The Maritime Life Assurance Company

EVIDENCE OF INSURABILITY

Maritime Life

SECTION 1 - TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Mayne Logistics Loomis **961581**

PLAN SPONSOR - Name | Policy # / Divison / Class **OR** Control # | Division Name (if appropriate)

PLAN ADMINISTRATOR - Name | Phone No. | Fax # | E-mail address

Plan Sponsor Address | City | Province | Postal Code

PLAN MEMBER - Name | ID or SIN # | Annual Salary | Hire Date (dd/mm/yy) | Occupation

Coverage being applied for:

	Current Coverage	New Amount Applied For
☐ **Employee life Insurance**		
☐ **Spousal Life Insurance**		
☐ **Long Term Disability Insurance**		
☐ **Other**		

Is Plan Member actively at work? ☐ **Yes** ☐ **No**

Plan Administrator Signature **Date**

SECTION 2 - TO BE COMPLETED BY THE PLAN MEMBER

PLAN MEMBER – Last Name | First Name and Initial | Height (ft/in or m/cms) | Weight (lbs/kgs) ☐ Male ☐ Female

Home Address | City | Province | Postal Code

Date of Birth (dd/mm/yy) | Place of Birth | Home Phone | Business Phone

SMOKING STATUS DECLARATION
Have you used any form of tobacco or cannabis within the last twelve months?
☐ Yes ☐ No

Regular Physician Name | Physician Address | Date/Reason for last consultation

SECTION 3 - DEPENDENT INFORMATION (IF APPLYING FOR SPOUSAL / DEPENDENT COVERAGE)

SPOUSE – Last Name | First Name and Initial | Height (ft/in or m/cms) | Weight (lbs/kgs) ☐ Male ☐ Female

Home Address | City | Province | Postal Code

Date of Birth (dd/mm/yy) | Place of Birth | Home Phone | Business Phone

SMOKING STATUS DECLARATION
Have you used any form of tobacco or cannabis within the last twelve months?
☐ Yes ☐ No

CHILD – Last Name | First Name and Initial | Date of Birth (dd/mm/yy) | Height (ft/in or m/cms) | Weight (lbs/kgs) ☐ Male ☐ Female

CHILD – Last Name | First Name and Initial | Date of Birth (dd/mm/yy) | Height (ft/in or m/cms) | Weight(lbs/kgs) ☐ Male ☐ Female

Spouse/Dependent Regular Physician Name | Physician Address | Date/Reason for last consultation

If you have more than two children, please attach separate sheet (signed and dated) and include all personal information as requested above.

