->
- 12 **Growths, cysts, lumps and tumors** -->
- 14 **Medical general questionnaire** -->

## 1 High blood pressure

a) Date of diagnosis: (Y M D) What were the figures? Systolic: _____ Diastolic: _____

b) Have you ever received treatment for high blood pressure? ☐ Yes ☐ No If yes, nature of treatment: _____

c) What medication were you prescribed? _____ Dosage: _____ Duration: _____

d) Do you still take it? ☐ Yes ☐ No When did you stop taking it? (Y M D)

Why? _____

e) What is your current blood pressure? _____ ☐ Unknown

f) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: (Y M D)

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 2 Gastrointestinal disorders

a) Indicate the symptoms: ☐ Black stool ☐ Blood or mucus in stool ☐ Constipation ☐ Diarrhea
☐ Troubles related to meals ☐ Vomiting blood ☐ Weight loss
☐ Other: _____

Date of first episode: (Y M D) Date of last episode: (Y M D) Frequency: _____

b) Diagnosis: ☐ Colitis ☐ Colon polyps (complete section d) ☐ Crohn's disease ☐ Duodenal ulcer ☐ Dyspepsia ☐ Gastric ulcer
☐ Ulcerative colitis ☐ Other: _____

c) Examinations: ☐ Barium enema ☐ Barium meal ☐ Gastroscopy ☐ Fecal occult blood test
☐ Examination of colon (colonoscopy) (complete section d) ☐ Other: _____

Date: (Y M D) Results: _____

d) Please provide details of all previous colonoscopies

Last Colonoscopy: Date Y M D Reason _____

Number of polyps removed _____ Pathology of polyps (if known) _____

Any polyps left? ☐ Yes ☐ No Next follow-up colonoscopy recommended Y M D

Previous Colonoscopy: Date Y M D Reason _____

Number of polyps removed _____ Pathology of polyps (if known) _____

Previous Colonoscopy: Date Y M D Reason _____

Number of polyps removed _____ Pathology of polyps (if known) _____

Date, number of polyps and pathology of any other previous colonoscopies in the past Y M D

_____

e) Hospitalization? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D Results: _____

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

Current medication? ☐ Yes. Indicate which one: _____

☐ No. Since when: Y M D

g) Complete recovery? ☐ Yes ☐ No If yes, indicate since when: Y M D

h) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

i) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 3 Concussion, convulsions, dizziness, epilepsy, loss of consciousness

a) Have you ever had: ☐ Concussion ☐ Convulsions ☐ Dizziness ☐ Epilepsy ☐ Loss of consciousness

Date of first episode: Y M D Date of last episode: Y M D Frequency: _____

b) Have you ever suffered from concussion? ☐ Yes ☐ No If yes, did you lose consciousness? ☐ Yes ☐ No

If yes, duration: _____ Post-concussion symptoms? ☐ Yes ☐ No

If yes, specify: _____ Still present? ☐ Yes ☐ No

c) Have you ever had convulsions? ☐ Yes ☐ No If yes, any sensation prior to episode? ☐ Yes ☐ No

☐ Complete loss of consciousness ☐ Loss of urine ☐ Tongue biting ☐ Twitching of the arms and legs

d) Do you or have you ever suffered from epilepsy? ☐ Yes ☐ No

If yes, kind of seizure: ☐ Grand mal ☐ Petit mal ☐ Absence seizures

Date of first seizure: Y M D Date of last seizure: Y M D Frequency: _____

e) Are you prone to fainting? ☐ Yes ☐ No If yes, date of last episode: Y M D Frequency: _____

Reason: _____

f) Examinations: ☐ Electroencephalogram ☐ CT Scan of brain ☐ Other: _____

Date: Y M D Results: _____

g) Hospitalization? ☐ Yes ☐ No If yes, indicate the date: Y M D

h) Medication prescribed (name): _____ Dosage: _____ Duration: _____

Do you take it regularly? ☐ Yes ☐ No If no, why did you stop? _____

Since when? Y M D

Has there been any change in the medication during the last year? If yes, provide details: _____

i) Complete recovery? ☐ Yes ☐ No If yes, indicate since when: Y M D

j) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

k) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 4 Urinary trouble

a) Indicate the type of symptoms: ☐ Any stone or gravel passed ☐ Blood in urine ☐ Difficulty urinating ☐ Fever ☐ Frequent urination ☐ Nausea, vomiting ☐ Pain when urinating ☐ Urinary tract infection

