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# STATEMENT OF HEALTH - GROUP INSURANCE

**NOTICE: ANY UNANSWERED OR INCOMPLETE QUESTIONS WILL DELAY YOUR APPLICATION**

## SECTION A

Policy No.: _____ Section No.: _____ ID No.: _____

## SECTION B - EMPLOYEE INFORMATION

First Name: _____ Last Name: _____

Place of Birth (City/Country): _____ Occupation: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Daytime Phone Number: _____ Email: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____

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: _____
(Ex: Diet, exercise, illness)

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

**SPOUSE:**

First Name: _____ Last Name: _____

Place of Birth (City/Country): _____ Occupation: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____

What is their height? _____ ft _____ in _____ cm
Weight? _____ lbs _____ kg

Have they lost more than 4.5 kg or 10 lbs in the past year? ○ Yes ○ No
If "Yes", state amount and reason: _____
(Ex: Diet, exercise, illness)

**CHILD / CHILDREN:**

| First Name | Last Name | Date of Birth Day | Month | Year | Age | Height feet | inches | cm | Weight lbs | kg |
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## 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 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:<br>a) HIV (Human Immunodeficiency Virus) or any other immunological disorder?<br>b) Hypertrophy of lymph nodes (glands), chronic diarrhea, persistent lesions, infections of unknown origins? | ○<br>○ | ○<br>○ | ○<br>○ | ○<br>○ |
| 9. **General:** Anemia or other blood disease, cyst, tumor, cancer, or other physical or mental disorder, sight or hearing disorder, not mentioned previously. | ○ | ○ | ○ | ○ |
| 10. Within the past 5 years, have you had a medical condition or abnormal test results not already mentioned on this form? | ○ | ○ | ○ | ○ |
| 11. Have you ever been advised to reduce your consumption of alcohol, received treatment for alcohol addiction (including Alcoholics Anonymous), consumed 5 or more alcoholic drinks per day on average, or have any other history of alcohol dependency, alcohol abuse, or frequent binge drinking? | ○ | ○ | ○ | ○ |
| 12. Have you ever used narcotics, stimulants, hallucinogens or other recreational drugs (including cannabis) except as prescribed by a physician, received treatment for drug addiction, or have any history of drug dependency or abuse? | ○ | ○ | ○ | ○ |
| 13. In the past 12 months, have you used any nicotine or smoking cessation products of any kind (including e-cigarettes)? | ○ | ○ | ○ | ○ |
| 14. 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? | ○ | ○ | ○ | ○ |

**STOP! BEFORE CONTINUING PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS ABOVE!**

## SECTION E - DETAILS OF "YES" ANSWERS OF SECTION D

| 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. |
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## SECTION F - IF YOU ARE CURRENTLY PRESCRIBED MEDICATION, PLEASE COMPLETE THE SECTION BELOW

| Name of person | Name of medication and reason *ex: "ventolin, for asthma" or "anaprox, backpain"* | Strength, quantity and frequency *ex: "50mg, twice daily" or "10mg, as needed"* | Date treatment started, or approximate duration if unknown? *ex: "June 2015" or "about 5 years"* | Is treatment effective? **Yes** | **No** |
|---|---|---|---|---|---|
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |

## SECTION G - NICOTINE AND DRUG CONSUMPTION

In the past 12 months, have you or your spouse used any nicotine, narcotics or other drugs? ○ Yes ○ No
If yes, please specify weekly consumption below. If you have stopped using these products in the last 12 months, indicate usage before you stopped.

| | Employee, Spouse or both? | *ex: "7 packs per week"* |
|---|---|---|
| Cigarettes | ○ E ○ S ○ B | |
| Cigars | ○ E ○ S ○ B | |
| Narcotics or other drugs | ○ E ○ S ○ B | |

## SECTION H - FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION I.

| **Within the past 5 years, have you:** | **Employee** Yes | **Employee** No | **Dependent(s)** Yes | **Dependent(s)** No |
|---|---|---|---|---|
| 1. Consulted or been examined or treated by a physician or other practitioner, aside from regular check-ups? | ○ | ○ | ○ | ○ |
| 2. Been a patient in a hospital, clinic, sanatorium or other medical facility? | ○ | ○ | ○ | ○ |
| 3. Undergone an electrocardiogram, chest x-ray, laboratory tests or other tests for diagnostic purposes? | ○ | ○ | ○ | ○ |
| 4. Requested or received a pension for disability or injury? | ○ | ○ | ○ | ○ |

## SECTION I - DETAILS OF "YES" ANSWERS OF SECTION H

| 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. |
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## SECTION J - CURRENT MEDICAL RECORDS

If "Yes" for dependent(s), indicate their name(s)
1. Are you under medical treatment? Employee: ○ Yes ○ No Dependent(s): ○ Yes ○ No Name: _____

2. Please give the name and address of physician who has your medical records.

**PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS ABOVE BEFORE CONTINUING!**

## SECTION K - FAMILY HISTORY

For the employee or spouse, 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) | Related to employee or spouse? | 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") |
|---|---|---|---|---|
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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)

Signature of Child (if over 18 years)

Date

**Blue Cross Life Insurance Company of Canada underwrites all life and disability benefits.*

**Before submitting this form, please ensure you have answered all questions and signed and dated it.**
**FAILURE TO DO SO WILL DELAY YOUR APPLICATION**

**Please note that we may follow up with you to collect more details if required.**

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.