MEDAVIE BLUE CROSS™

STATEMENT OF HEALTH

PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-800-667-4511 FAX: 506-869-9654 E-MAIL: groupmedicalunderwriting@medavie.bluecross.ca

1. Employee Name: _____ Occupation: _____

   Applicant Name: _____ Place of Birth: _____ Date of Birth: _____ (DD MM YY)

   Address: _____

   E-mail Address: _____

   Daytime Contact No: _____ Policy No. _____ ID No: _____

2. Name and address of usual personal physician or medical clinic: If none, please state so: _____

3. Have any of your parents, brothers or sisters, before attaining age 60, ever had cancer, heart or kidney disease, mental or nervous disorder, or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease)? ☐ Yes ☐ No If yes, provide the following details:

Family member (mother, father, brother, sister)	Age at onset of condition	Name of condition (type of cancer, heart or kidney disease, etc.)

4. **a)** What is your height? _____ ft _____ in _____ cm **c)** Have you lost more than 4.5 kg or 10 lbs in the past year? ☐ Yes ☐ No

   b) What is your weight? _____ lbs _____ kg If "Yes", state amount and reason: _____

	Yes	No	Remarks
5. Have you ever consulted a physician, been treated for, or had any known indication of diabetes, asthma or bronchitis, ulcer, colitis or Crohn's, arthritis, nervous or mental disorder, back or neck disorder?	☐	☐	**If "yes" to any disorder(s) in question 5, please circle applicable condition, refer to the back of this form and complete the applicable section(s).**
6. Have you ever consulted a physician, been treated for, or had any known indication of chest pain, heart or circulatory disorder, high blood pressure, blood disorder, thyroid disorder, cancer, tumours, neurological disorder, convulsions, epilepsy, lung or breathing disorder, sleep apnea, bowel, stomach or gastrointestinal disorder, liver disorder, kidney disorder, prostate or urinary disorder, bone, muscle or joint disorder, sight or hearing disorder?	☐	☐	**Circle condition and provide details. (Date, Duration, Treatment and Current Status)**
7. Have you used any nicotine or used any smoking cessation products in any form (including e-cigarettes) in the past 12 months?	☐	☐	**Details**
8. Are you currently taking any prescription medication? If yes, please indicate the name of medication, reason for taking, strength and dosage.	☐	☐	**Reason, Name, Strength and Dosage**
9. Have you ever used narcotics, stimulants, hallucinogens or others drugs except as prescribed by a physician or received treatment for drug addiction?	☐	☐	**Dates and Details**
10. Have you ever been advised to reduce your consumption of alcohol or received treatment for alcohol addiction (including Alcoholics Anonymous)?	☐	☐	**Dates and Details**
11. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐	**Date, Reason, Duration and Current Status**
12. Have you ever been tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), or HIV (Human Immunodeficiency Virus) or any other immunological disorder?	☐	☐	**Dates and Details**
13. Do you currently have a referral, testing, treatment or investigation pending or contemplated, but not yet completed, or are you aware of any symptoms or problems that require medical attention?	☐	☐	**Dates and Details**
14. Within the past 5 years, have you had a medical condition or abnormal test results **not already mentioned** on this form?	☐	☐	**Dates and Details**

I, the undersigned, declare the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada® ("Blue Cross Life") and/or Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me, and to manage the Company's business. I hereby authorize any physician, pharmacy, health practitioner, hospital, clinic or other medical or medically related facility, insurance company, government or regulatory authority, MIB, Inc. ("MIB", formerly Medical Information Bureau) or other organization, institute or person that has any records or knowledge of me or my health to give Blue Cross Life, Medavie Blue Cross or its reinsurers any such information. I further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my personal physician or other medical practitioner. I also authorize Blue Cross Life and Medavie Blue Cross to make a brief report of my personal health information to MIB. This consent is valid for as long as the contract is in force, unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and I'm aware of the risks and benefits of consenting or refusing to consent. I have received and read the attached notice form describing the procedures of the MIB. I may contact Medavie Blue Cross at 1-800-667-4511 with any questions related to the collection, use or disclosure of my personal information.

