QUESTIONNAIRE CRITICAL ILLNESS
CHILDREN 0 TO 17

General Information	
First name	Name
Date of birth Y Y Y Y M M D D	Application number

	Yes	No
1. Does the child already have a critical illness insurance in force or have any other application pending? If yes, details: _____	☐	☐
2. Are you aware of any symptoms, signs or discomfort for which the child has not yet consulted a physician or received treatment? If yes, details: _____	☐	☐
3. Have any members of your family, including father, mother, brother or sister, had any of the following illnesses: heart disease, transient ischemic attack (TIA), cerebrovascular accident (CVA), primary pulmonary hypertension, cancer (provide type), diabetes, kidney disease, mental or neurological illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, multiple sclerosis, Alzheimer's disease, muscular dystrophy, Parkinson's disease, or any other hereditary disorder? If yes, complete the section below:	☐	☐

Family member	Illness	Age at onset	Age if living	Age at death	Cause of death

	Yes	No
4. Has the child ever consulted a physician or been diagnosed for one of the following illnesses: heart disease, transient ischemic attack (TIA), cerebrovascular accident (CVA), primary pulmonary hypertension, cancer (provide type), diabetes, kidney disease, mental or neurological illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, multiple sclerosis, muscular dystrophy, autism, cerebral palsy, trisomy 21, cystic fibrosis, blindness, deafness or any other hereditary disease or a mental or physical handicap? If yes, complete the section below:	☐	☐

Child	Illness	Age at unset	Age if living

I declare that the above statements and answers are complete and true and shall form part of the application for critical illness insurance with SSQ, Life Insurance Company Inc. I understand that the conditions insured under the critical illness insurance applied for are limited to only those conditions as defined in the policy.

Signature of the witness	Signature of the insured
Name of the witness	Date Y Y Y Y M M D D