MEDAVIE BLUE CROSS™

STATEMENT OF HEALTH

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MONTREAL QC H3A 6T6
TEL: 514-286-8454 FAX:514-286-8444

1. Employee Name: _____ Occupation: _____

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

   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. **a)** Family History:

	Age if Living	State of Health	Age at Death	Cause of Death
Father				
Mother				

b) Have any of your parents, brothers or sisters, before attaining age 60, ever had heart or kidney disease, mental or nervous disorder, colon or breast cancer or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease)? ❑ Yes ❑ No If "Yes", give details:

_____

_____

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

Weight? _____ lbs _____ kg If "Yes", state amount and reason: _____

	Yes	No	Remarks
4. 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 4, please circle applicable condition, refer to the back of this form and complete the applicable section(s).**
5. 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)**
6. Have you used any nicotine or used any smoking cessation products in any form in the past 12 months?	❑	❑	**Details**
7. Are you currently taking any prescription medication? If yes, please indicate the reason, name, strength and dosage.	❑	❑	**Reason, Name, Strength and Dosage**
8. Have you ever: a) used narcotics, hallucinogens or similar drugs except as prescribed by a physician, or	❑	❑	**Dates and Details**
b) been advised to reduce your consumption of alcohol or ever received treatment for drug or alcohol addiction (including Alcoholics Anonymous)?	❑	❑	
9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	❑	❑	**Date, Reason, Duration and Current Status**
10. 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**
11. 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**
12. 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 questions on 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 and to manage the Company's business. I authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, MIB, Inc. formally known as 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 their reinsurer 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. 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 am 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 MIB. I can contact Medavie Blue Cross should I have questions as 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.

Date _____ Signature of Applicant _____

FORM-019(E) 05/12

PLEASE DETACH AND RETAIN

MIB PRE-NOTICE

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, 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 or health coverage, or a claim for benefits is submitted to such company, MIB, on request, will 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 information in MIB's files, you may contact MIB and seek a correction. The address of MIB's information office is:

MIB, Inc.
330 University Avenue
Toronto, Ontario M5G 1R7

Telephone: 416-597-0590
Website: www.mib.com

Blue Cross Life Insurance Company of Canada or their 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.

Please complete applicable section if you answered "Yes" to Question #4

1. DIABETES

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

d) Do you follow a diabetic diet? ❑ Yes ❑ No
e) Have you ever had any of the following: ❑ Yes ❑ No
❑ Eye trouble ❑ 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.

2. ASTHMA OR BRONCHITIS

a) Type: ❑ Asthma ❑ Bronchitis
b) Severity: ❑ Mild ❑ Moderate ❑ Severe
c) Date of onset of this condition: _____
d) Frequency of symptoms or episodes (ie. weekly, monthly) : _____
e) Date of any hospitalization or emergency room visits: _____

f) Have you required the use of oral steroids (ie. Prednisone)?
❑ Yes ❑ No If "Yes", dates and duration:
g) Have you ever been referred to a specialist or have you ever had a pulmonary function test? ❑ Yes ❑ No If "Yes", dates and details

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

4. ARTHRITIS

a) Type: ❑ Rheumatoid ❑ Osteoarthritis ❑ Gout ❑ Rheumatism
b) Date of onset: _____
c) Frequency of attacks 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:

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 attack or episode: _____

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

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 attack or episode: _____
d) Date of last attack or episode: _____
e) Frequency of attacks or episodes: _____
f) Type of treatment: _____
g) Frequency of treatments: _____
h) Date of last treatment: _____

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?