b) Date of first episode: Y M D Date of last episode: Y M D

Frequency: _____ Duration: _____

c) Examinations: ☐ Abdominal ultrasound ☐ CT Scan of abdomen ☐ Cystoscopy ☐ Pyelography ☐ Urinalysis ☐ Other: _____

d) Diagnosis: _____ Date: Y M D

e) Hospitalization? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

Do you still take it? ☐ Yes ☐ No

g) Complete recovery? ☐ Yes ☐ No If yes, indicate since when: Y M D

h) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

i) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 5 Nervous disorders

a) Please specify nature of problem or diagnosis as specified by attending physician:

☐ ADHD ☐ Adjustment/situational problems* ☐ Anxiety, nervousness ☐ Bipolar disorder ☐ Burnout

☐ Depression ☐ Fatigue ☐ Personality disorder ☐ Other: _____

*Specify circumstances (death, job loss, divorce/separation, other): _____

Suicidal thoughts? ☐ Yes ☐ No Date: Y M D

Suicide attempt? ☐ Yes ☐ No Date: Y M D

b) For **each problem/diagnosis,** please specify:

Number of episodes, dates of first and last episodes:

| Problem/diagnosis | Number of episodes | Date of first | Date of last |
|---|---|---|---|
| | | Y M D | Y M D |
| | | Y M D | Y M D |

Limitations: absence from work, absence from school, reduction in daily activities: ☐ Yes ☐ No

| Problem/diagnosis | Nature of limitation | Most recent start date | Most recent end date |
|---|---|---|---|
| | | Y M D | Y M D |
| | | Y M D | Y M D |

Name and address of the or dosage (family doctor and/or psychiatrist) consulted or name of hospital:

| Name and address of physician/hospital | Frequency of consultations with attending physician | If doctor: dates of first and last consultation<br>If hospitalization: date and length of stay |
|---|---|---|
| | | |
| | | |

Treatment and/or medication

| Medication | Dosage | Start date | End date |
|---|---|---|---|
| | | Y M D | Y M D |
| | | Y M D | Y M D |

| Psychotherapy | Frequency of consultations | Start date | End date |
|---|---|---|---|
| | | Y M D | Y M D |
| | | Y M D | Y M D |

c) Have there been changes in your prescribed medication or dosage over the past year? ☐ Yes ☐ No

If yes, please specify: _____

d) Are you still experiencing symptoms? ☐ Yes ☐ No If so, which symptoms? _____

e) Do you consider yourself completely cured? ☐ Yes ☐ No If so, since when? Y M D

## 6 Respiratory disorders

a) What is the nature of the problem or diagnosis as specified by attending physician?

☐ Allergies ☐ Asthma ☐ Bronchitis ☐ Chronic obstructive pulmonary disease (COPD) ☐ Emphysema

☐ Other: _____

b) Symptoms:

| | | | | | |
|---|---|---|---|---|---|
| Coughing up blood | ☐ Yes | ☐ No | Crackles | ☐ Yes | ☐ No |
| Nocturnal symptoms | ☐ Yes | ☐ No | Shortness of breath | ☐ Yes | ☐ No |
| Sputum | ☐ Yes | ☐ No | Wheezing | ☐ Yes | ☐ No |

Other: _____

c) What precipitates the symptoms?

☐ Allergies ☐ Cold air ☐ Emotions ☐ Environmental irritants (e.g. smoke, toxic odours) ☐ Exercise

☐ Respiratory tract infections ☐ Other: _____

d) Have you gone to the hospital emergency room in the past 12 months?

☐ Yes ☐ No Number of emergency room visits in the past 12 months: _____

Physician or hospital and address: _____

e) Have you been hospitalized in the past 12 months?

