



Name of Life Insured _____ Policy No. _____
(Print) First Name Last name

1. Please describe your symptoms: _____

2. Was blood ever vomited? Yes No If so, when? _____

3. Have you passed bloody or tarry stools? _____

4. Were blood transfusions required? Yes No If so, how many? _____ When? _____

5. Have you ever had hepatitis? Yes No What type? _____ A, B or C _____ When? _____
 Are you know to be a hepatitis carrier? Yes No

6. Have you lost weight? Yes No If so, how much? _____ When? _____

7. Are your symptoms related to certain foods or diets? Yes No Explain: _____

8. Do your symptoms occur regularly before, during or after eating? _____
 Please elaborate: _____

9. When did you first experience symptoms, and how often since? _____

10. Are your symptoms becoming more frequent or more severe? _____
 Give date of last attack: _____

11. Who is your attending physician? _____
 When was attending physician last consulted? _____

12. Were any specialist physicians consulted? Yes No If "Yes", give names and dates: _____

13. Were any special test performed, including X-rays, ultrasound or colonoscopy? Yes No
 If "Yes", what was the diagnosis? _____

14. Were you advised to take medication? Yes No If "Yes", describe type and amount: _____

15. Are you still taking treatment? _____

16. Have you had surgery for the complaint? Yes No Is surgery likely? Yes No If so, when? _____

17. If surgery was performed, were there any complications or further symptoms? _____

(If necessary, use the reverse side of sheet for additional remarks.)
 The above answer form part of an application to Desjardins Financial Security Life Assurance Company for new or changed insurance on my life and are, to the best of my knowledge and belief, true and complete.

Dated at _____ this _____ day of _____

Signature of Life Insured Signature of Witness

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| Name of Field Office | Field Office No. | Name of Representative | Rep. Code | Date Sent To H.O. |
|----------------------|------------------|------------------------|-----------|-------------------|