This consent complies with federal and provincial privacy laws. A photocopy of this authorization shall be as valid as the original.

Applicant Name _____ Policy No. _____

Please complete applicable section if you answered "Yes" to Question #5

1. DIABETES

a) Date of onset of diabetes: _____
b) Type of diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational
c) Type of treatment: ☐ Insulin ☐ Oral medication ☐ Diet
d) Any history of diabetic comas or insulin reactions? ☐ Yes ☐ No
If "Yes" give details.

e) Do you follow a diabetic diet? ☐ Yes ☐ No
f) Have you ever had any of the following: ☐ Yes ☐ No
☐ Eye trouble ☐ Protein or Albumin in the urine
☐ Numbness or a tingling sensation in the limbs.
Give full details including name and address of doctor(s) consulted for these conditions.

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2. ASTHMA OR BRONCHITIS

a) Type: ☐ Asthma ☐ Bronchitis
b) Severity: ☐ Mild ☐ Moderate ☐ Severe
c) Date of diagnosis or onset of symptoms: _____
d) Frequency of symptoms or episodes: _____
e) Date of last episode: _____
f) Type of treatment and how often required: _____
g) Date(s) of any hospitalization or ER visits: _____

h) How often do you experience night-time symptoms?

_____

i) Have you ever hade any pulmonary functions tests, referral to a specialist or use of oral steroids (ie. Prednisone)? Circle and provide details.

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3. ULCER, COLITIS OR CROHN'S

a) Type: 1. Ulcer ☐ Duodenal ☐ Gastric
2. Colitis ☐ Ulcerative ☐ Mucus ☐ Spastic
3. Crohn's ☐
b) Frequency of attacks or episodes: _____
c) Date of last attack or episode: _____
d) Any hemorrhage (bleeding)? _____

e) Type of surgery (if required)? _____
f) Type of treatment: _____
g) Any loss of time from work? ☐ Yes ☐ No
If "Yes" give date and duration

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4. ARTHRITIS

a) Type: ☐ Rheumatoid ☐ Osteoarthritis ☐ Gout ☐ Rheumatism
b) Date of onset: _____
c) Frequency of symptoms or episodes: _____
d) Type of treatment: _____

e) Any loss of time from work? ☐ Yes ☐ No
If "Yes" give dates and duration

_____

f) What joints are affected and present condition regarding pain, deformity, limitations of movement:

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5. NERVOUS OR MENTAL DISORDER

a) Type of symptoms: ☐ Weight Loss ☐ Depression ☐ Insomnia
☐ Suicidal thoughts ☐ Fatigue ☐ Nervousness ☐ Anxiety ☐ Phobia
b) What was the cause? _____

_____
c) Date of onset: _____
d) Date of last symptoms or episode: _____

e) Type and duration of treatment: _____
f) Date last treated: _____
g) Any hospitalization required? ☐ Yes ☐ No
h) Date and duration of any time off work: _____
i) Name and address of physician(s) consulted: _____

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6. BACK OR NECK DISORDER

a) What area of the back was involved: ☐ Neck ☐ Middle (Thoracic)
☐ Low (Lumbo Sacral)
b) What was the cause? _____

_____
c) Date of first symptoms or episode: _____
d) Date of last symptoms or episode: _____
e) Frequency of symptoms or episodes: _____
f) Type of treatment: _____
g) Frequency of treatments: _____

i) Any loss of time from work: ☐ Yes ☐ No
If "Yes" give date and duration _____

j) Have you had any X-rays or other investigation of your back?
If "Yes" give date, results and name of physician

_____

k) Any surgery performed or anticipated? If "Yes" give date and results

_____

l) What is your present condition regarding pain, limitation of movement and activity?