



Declaration of Insurability

(Please Print in Ink Only)

COMPANY NAME: _____

APPLICANT: _____ BIRTHDATE: ____/____/____
(Last Name) (First Name) MM DD YY

Home Address: _____

Occupation: _____ Monthly Earnings \$ _____ Daytime Phone # () _____

S.I.N. # ____/____/____ SEX ____ F ____ M Height _____
Weight _____

Any weight lost or gained in the last 12 months? Yes ____ No ____ and whether Lost ____ or Gained ____

If "Yes" by how much? _____ (Kgs. or Lbs.) and Why? _____

SECTION I:

1. Within the past twelve months have you consulted a physician or any medical practitioner, been treated for, taken medication for, or had any known indication of any of the following conditions or disorder of (please state "Yes" or "No" beside each of the following):

- | | |
|--|---|
| Chest pain or discomfort, high cholesterol or blood pressure _____ | Neuritis, nervous system disorder _____ |
| Circulatory problems _____ | Fainting or dizziness, paralysis _____ |
| Disorder of the stomach or intestines _____ | Diabetes _____ |
| Ulcer, indigestion, gall bladder _____ | Hepatitis _____ |
| Lungs, respiratory system, asthma, shortness of breath _____ | Sleep Apnea _____ |
| Bronchitis, tuberculosis _____ | Bladder, urinary tract _____ |
| Back, neck, knees, hips, muscles, bones, joints _____ | Prostate, breast or reproductive system _____ |
| Fibromyalgia or chronic fatigue _____ | Allergies _____ |
| Mental or Emotional Disorder _____ | Arthritis, rheumatism _____ |

Disorder of the eyes (excluding near or far sightedness), ears (excluding infection that has resolved) or skin (excluding minor rash or irritation)? Yes ____ No ____

Been advised that a medical test was abnormal or follow-up is required? Yes ____ No ____

2. Do you have any symptoms or complaints for which you have not yet sought treatment? Yes ____ No ____

3. Within the past three years have you had any disease or disorder which has limited or interfered with your ability to perform your daily activities for more than 5 consecutive days? Yes ____ No ____

4. Within the past 5 years have you:

a) been confined in a hospital or other institution, been off work, received disability or worker's compensation benefits for more than 5 days or disability pension due to an accident or illness? Yes ____ No ____

b) had an application for insurance declined, postponed, rated or modified in any way? Yes ____ No ____

5. Have you ever consulted a physician or any medical practitioner, been treated for or any known indication of:

a) heart or circulatory problems including heart attack, stroke, cancer or tumour, epilepsy, multiple sclerosis, disorder of the liver, intestines, kidney, blood or immune system? Yes ____ No ____

b) drug or alcohol abuse, used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, taken drugs for other than medicinal purposes, been advised to drink less alcohol, received treatment for drug addiction or alcoholism, or been charged with driving while impaired? Yes ____ No ____

c) AIDS, ARC, HIV, enlargement of lymph nodes (glands), chronic diarrhea, unusual skin lesions, or unexplained infections or other immunological disorder? Yes ____ No ____

6. List all medications requiring a prescription, that you or your dependents take (exclude birth control pills):

Name of your medication(s)? _____ Approximate Monthly Cost \$ _____

Any other medication(s)? _____ Approximate Monthly Cost \$ _____

Dependent's Name? _____ Medications? _____ Approximate Cost \$ _____

Dependent's Name? _____ Medications? _____ Approximate Cost \$ _____

Do you or your dependents receive physiotherapy, chiropractic or massage therapy treatments? Yes ____ No ____

Patient's name _____ Nature of treatment _____ Approximate Monthly Cost \$ _____

Patient's name _____ Nature of treatment _____ Approximate Monthly Cost \$ _____

Patient's name _____ Nature of treatment _____ Approximate Monthly Cost \$ _____

(Please see over and continue)



Declaration of Insurability (continued)

SECTION II:

1. Do you have any other physical impairment or deformity or health problems or symptoms of illness or disease not listed in Section I? Yes _____ No _____
2. Within the past 5 years, have you been hospitalized or under medical observation or had medical, or surgical treatment or currently receiving medical treatment other than stated in Section I? Yes _____ No _____
3. Name of address of your personal physician or any medical practitioner(s) or chiropractor consulted in the past 5 years:
 - a) _____
 - b) _____
 - c) _____
4. Date and reason for last consultation(s) for each of the above:
 - a) _____
 - b) _____
 - c) _____
5. Provide details of any medication or treatment prescribed, or advice recommended:

6. Provide details of all yes answers to any questions in Section I or Section II:

Question Number	Nature of Disorder	Date of Onset / Recovery	Medication and/or Treatment	Approximate Monthly Cost	Attending Physician or Hospital (name & address)
		/		\$	
		/		\$	
		/		\$	
		/		\$	

SECTION III – Declaration and Authorization to obtain Medical Information

I hereby declare that the above answers and statements are complete and true and that any misstatements or failure to report information may be used as the basis for rescission of this insurance, as issued to me. I understand that if the insurance applied for becomes effective, I will be subject to all the terms of the group policy. I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance would have become effective, I am actively engaged in my occupation on a full-time basis (full time is defined as 24 hours per week or more). I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company. I understand the information provided on this document will be treated as confidential and is gathered for the purpose of underwriting the insurance applied for.

I further understand that additional information including medical testing, may be required as part of the underwriting process and that this information, including medical test results, will not be shared with my employer.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health to give Canadian Group Benefit Insurance Programs or its reinsurer(s) any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease, ailment or condition. A photocopy of this authorization shall be as valid as the original.

Dated at (City, Prov.) _____ this _____ day of _____, 20_____

(Applicant's Signature) (Signature of Witness)