PLEASE COMPLETE THE BACK OF THIS FORM AND ENSURE IT IS SIGNED AND DATED

SECTION 4 - TO BE COMPLETED BY THE PLAN MEMBER

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers or have ADDITIONAL CHILDREN to report on, please attach a separate sheet (signed & dated) to avoid unnecessary delays in processing this application.	Member/ Employee		Spouse		Child 1		Child 2	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you had any indication of or been treated for:								
a) any disease or disorder of the eyes, ears, nose, mouth or throat, or any allergies including any job-site environmental sensitivity?	☐	☐	☐	☐	☐	☐	☐	☐
b) lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or other respiratory disorder?	☐	☐	☐	☐	☐	☐	☐	☐
c) dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, chronic anxiety, burnout, fatigue, depression, or eating disorder?	☐	☐	☐	☐	☐	☐	☐	☐
d) chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐	☐	☐	☐	☐	☐	☐
e) hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver, or gall bladder?	☐	☐	☐	☐	☐	☐	☐	☐
f) sugar, albumin, protein, blood and/or pus in the urine, sexually transmitted disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐	☐	☐	☐	☐	☐	☐
g) any hereditary disorders or diabetes, thyroid or other endocrine disorders?	☐	☐	☐	☐	☐	☐	☐	☐
h) gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	☐	☐	☐	☐	☐	☐	☐	☐
i) disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	☐	☐	☐	☐	☐	☐	☐	☐
j) anemia, or other disorder of the blood or have you ever received a blood transfusion or blood products?	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you ever used or dealt in barbiturates, narcotics, or other drugs or hallucinogens, including marijuana and cocaine, except as prescribed by a physician or received or been advised to receive or or currently receiving treatment or counselling for the use of alcohol or drugs?	☐	☐	☐	☐	☐	☐	☐	☐
3. Have you had any driving infractions within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐
4. Have you ever tested positive for, been diagnosed with, or told you have Acquired Immune Deficiency Syndrone (AIDS), or Human Immunodeficiency Virus (HIV) disease?	☐	☐	☐	☐	☐	☐	☐	☐
5. Do you participate in organized contact sports or hazardous activities (e.g. mountain climbing, hang-gliding, scuba-diving, parachuting, flying (pilot/crew member) motorized racing)?	☐	☐	☐	☐	☐	☐	☐	☐
6. Do you contemplate a trip or taking up residence outside Canada or the USA? (Specify location and duration)	☐	☐	☐	☐	☐	☐	☐	☐
7. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	☐	☐	☐	☐	☐	☐	☐	☐
8. Are you currently unable to work, whether inside or outside the home? How many work days have you lost due to disability/illness in the last two years? _____	☐	☐	☐	☐	☐	☐	☐	☐
9. Other than above, have you within the last five years:								
a) been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐	☐	☐	☐	☐	☐	☐
b) received medical or surgical attention due to illness or injury?	☐	☐	☐	☐	☐	☐	☐	☐
c) been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐	☐	☐	☐	☐	☐	☐
d) had an electrocardiogram, x-ray or other diagnostic tests with abnormal findings or indicating any health problems?	☐	☐	☐	☐	☐	☐	☐	☐
e) sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care etc.?	☐	☐	☐	☐	☐	☐	☐	☐
f) requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐	☐	☐	☐	☐	☐	☐
10. Are you currently pregnant? If so, due date: _____	☐	☐	☐	☐	☐	☐	☐	☐

SECTION 5 - FOR EVERY 'YES' ANSWER GIVEN IN SECTION 4 ABOVE, PLEASE PROVIDE FULL DETAIL, IF NOT ALREADY INDICATED

Question #	Person to whom it applies	Nature of disorder	Date of first occurrence	Current status and treatment

SECTION 6 - DECLARATION AND AUTHORIZATION

I declare that the information in this application is true and complete to the best of my knowledge, and, along with any other forms signed by me for this application, forms the basis for any insurance issued. In the event that I have provided my social insurance number ("SIN"), then, upon approval of this application, I authorize the use of my SIN for the purposes of identification, tax reporting, and the administration of my group benefits.

I authorize my employer or plan sponsor and Maritime Life, its affiliates, subsidiaries, their authorized employees or service providers including, but not limited to, the Medical Information Bureau, reinsurers, any health care professionals or health or social service establishments, or other organization, institution or person who has knowledge of me, or my health, or my minor children or their health, to collect, use, exchange, or share with or disclose to each other my personal information or the personal information of my minor children, solely for the purpose of underwriting, issuing, administering, and managing my group benefit plan in the course of daily operations. I hereby authorize Maritime Life, in its discretion, to share any of my health information or the health information of my minor children, with my physician or the physician for my minor children, whichever the case may be.

I understand that Maritime Life, its affiliates, subsidiaries, their employees and service providers are subject to strict standards and policies to ensure that my personal information is secure and remains confidential. I understand that Maritime Life does not sell, lease, or trade personal information, and that any personal information collected by Maritime Life will be kept strictly confidential and is to be used by authorized individuals only. Authorized individuals include employees, agents, or representatives of Maritime Life in the performance of their job, persons whom I have authorized, or persons permitted by law to use my personal information. I understand that I have the right to request and receive a copy of my personal information maintained by Maritime Life at any time. However, I also acknowledge that where medical information has been provided to Maritime Life through a third party, Maritime Life will release that information to me only through my physician.

A reproduction of this consent is as valid as the original.

_____ (dd/mm/yy)
Plan Member's Signature

Declaration by Spouse and Dependent (over age 16): I declare that I have read the above Declaration and Authorization, and adopt all of the terms thereof.

_____ (dd/mm/yy)
Signature of Spouse (if applying)

_____ (dd/mm/yy)
Signature of Dependent over 16 (if applying)