MEDAVIE BLUE CROSS™

100-1981 MCGILL COLLEGE AVE MONTREAL
QC H3A 3A7

EVIDENCE OF HEALTH - GROUP INSURANCE

NOTICE: ANY INCOMPLETE REQUEST OR UNANSWERED QUESTION WILL DELAY THE STUDY OF YOUR FILE

SECTION A

Contract No.: _____ Section No.: _____ ID No.: _____

SECTION B - EMPLOYEE INFORMATION

First Name: _____ Last Name: _____

Place of Birth: _____ Occupation: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home: _____ Office: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Gender: ○ M ○ F

What is your height? _____ ft _____ in _____ cm

Weight?_____ lbs _____ kg

Have you lost more than 4.5 kg or 10 lbs in the past year? ○ Yes ○ No

If "Yes", state amount and reason: _____

SECTION C - PLEASE COMPLETE IF THE INSURANCE REQUESTED IS FOR DEPENDENTS

First Name: _____ Last Name: _____

Place of Birth: _____ Occupation: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Gender: ○ M ○ F

What is your height? _____ ft _____ in _____ cm

Weight?_____ lbs _____ kg

Have you lost more than 4.5 kg or 10 lbs in the past year? ○ Yes ○ No

If "Yes", state amount and reason: _____

CHILD / CHILDREN:

Name	Given Name	Sex M	Sex F	Date of Birth Day	Date of Birth Month	Date of Birth Year	Age	Height (ft. in./cm)	Weight (lb./kilo)
		○	○						
		○	○						
		○	○						

SECTION D - FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION E.

In your lifetime, have you been treated for, or shown symptoms of any of the following diseases?	Employee Yes	Employee No	Dependent(s) Yes	Dependent(s) No
1. **Cardiovascular system:** Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or any impairment of the heart or blood vessels.	○	○	○	○
2. **Respiratory system:** Asthma, sleep apnea, chronic bronchitis, spitting of blood, tuberculosis, emphysema or any impairment of the respiratory system.	○	○	○	○
3. **Digestive system:** Colitis, Crohn's disorder, ulcer, bleeding from stomach or bowel, or other impairment of the stomach, gallbladder, liver (hepatitis, cirrhosis), or the intestines.	○	○	○	○
4. **Genito-urinary system:** Sugar, albumin, blood or pus in the urine, or any impairment of the kidneys, bladder, prostate or reproductive organs.	○	○	○	○
5. **Endocrine system:** Diabetes, impairment of the thyroid or any other impairment of endocrine system.	○	○	○	○
6. **Musculo-skeletal system:** Rheumatism, arthritis, gout, muscle or bone disease including spinal cord, back, neck disorder, and joints.	○	○	○	○
7. **Nervous system:** Convulsions, epilepsy, migraine, paralysis, degenerative disease, depression or other mental or nervous disorder.	○	○	○	○
8. **Immunological system:** Have you ever had or been told that you had one of the following ailments, or have you undergone tests or received medical counsel for any of these:				
a) AIDS (Acquired Immune Deficiency Syndrome), or any other immunological disorder?	○	○	○	○
b) Hypertrophy of lymph nodes (glands), chronic diarrhea, persistent lesions, infections of unknown origins?	○	○	○	○
9. **General:** Drug abuse, anemia or other blood disease, cyst, tumor, cancer, or other physical or mental disorder not mentioned previously.	○	○	○	○
10. Have you ever been advised to reduce your consumption of alcohol or ever received treatment for alcohol or drug addiction (including Alcoholics Anonymous)	○	○	○	○

SECTION E - DETAILS OF "YES" ANSWERS

Question Number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in outpatient clinic or in a doctor's office.

FORM-560E 11/17

PERSONAL INFORMATION REPORT AND EXCHANGE NOTICE

DETACH AND GIVE TO THE EMPLOYEE

SECTION F - FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE IN SECTION G.

Within the past 5 years, have you:	Employee		Dependent(s)	
	Yes	No	Yes	No
1. Consulted or been examined or treated by a physician or other practitioner?	○	○	○	○
2. Been a patient in a hospital, clinic, sanatorium or other medical facility?	○	○	○	○
3. Undergone an electrocardiogram?	○	○	○	○
4. Undergone a chest x-ray?	○	○	○	○
5. Undergone laboratory tests or other tests for diagnostic purposes?	○	○	○	○
6. Requested or received a pension for disability or injury?	○	○	○	○
7. Been advised to submit to an examination, hospitalization or operation that has not yet taken place?	○	○	○	○

SECTION G - DETAILS OF "YES" ANSWERS OF SECTION F

Question Number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in outpatient clinic or in a doctor's office.

SECTION H - AT PRESENT

1. Are you under medical treatment? Employee: ○ Yes ○ No Dependent(s): ○ Yes ○ No
2. Name and address of physician who has your medical records. _____
3. Are you taking any medications? Employee: ○ Yes ○ No Dependent(s): ○ Yes ○ No
4. If yes, name of medication, strength, daily dosage and how long you have been using them. _____

SECTION I

1. Do you or did you ever use nicotine in any form, cigars, pipe, alcoholic beverages, narcotics or other drugs? ○ Yes ○ No

If yes, indicate the quantity per week	Cigarettes		Cigars		Pipe		Alcoholic beverages		Narcotics or other drugs	
	Now	In the past	Now	In the past	Now	In the past	Now	In the past	Now	In the past
Employee										
Dependents										

2. If it is the case, give the date on which you stopped smoking: _____

SECTION J - FAMILY HISTORY

Have any of your parents, brothers or sisters, before attaining age 60, ever had colon or breast 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.)	If you have been investigated for this condition, indicate date and results (if no investigation done, state "none")

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.

Signature of Applicant _____ Signature of Spouse (if spouse is applying) _____

Date _____

PLEASE DETACH AND RETAIN

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada® or their reinsurer, may, however, make a brief report thereon to MIB, Inc. ("MIB", formerly Medical Information Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability or health coverage, or a claim for benefits is submitted to such company, MIB will, on request, supply such company with the information it may have in its files. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's files, you may contact MIB and seek a correction. Information for consumers about MIB may be obtained on its wesite at www.mib.com.

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Blue Cross Life Insurance Company of Canada or its reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.