☐ Yes ☐ No If yes, specify date: Y M D Duration: _____

Hospital: _____

f) Date of last episode: Y M D Frequency of episodes: _____/day _____/week _____/month _____/year

g) Tests:

☐ Chest x-ray Date Y M D Result: _____

☐ Pulmonary function test (spirometry) Date Y M D Result: _____

☐ Other: _____ Date Y M D Result: _____

h) Prescribed medication:

| Name of current medication | Form | | Frequency |
|---|---|---|---|
| _____ | ☐ Inhaler | ☐ Tablets | _____/day _____/week _____/month _____/year |
| _____ | ☐ Inhaler | ☐ Tablets | _____/day _____/week _____/month _____/year |
| _____ | ☐ Inhaler | ☐ Tablets | _____/day _____/week _____/month _____/year |

Have you used oral steroids in the past year? ☐ Yes ☐ No

If yes, indicate name, dosage and duration: _____

i) Have you fully recovered? ☐ Yes ☐ No If yes, since when: Y M D

j) Disability or absence from work or school? ☐ Yes ☐ No

If yes, specify date: Y M D Duration: _____

Y M D Duration: _____

k) Reduction in daily activities? ☐ Yes ☐ No If yes, please explain: _____

l) Name and address of attending physician who is monitoring your condition and who prescribed the current medication:

_____

m) Date of last consultation: Y M D

n) Smoker: ☐ Yes ☐ No Amount and frequency: _____/day _____/week Other (specify): _____

## 7 Musculoskeletal trouble (including neck and back pain)

a) Probable cause: ☐ Accident ☐ Posture ☐ Sport ☐ Other: _____

b) Site of the pain or discomfort:

☐ BACK: ☐ Neck (cervical) ☐ Middle (thorax) ☐ Lower back (lombosacral) including sciatic nerve

☐ Knee ☐ Other joints: _____

Date of first episode: Y M D Date of last episode: Y M D

Number of times: _____ Duration of the longest episode: _____

c) Examinations: ☐ Arthroscopy ☐ Radiography ☐ Other: _____

d) Diagnosis: _____ Date: Y M D

e) Hospitalization? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

g) Other treatment: ☐ Massage therapy ☐ Physiotherapy ☐ Treatment by chiropractor ☐ Other: _____

Date of first treatment: Y M D Date of last treatment: Y M D

Number of consultations per year: _____

h) Since when have you been free of discomfort? _____

i) Complete recovery: ☐ Yes ☐ No If yes, since when: Y M D

j) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

k) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 8 Chest pain

a) Indicate the symptoms: ☐ Chest pain ☐ Palpitation ☐ Shortness of breath

☐ Other: _____

b) What triggers the symptoms? ☐ Excitement ☐ Exercise ☐ Exertion ☐ Meals ☐ Strain

☐ Other: _____

Date of first episode: Y M D Date of last episode: Y M D

Frequency: _____ Duration: _____

c) Examinations: ☐ Echocardiogram ☐ Magnetic resonance imaging (MRI) ☐ Resting electrocardiogram ☐ Stress electrocardiogram

☐ Thallium stress test ☐ Other: _____

Date: Y M D Results: _____

d) Diagnosis: _____ Date: Y M D

e) Hospitalization? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

g) Past or future follow-up examinations? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

h) Complete recovery? ☐ Yes ☐ No If yes, indicate since when: Y M D

i) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

j) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 9 Arthritis, rheumatism, gout

a) Nature of disorder: ☐ Arthritis ☐ Arthrosis ☐ Gout ☐ Rheumatism ☐ Other: _____

b) Site of the pain: ☐ Elbow ☐ Foot and ankle ☐ Hand and wrist ☐ Hip ☐ Knee ☐ Neck ☐ Shoulder ☐ Vertebral column ☐ Other: _____

c) Indicate the symptoms: ☐ Cracking of the joints ☐ Fever ☐ Nodules ☐ Pain during movement ☐ Redness of the joints ☐ Sore throat ☐ Stiffness of the joints upon awakening ☐ Swelling of the joints ☐ Other: _____

Date of first episode: Y M D Date of last episode: Y M D Frequency: _____

d) Treatments: ☐ Exercise ☐ Infiltration ☐ Physiotherapy ☐ Surgery ☐ Other: _____ Date: Y M D Frequency: _____

e) Hospitalization? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

Results: _____

Were there any heart complications? ☐ Yes ☐ No

If yes, details: _____ Date: Y M D

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

Current medication? ☐ Yes. Indicate which one: _____ ☐ No. Since when: Y M D

g) Complete recovery? ☐ Yes ☐ No If yes, since when: Y M D

h) Disability or absence from work or school? ☐ Yes ☐ No If yes, date: Y M D Duration: _____

i) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: Y M D

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

## 10 Sleep apnea

Date of diagnosis/consultation: Y M D

a) Degree of apnea according to attending physician: ☐ Light ☐ Moderate ☐ Severe ☐ None

b) Polysomnography: Date: Y M D Result: _____

c) Treatment and recommendation from attending physician:

☐ Change in sleeping position

☐ Surgery (specify type, date and result): _____

☐ Oral appliance (specify): _____

☐ CPAP – BiPAP Date started using: Y M D

Hours of use per night: _____ hours Frequency of use per week: _____/week

Still used? ☐ Yes ☐ No If no, why? _____

d) Since starting the treatment, do you still experience daytime sleepiness or disturbance of your daily activities? ☐ Yes ☐ No

Specify: _____

e) Have you ever had an industrial or motor vehicle accident? ☐ Yes ☐ No

Specify the circumstances: _____ Date: Y M D

f) Have you gone on disability leave or been off work for this condition? ☐ Yes ☐ No

Specify the beginning and end date for each episode:

Beginning: Y M D End: Y M D

Beginning: Y M D End: Y M D

Beginning: Y M D End: Y M D

Beginning: Y M D End: Y M D

g) Name and address of attending physician: _____

Frequency of consultations: _____ Date of last visit: Y M D

## 11 Diagnostic tests

a) Please indicate test(s) carried out or prescribed by your physician:

☑ Ultrasound, specify: ☐ Abdominal ☑ Breast ☐ Cardiac ☐ Pelvic ☐ Thyroid ☐ Other: _____

☐ Mammogram ☐ Magnetic Resonance Imaging (MRI), CT Scan; specify which body part(s): _____

☑ Other: Biopsy

| Type of test | Date of last test | Frequency within last 5 years | Reason, nature of problems or symptoms | Result and/or diagnosis | Last name, first name and address of physician who has the results on file |
|---|---|---|---|---|---|
| Ultrasound | Y 2016 M 02 D 26 | 0 | Pain in right breast | Fibroadenoma | Dr Lehman Jennifer, 100E 77th St New York NY 10075 USA |
| Biopsy | Y 2013 M 12 D 06 | 0 | Pain in right breast | Fibroadenoma | Dr Lehman Jennifer, 100E 77th St New York NY 10075 USA |
| | Y M D | | | | |

b) According to the diagnosis, specify treatment or prescribed medication:

| Diagnosis | Treatment / Medication | Dosage or length of treatment |
|---|---|---|
| Fibroadenoma | Lumpectomy | Outpatient Surgery |
| | | |
| | | |
| | | |

c) Were you referred to a specialist? ☑ Yes ☐ No

If so, specify the speciality: Lenox Hill Hospital

Date of consultation: Y 2014 M 01 D 01

Specialist's last name, first name and address:

Dr Lehman Jennifer, 100E 77th St New York NY 10075 USA

## 12 Growths, cysts, lumps and tumors questionnaire

a) When was the growth, cyst, lump or tumor first discovered (regardless of whether it was discovered by you or your doctor)?

Y 2013 M 11 D 01 Where was it located? Right breast

b) Did you have any symptoms that occurred around the same time or since the growth was discovered (pain in the immediate area, swelling, redness, change in size or color, weight loss, etc.)? ☑ Yes ☐ No

If yes, what were the symptoms? Pain in area

c) Has the growth been removed? ☑ Yes ➜ answer questions i) ☐ No ➜ answer questions ii)

Yes, questions i)

Date of removal Y 2014 M 02 D 05

Method of removal: ☐ Cryosurgery ☐ Fine needle aspiration ☐ Core needle ☐ Excisional biopsy

☑ Other Lumpectomy

Did you have treatment following removal? ☐ Medication ☐ Radiotherapy ☐ Chemotherapy

☐ Other

Have you been advised of any additional treatment you will need in the future or recommended follow-up consultation? ☐ Yes ☑ No

If yes, please provide details:

No, questions ii)

Details of investigations which have been carried out (ultrasound, etc.), include date(s) and result of tests

Y M D Exams Results

Any future treatment recommended?

d) Please state the precise diagnosis if known: ☑ Breast fibroadenoma ☐ Cyst ☐ Other

e) Do you have any associated diseases or complications related to the growth? ☐ Yes ☑ No

If yes, please provide details:

f) Have you ever had any past history of the same medical issue as mentioned above? ☐ Yes ☑ No

If yes, please provide dates, diagnosis of each occurrence and treatment:

Y M D Diagnosis: Treatment:

Y M D Diagnosis: Treatment:

