La Capitale

☐ TOTAL LOSS OF AUTONOMY ☐ LONG-TERM CARE

Insured's statement

Insured's last name

Insured's first name

Date of birth: Year Month Day

Sex: ☐ F ☐ M

Contract No.

Client No.

Address (No., street, apartment, city, province)

Postal code

Area code Telephone

When disclosing medical and health information, the results of any genetic test should not be included.

1 Is the insured represented by a legal guardian to a person of full age? ☐ Yes ☐ No – **If so:**

Guardian's last name

Guardian's first name

Relationship to the insured

Address (No., street, apartment, city, province)

Postal code

Area code Home telephone

Area code Work telephone

2 Does the insured reside at the above-mentioned address? ☐ Yes ☐ No

If so, with whom does the insured reside?

- ☐ Alone
- ☐ Spouse
- ☐ Family member
- ☐ Other: ______________________

If not, where does he or she reside?

- ☐ In a residential care institution
- ☐ In a hospital
- ☐ At the residence of a family member
- ☐ Other: ______________________

3 Has the insured travelled outside of Canada and the United States since the onset of dependency? ☐ Yes ☐ No

If so, from Year Month Day to Year Month Day

4 Has the insured undergone a psychosocial or functional assessment by a healthcare professional at a CLSC? ☐ Yes ☐ No

If so, name and address of the CLSC:

5 Name and address of the insured's family physician:

Name of physician

Address (No., street, city, province)

Postal code

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

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6 Names and addresses of all physicians and other healthcare professionals consulted:

Name	Address	Date of consultation
		Year / Month / Day
		Year / Month / Day
		Year / Month / Day

7 Names and addresses of hospitals or institutions the insured visited or to which the insured was admitted:

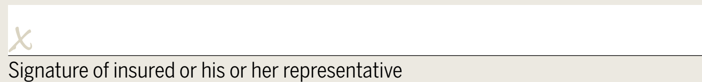
Name (hospital or institution)	Address	Length of hospitalization:
		From Year / Month / Day to Year / Month / Day
		From Year / Month / Day to Year / Month / Day
		From Year / Month / Day to Year / Month / Day

8 State the reasons why the insured has not stayed in a hospital or other institution: __________

9 Additional information: __________

I acknowledge and agree that the answers in this form are true and complete.

Signed at __________ on this ____ day of __________ 20 ____ .



Signature of insured or his or her representative

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