

QUESTIONNAIRE REGARDING TOBACCO USAGE

IDENTIFICATION

Person to be insured

Last name	First name	Application or contract number
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INFORMATION

1. During the last twelve months, did you use tobacco in the following forms:	cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quantity per day
	cigars	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quantity per day
	the pipe	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quantity per day
	any other form of tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quantity per day
2. a) During your lifetime, did you use tobacco in the following forms on a regular basis:	cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	cigars	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	the pipe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	any other form of tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, what was your daily consumption?		
b) On what date did you stop to use tobacco in the following forms:	cigarettes		
	cigars		
	the pipe		
	any other form of tobacco		
c) Did you stop smoking due to health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, reason	
d) Did your doctor advise you to quit smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, reason	
		Name and address of the doctor	

DECLARATION

Canassurance Hospital Service Association and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada agrees to issue an insurance at the current rate for non-smokers providing the insured has not smoked during the twelve months preceding the date of this statement and his/her health condition has not changed since the effective date of his/her insurance.

I certify to having read the above warning and that this statement is complete and true.

 Signature of the person to be insured Witness Date (DD-MM-YYYY)