La Capitale

INSURED DECLARATION
Long term care

- This form must be competed by the insured, a close relative or legal representative, if applicable, and by the policyholder if different to the insured.
- The Insurer reserves the right to require any additional information it deems necessary.
- The Insurer assumes no liability for any expenses incurred in providing the proof required for claims.

Identification of the insured

Name: ______________________________ Gender: F ☐ M ☐

Address of Insured ______________________________ Date of Birth: ________-__________-__________ (Year Month Day)

______________________________ Postal Code

Contract No.:

____

Tel. : (______)______________________________ Home Tel.: (______)______________________________ Work

Identification of close relative or legal representative (if applicable)

Name: ______________________________ Relation to the insured: ______________________

Address: ____

Tel.: (______)______________________________ Home Tel.: (______)______________________________ Work

1. Are you currently living at the above address? Yes ☐ No ☐
   If yes, who do you live with? ☐ Alone ☐ Spouse ☐ Family member ☐ Other
   If not, specify where you live: ☐ Care facility ☐ Hospital ☐ Home of a family member ☐ Other

2. Are you represented by a tutor of a person of full age? Yes ☐ No ☐
   If yes, please enclose a copy of the incapacity mandate.
   Name: ______________________________ Relation to the insured: ______________________
   Address:
   ____
   Tel.: (______)______________________________ Home Tel.: (______)______________________________ Work

3. Since your state of dependency began, have you travelled outside Canada and the U.S.? Yes ☐ No ☐
   If yes, specify period: From ________-______-______ (Year Month Day) to ________-______-______ (Year Month Day)

4. What is the primary diagnosis entitling the insured to receive benefits?
   ____
   ____

4.1 If applicable, please specify the other diagnoses contributing to the insured's state of dependency.
   ____
   ____

4.2 Please describe the insured's state of dependency.
   ____
   ____

5. Physicians consulted for the state of dependency

Name	Address	Telephone No.	Date Year / Month / Day

5.1 Has the insured been hospitalized, or stayed in another establishment, during the last 90 days? Yes ☐ No ☐

Last Name	Address	From Year / Month / Day	To Year / Month / Day

5.2 If the insured's stay was not in a hospital or hospital centre, please specify reasons:

____

____

5.3 List of carers currently providing you with assistance for Activities of Daily Living (include health care professionals, friends and family members).

Name	Health care professional?	Address	Telephone No.	Date	Description of assistance provided
	Yes ☐ No ☐				
	Yes ☐ No ☐				
	Yes ☐ No ☐				

6. Check the Activities of Daily Living that the insured is usually incapable of carrying out without the assistance of another person, in accordance with the definitions provided in the contract.

☐ **Bathing, since this date:** ____________________
The ability to wash oneself in a bath or shower, including the entering into and exiting from the bath or shower; or by sponge bath.

☐ **Dressing, since this date:** ____________________
The ability to put on or take off, and button and unbutton, all requisite clothing, including the putting on of orthopaedic braces, artificial limbs or other surgical accessories.

☐ **Transferring, since this date:** ____________________
The ability to move towards a bed, to get into and out of bed and the ability to sit on a chair or a wheelchair and to get up from it with or without the assistance of auxiliary equipment.

☐ **Toileting, since this date:** ____________________
The ability to go to the bathroom and return after having taken care of all one's personal hygienic needs.

☐ **Continence, since this date:** ____________________
The ability to control bowel and bladder functions voluntarily, with or without surgical appliances or protection from incontinence, in such a way that an acceptable degree of hygiene is maintained.

☐ **Feeding, since this date:** ____________________
The ability to eat by oneself the foods and beverages prepared and served by other persons.

I, the undersigned, hereby certify that the answers to the above questions are true and complete to the best of my knowledge. I understand that these answers shall be considered as valid as if they had been provided under oath.

Signed at ______________________ on this ________ day of ______________________ 20 ______.

____
Signature of witness

____
Signature of insured or legal representative

____
Signature of policyholder