



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

SECTION A												
Contract No.: Section	n No.:				ID No	o.:						
SECTION B												
Name:				Given	Name:							
Place of Birth:				Occup	ation:							
Address:												
City: F	rovince:			Postal	Code:							
Telephone: Home:				Office:								
Social Insurance Number:				Date o	of Birth (DD/MM/	YYY):						
Height (ft. in./cm): Present Weight ([lb./kilo):		;	Sex:	□ M □ F	:	A	\ge:				
SECTION C - PLEASE COMPLETE IF THE INSUI	RANCE	REQ	UESTED	IS FO	OR DEPEND	ENTS						
SPOUSE:												
Name:				Given	Name:							
Place of Birth:				Occup	ation:							
Date of Birth (DD/MM/YYYY):			:	Sex:	□ M □ F	:						
Height (ft. in./cm): Prese	nt Weight	(lb./kile	o):				Age:					
CHILD / CHILDREN:												
Name Given Name	Se		D	ate of		Age	Heigh		We	ight		
	M	F	Day	Mont	h Year		(ft. in./cn	1)	(lb./	/kilo)	-	
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SECTION D - FOR EACH OF THE FOLLOWING DETAILS IN SECTION E.	QUEST	IONS	S ANSWE	EKED	"YES", IDEI	VIII-Y II	IE PERSC	ON AND	GIVE			
In your lifetime, have you been treated for, or shown	sympton	s of	the follow	wina d	iseases?			Subso		Depend		
Cardiovascular system: Chest pain, palpitations, high						heart		Yes	No 🗆	Yes	No D	
murmur, heart seizure or any impairment of the heart									_	_	_	
Respiratory system: Asthma, chronic bronchitis, spit impairment of the respiratory system.	ling of bic	00a, tl	uberculosi	s, emp	inysema or an	У						
3. Digestive system: Colitis, ulcer, bleeding from stoma	ch or bow	el, or	other imp	oairmer	nt of the stoma	ach, gallbl	adder,				_	
//	ıs in the ι	ırine,	or any imp	nairma	liver (hepatitis, cirrhosis), or the intestines.							
4. Genito-urinary system: Sugar, albumine, blood or pus in the urine, or any impairment of the kidneys, bladder, prostate or reproductive organs.											_ 	
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5. Endocrine system: Diabetes, impairment of the thyro	•			ent of e	ndocrine syste	em.	and joints.				_	
 Endocrine system: Diabetes, impairment of the thyro Musculo-skeletal system: Rheumatism, arthritis, gou Nervous system: Convulsions, epilepsy, cephalea, pa 	ut, muscle	or bo	one diseas	ent of e se inclu	ndocrine syste	em. ord, back a			<u> </u>			
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AUTHORIZATIONPLEASE DO NOT DETACH

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FORM-560(E) 10/10

PERSONAL INFORMATION REPORT AND EXCHANGE NOTICE

DETACH AND GIVE TO THE SUBSCRIBER

SE	CTION F - FOR EACH	OF THE F	OLLOWIN	G QUESTION	IS ANSW	/ERED "	YES", IDEN	TIFY THE	PERSON	I AND	GIVE		
	DETAILS IN		N G.							Subse	criber	Depend	ent(s)
	hin the past 5 years, have Consulted or been examine				-+i+iO				_	Yes	No	Yes	No
2.	Been a patient in a hospital Undergone an electrocardio	, clinic, sana	, , ,										
4.	Undergone a chest x-ray?	-	As for all and	-ti									0
6.	Undergone laboratory tests Requested or received a pe	ension for di	sability or inju	ıry?									
	Been advised to submit to a					as not yet	taken place?						
	lestion Name of persor			n, examinations		е [Duration of	Name ar	nd address	of doc	tors and	l hospitals	_
Νι	umber	tr	eatments, dr	ugs, results			illness		if hospitaliz tient clinic				וווי
													-
L													Ш
SE	CTION H - AT PRESEN	Т											
1.	Are you under medical trea	ıtment? Sı	ubscriber: 🗖	Yes □ No	Depend	lent(s): 🗆	ıYes □ No)					
2.	Name and address of phys	ician who ha	as your medi	cal records.									
3.	Are you taking any drugs?	Subscribe	r: □ Yes □	No Depe	endent(s):	☐ Yes							
	If yes, name of medication,			·	, ,								
	CTION I												
1.	Do you or did you ever use If yes, indicate the	cigarettes, ciga		alcoholic bever Cigars									
	i			Ciuais	I .		Pipe	Alcoholic	beverages	Na	rcotics o	or otner ari	ugs
	quantity per week	Now	In the past		the past	Now	In the past	Alcoholic	beverages In the pas	_	Now	In the p	
	Subscriber						'			_			
2.	Subscriber Dependents	Now	In the past	Now In			'			_			
	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
	Subscriber Dependents	Now te on which	In the past	Now In			'			_			
	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
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	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
	Subscriber Dependents If it is the case, give the date	Now te on which	In the past	Now In			'			_			
SE	Subscriber Dependents If it is the case, give the date CTION J - ADDITIONAL	Now te on which	you stopped	Now In	the past	Now	In the past	Now	In the pas	st .	Now	In the p	
SE I, the	Subscriber Dependents If it is the case, give the date of the case of the cas	Now te on which REMARK	you stopped S above questinsurance Cor	Now In smoking:	the past	Now he reverse	In the past	Now re complete vie Blue Cros	In the pas	te and	form par	In the p	ast
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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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