QUÉBEC BLUE CROSS®

Questionnaire

Aviation

IDENTIFICATION

Last name:	First name:
Contract Nº:	Date of birth: M M D D Y Y Y Y

INFORMATION

1. What type of licence do you hold?
   ☐ Student ☐ Private ☐ Commercial ☐ Airline ☐ IFR (Instrument Flight Rating)

2. How many hours have you flown?
   a) As a student? ________________________________
   b) As a pilot? ___________________________________
   c) In the last twelve (12) months? __________________
   d) In the next twelve months? ______________________
   e) Date of the last flight? _________________________

3. What the type of aircraft do you pilot? ____

4. Specify the purpose of flying: ☐ Professional ☐ Recreational

5. a) Have you ever had a flying accident? ☐ Yes ☐ No
   b) If yes, please provide details: ____

6. Have you ever been grounded or fined for a violation? ☐ Yes ☐ No
   b) If yes, please provide details: ____

7. a) Do you anticipate any flying outside of North America? ☐ Yes ☐ No
   b) If yes, please specify where and when: ____

8. a) Are you planning any change in your flying activities? ☐ Yes ☐ No
   b) If yes, please provide details: ____

9. If an additional premium or exclusion rider must be added due to the risk related to aviation, which of the following two options would you prefer?
   ☐ Extra premium ☐ Exclusion rider

10. Please provide any information relevant to the evaluation of the risk. ____

DECLARATION

I hereby declare that the above information is complete, accurate and current. I agree that this information will be used as the basis of the assessment carried out in order to establish my eligibility for Canassurance Hospital Service Association and/or Canassurance Insurance Company coverage. I also understand that, once my application has been assessed and approved, the information contained in this form will be an integral part of the insurance policy that will be issued. Any false statements in this form will lead to legal measures, including policy cancellation.

_________________________________ M M D D Y Y Y Y
Signature of the Insured Date

_________________________________ M M D D Y Y Y Y
Signature of policy holder (if different from Insured) Date

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