Statement of Health

Late Application For: ☐ Health & Travel Coverage or ☐ Participation Long Term Disability Plan

New Nouveau Brunswick

Employer *(department, hospital, school district or agency)* | Employee Name | Policy No.

Name of Applicant *(employee/spouse/child)* | Sex | Address | Postal Code

Date of Birth | Phone Number | Email Address

Exact Height _____ ☐ cm ☐ ft. & in. Weight loss of more than 10 lbs. (4.5 kgs.) in past 12 months ☐ Yes ☐ No

Exact Weight _____ ☐ kg ☐ lb. If yes, state weight loss _____ ☐ kg ☐ lb. Reason: _____

1. A. Name and address of last medical advisor consulted: _____
   B. When and why last visited? _____
   C. What treatment was given or medication prescribed? _____

2. Have you ever consulted a physician or practitioner for or ever had any indication of (please specify which)	Yes	No
A. Disorder of eyes, ears, nose or throat? (excluding eyeglasses, colds, sore throats and flu)	☐	☐
B. Severe headaches, dizziness, fainting, loss of consciousness, seizures, epilepsy, speech disorder, paralysis, stroke, nervous breakdown, mental trouble, depression, severe anxiety or other disorder of nervous system?	☐	☐
C. High blood pressure, palpitation or pain about the heart or chest, difficult breathing, angina or coronary disease, rheumatic fever, heart murmur or other disorder of heart or blood vessels?	☐	☐
D. Persistent cough or hoarseness, coughing of blood, asthma, pleurisy, bronchitis, tuberculosis or other disorder of the lungs?	☐	☐
E. Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding, pain or other disorder of stomach, gall bladder, liver, intestines or rectum?	☐	☐
F. Sugar, albumin or blood in urine, sexually-transmitted disease, kidneystone or colic, or any other disorder of kidney, bladder or genital organs?	☐	☐
G. Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar?	☐	☐
H. Cancer or other tumor, enlarged glands or skin disease?	☐	☐
I. Diabetes, thyroid or other endocrine disorder?	☐	☐
J. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immunological disorder?	☐	☐
K. Any other conditions, illnesses, diseases, injuries, operations or hospitalizations not mentioned above?	☐	☐

Give details of "yes" answers.
Identify question number and circle applicable items.
Include diagnosis, dates and treatment.

3. During the past 5 years, have you used alcoholic beverages? If "yes", complete questions a) to d).
   A. Frequency of use (daily, weekly) _____
   B. Number of drinks consumed on each occasion? _____
   C. Date last used _____
   D. Any treatment for alcohol use _____

4. In the last 10 years have you used heroin, morphine, other narcotics, barbiturates, amphetamines, or psychoactive (marijuana, LSD, etc.) drugs except as prescribed by a physician? ☐ ☐

5. Have you smoked cigarettes, cigarillos or marijuana in the past 12 months? ☐ ☐

6. Have you ever been tested for exposure to the AIDS virus? If "yes", give reasons and results. ☐ ☐

7. Has an application for insurance on your life / health ever been declined, rated or modified in any way? If "yes", give date, reason and company.

8. Have you applied for or received a pension or compensation because of illness or injury? If "yes", give dates and details. ☐ ☐

9. Have you lost any time from work during the past 12 months because of sickness or illness? Specify amount of time missed and why.

10. Are you in need of a surgical operation or do you expect to receive any health care (including attention due to pregnancy or infertility) in the future? If "yes", give dates and details. ☐ ☐

11. Are you currently receiving any treatment/medication? If "yes", give details.

12. Description of job duties.

13. Salary _____ ☐ bi-weekly ☐ annual

I declare that the statements I have made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided.

Signature of Applicant *(in ink)* _____

Date _____

Any expense incurred in providing this or additional information is the responsibility of the applicant.

Return to: Medavie Blue Cross, Attn: Group Medical Underwriting, 644 Main St., P.O. Box 220, Moncton, NB, E1C 8L3