Y M D Diagnosis: Treatment:

g) Disability or absence from work or school? ☐ Yes ☑ No

If yes, dates and duration

Y M D

Duration: _____

Y M D

Duration: _____

Y M D

Duration: _____

h) Please provide any other relevant details about your condition:

_____

_____

_____

i) Name of the physician who treated you or who is currently treating you:

Last name: Lehman First name: Jennifer Date of last consultation: Y 2016 M 02 D 26

Name of the clinic or hospital consulted most often: Lenox Hill Hospital

Address of the clinic or hospital:

Address: 100 E 77th St City: New York

Province: NY Postal code: 10075 Phone: 212-434-2000

## 13 Children's Height and Weight Questionnaire

Name of child: Rohan Ghag Date of birth: Y 2022 M 12 D 15

Child information:

Current: Height: _____ ft _____ in _____m 70 cm Weight: 19 lbs _____kg

One (1) year ago: Height: _____ ft _____ in _____m _____cm Weight: _____lbs _____kg

If three (3) years old or under: Has the child reached the normal milestones (sitting up, crawling, walking, talking, etc.) for his or her age?

☑ Yes ☐ No If no, explain: _____

If four (4) to 14 years old, is the child in the correct grade in school for his or her age? ☐ Yes ☐ No

If no, what grade is the child in? _____ Explain: _____

Is the child involved in sports? ☐ Yes ☐ No If yes, specify which sport(s): _____

## 14 Medical general questionnaire

a) Please provide the exact diagnosis of your condition: Breast Fibroadenoma

b) When was your diagnosis made? M 11 Y 2013

c) Have you had any treatments (including medication) for your condition?

☐ No ☑ Yes ➜ Please provide more information regarding the treatment(s) received (surgery, medication, dosage, duration, frequency, follow-up, etc.):

Out patient surgery (lumpectomy) on 2014-02-05

_____

d) Have you had any exams or tests for your condition?

☐ No ☑ Yes ➜ Please provide more information regarding the exams or the tests performed (type of exams, results, dates, follow-up, etc.):

First ultrasound in Nov 2013. Biopsy on right breast in Dec 2013. Follow up ultrasounds after lumpectomy until 2016-02. No further issues were diagnosed after original diagnoses and no followups were recommended.

_____

_____

e) Have you been off work or disabled because of this condition?

☑ No ☐ Yes ➜ Please indicate the beginning and end dates of your disability period:

Start: M M Y Y End: M M Y Y

Start: M M Y Y End: M M Y Y

Start: M M Y Y End: M M Y Y

f) Have you been hospitalized because of this condition?

☑ No ☐ Yes ➜ Please provide the dates and duration of your hospitalizations:

Date: M M Y Y Duration: _____

Date: M M Y Y Duration: _____

Date: M M Y Y Duration: _____

g) Are you fully recovered from this condition?

☑ Yes ➜ Please indicate since what date you have been fully recovered: M M Y Y 0 2 2 0 1 4

☐ No ➜ Please provide more details about your condition: _____

h) Please provide any other relevant details about your condition:

-

i) Name of the physician who treated you or who is currently treating you:

Last name: Lehman First name: Jennifer Date of last consultation: Y Y M M D D 2016 02 26

Name of the clinic or hospital consulted most often: Lenox Hill Hospital

Address of the clinic or hospital:

Address: 100 E 77th St City: New York

Province: NY Postal code: 10075 Phone: 212-434-2000

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a) Please provide the exact diagnosis of your condition: Breast Fibroadenoma

b) When was your diagnosis made? M M Y Y 11 2013

c) Have you had any treatments (including medication) for your condition?

☐ No ☑ Yes ➜ Please provide more information regarding the treatment(s) received (surgery, medication, dosage, duration, frequency, follow-up, etc.):

Out patient surgery (lumpectomy) on 2014-02-05

d) Have you had any exams or tests for your condition?

☐ No ☑ Yes ➜ Please provide more information regarding the exams or the tests performed (type of exams, results, dates, follow-up, etc.):

First ultrasound in Nov 2013. Biopsy on right breast in Dec 2013. Follow up ultrasounds after lumpectomy until 2016-02. No further issues were diagnosed after original diagnoses and no followups were recommended.

e) Have you been off work or disabled because of this condition?

