

Scuba Diving

Questionnaire

IDENTIFICATION

Last name:	First name:
Contract N°:	Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

INFORMATION

- How long have you been diving? _____
- a) Are you a certified diver? Yes No
 b) By which organization? PADI Naui SSI Other: _____
 c) Date of certification?
- Is diving required by your profession? Yes No
- Number of dives per year: _____
 Usual depth: _____ Maximum depth: _____
 Usual duration of dives: _____ Maximum duration of dives: _____
- Do you usually dive alone? Yes No With a partner? Yes No
- Where do you usually dive? Lakes and river Deep sea Ocean beaches Caverns Caves
- a) Have you ever had an accident? Yes No
 b) If yes, please provide details: _____
- a) Do you own your own equipment? Yes No
 b) Is your equipment regularly serviced? Yes No
 b) If yes, please provide details: _____
- What is the purpose of dives? Recreational Professional
- Date of the last dive?
- Do you intend to practice this sport in the future? Yes No
- 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.

_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature of the Insured	Date
_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature of policy holder (if different from Insured)	Date