☑ No ☐ Yes ➜ Please indicate the beginning and end dates of your disability period:

Start: M M Y Y End: M M Y Y

Start: M M Y Y End: M M Y Y

Start: M M Y Y End: M M Y Y

f) Have you been hospitalized because of this condition?

☑ No ☐ Yes ➜ Please provide the dates and duration of your hospitalizations:

Date: M Y Duration: _____

Date: M Y Duration: _____

Date: M Y Duration: _____

g) Are you fully recovered from this condition?

☑ Yes ➜ Please indicate since what date you have been fully recovered: M Y

☐ No ➜ Please provide more details about your condition: _____

h) Please provide any other relevant details about your condition:

-

i) Name of the physician who treated you or who is currently treating you:

Last name: Lehman First name: Jennifer Date of last consultation: Y M D 2016 02 26

Name of the clinic or hospital consulted most often: Lenox Hill Hospital

Address of the clinic or hospital:

Address: 100 E 77th St City: New York

Province: NY Postal code: 10075 Phone: 212-434-2000

## SIGNATURE

I hereby declare that the answers and statements provided herein form an integral part of my application to Industrial Alliance Insurance and Financial Services Inc., that they are full, complete and true, and that no circumstances have been concealed that might affect the risk of insurance for which I have applied.

Signed at _____ on _____ _____

Signature of the proposed insured

## AUTHORIZATIONS

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, MIB LLC, financial institutions, personal information agents or professional investigation agencies and any public holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance Insurance and Financial Services Inc. and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

**A photocopy of this authorization shall be as valid as the original.**

Signed at _____ this _____ day of _____ 20 _____

**X** _____ Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over)

**X** _____ Witness

**X** _____ Legal guardian or parent (if insured is not authorized to sign)

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, MIB LLC, financial institutions, personal information agents or professional investigation agencies and any public holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance Insurance and Financial Services Inc. and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

**A photocopy of this authorization shall be as valid as the original.**

Signed at _____ this _____ day of _____ 20 _____

**X** _____ Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over)

**X** _____ Witness

**X** _____ Legal guardian or parent (if insured is not authorized to sign)

**The consent forms below must be completed and signed by proposed insureds that reside or have resided in Alberta only.**

iA Financial Group ia.ca **INSURED 1**

### Consent to Disclosure of Individually Identifying Health Information (Authorized by Section 34 of the *Health Information Act*)

Please print in ink

I, _____ , authorize (the attached) individually identifying

☐ diagnostic, treatment and care information ☐ registration information ☐ health services provider information

concerning myself to be disclosed by _____ (name of custodian), in accordance with section 34 the *Health Information Act* (the "Act"), to Industrial Alliance Insurance and Financial Services Inc., for the following purpose(s):

_____

_____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting or refusing to consent to the disclosure of my individually identifying information. I understand that I may revoke this consent at any time.

Dated this _____ (day) of _____ (month), _____ (year) Expiry date (if any) _____ (day) of _____ (month), _____ (year)

Client or authorized representative's signature

**X** _____

Client or authorized representative's name

Source of representative's authority (if applicable) (E.g., executor, guardian, etc.) (Refer to section 104(1) of the Act.)

_____

Witness' signature

**X** _____

Witness' name

_____

HEAD OFFICE: Industrial Alliance Insurance and Financial Services Inc., 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3

iA Financial Group ia.ca **INSURED 2**

### Consent to Disclosure of Individually Identifying Health Information (Authorized by Section 34 of the *Health Information Act*)

Please print in ink

I, _____ , authorize (the attached) individually identifying

☐ diagnostic, treatment and care information ☐ registration information ☐ health services provider information

concerning myself to be disclosed by _____ (name of custodian), in accordance with section 34 the *Health Information Act* (the "Act"), to Industrial Alliance Insurance and Financial Services Inc., for the following purpose(s):

_____

_____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting or refusing to consent to the disclosure of my individually identifying information. I understand that I may revoke this consent at any time.

Dated this _____ (day) of _____ (month), _____ (year) Expiry date (if any) _____ (day) of _____ (month), _____ (year)

Client or authorized representative's signature

**X** _____

Client or authorized representative's name

Source of representative's authority (if applicable) (E.g., executor, guardian, etc.) (Refer to section 104(1) of the Act.)

_____

Witness' signature

**X** _____

Witness' name

_____

HEAD OFFICE: Industrial Alliance Insurance and Financial Services Inc., 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3