Assumption Life
Group Insurance

New Nouveau Brunswick

Statement of Health for Group Policy 954 - Supplementary Life

Employee's name _____ Date of birth (DD/MM/YYY) _____/_____/_____

Address _____

Gender ☐ M ☐ F Telephone – Home _____ Telephone – Work _____

Employer (department, hospital, school district, agency) _____

Occupation _____ Salary ☐ bi-weekly _____ ☐ annual _____

Late Application for Supplementary Group Life Insurance Coverage ☐ 1 x salary or ☐ 2 x salary

1. a. Your height _____ ft/in OR _____ m/cm b. Your weight _____ lbs OR _____ kg
   c. Name and address of your physician _____

	Yes / No
2. Has your weight changed by more than 9.08kg (20 lbs) in the last year? If yes, state the amount of gain _____ lbs/ _____ kg or loss _____ lbs/ _____ kg and the reason _____. If the reason is pregnancy, state the date/expected date of delivery. _____	☐ ☐

3. Have any of your close biological family members (father, mother, brother, sister), living or deceased, ever been diagnosed with any of the following: cancer, stroke, cardiac disorder, Huntington's disease, polycystic kidney disease or any other hereditary disease? **If yes, complete the following chart:** ☐ ☐

Relationship	Disease / Disorder (if cancer, state the location)	Age at onset of illness	Age if living	Age at death	Cause of death

4. Are you taking any medication? **If yes, complete the following chart:** ☐ ☐

Name of medication	Reason	Dosage	Frequency	Date began

5. In the past 12 months, have you used any substance or product containing tobacco, nicotine or marijuana? **If yes, specify:** ☐ ☐
   Type _____ **Quantity** _____ **Frequency** _____

6. Are you aware of any symptoms for which you have not yet consulted a physician or specialist or received treatment, or for which you have consulted a physician without having received a diagnosis? **If yes, specify the symptoms and the date or expected date of the appointment.** _____ ☐ ☐

7. In the past 10 years, have you used any drugs except as prescribed by a physician or received advice or treatment for alcohol or drug abuse? **If yes, complete question 11, on the following page.** ☐ ☐

8. In the past 10 years, have you consulted a physician or been treated for: high blood pressure, high cholesterol, asthma or other respiratory disorder, diabetes, back, neck or spinal disorder, arthritis, depression, anxiety or any other nervous disorder, ulcer, colitis or Crohn's disease? **If yes, complete the pertinent question 12 to 19, on the following page.** ☐ ☐

9. In the past 10 years, have you been absent from work due to injury or illness for more than 30 consecutive days or have you applied for or received a disability benefit or compensation due to injury, illness or disability? **If yes, complete question 20, on the following page.** ☐ ☐

10. Have you ever been tested for, received treatment for, or had any known indication of any of the following conditions or symptoms: **If yes, circle the relevant impairment(s) and complete question 20, on the following page.**

a. Chest pain, heart murmur, abnormal pulse, palpitations, stroke or any other heart, circulatory or blood disorder/disease?	☐ ☐
b. Disorder of the muscles, bones, or joints, amputation, fibromyalgia, chronic fatigue syndrome or paralysis?	☐ ☐
c. Convulsion, epilepsy, multiple sclerosis (MS), chronic vertigo, fainting, headaches or any other neurological disorder?	☐ ☐
d. Disorder of the bladder, kidney, liver (including hepatitis B or C), prostate, genital or reproductive organs, bowel, stomach, pancreas or gallbladder?	☐ ☐
e. Cancer, tumor or other abnormal growth?	☐ ☐
f. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-related complex), AIDS virus antibody, or any other immunological disorder?	☐ ☐
g. Disorder of the eyes (excluding corrective lenses), nose, throat or mouth?	☐ ☐
h. Do you suffer from any physical impairment, disorder or disease that have not been mentioned above?	☐ ☐

Declaration and Authorization

• I confirm that the information and answers that I have provided in this statement of health, including the answers provided to questions 11 to 20, if applicable and in any related document are true and complete and acknowledge that they constitute the basis for my insurance coverage. • I understand that if any answer is false or incomplete, the insurance coverage granted may be voided. • I understand that I may be refused for insurance coverage if, in the opinion of Assumption Life, I am not insurable for the insurance coverage. • I understand that any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date Assumption Life makes a decision must be reported to Assumption Life. • I understand that if I fail to do so, the insurance coverage granted may be voided. • I consent to the medical examinations, electrocardiograms, blood, urine and saliva tests as may be required to medically underwrite my application. • I further consent to Assumption Life releasing the results of these tests to its reinsurers, if required and to my attending physician. • I acknowledge receipt of Assumption Life's **Notice for Records and Personal Information**. • I authorize any physician, healthcare professional, hospital, clinic, or other medical or paramedical establishment, as well as any insurance company, administrator of the group insurance plan, administrator of a government program or any other benefits program or agency, institution or person that holds records or information pertaining to me or my health status to exchange such records or information with Assumption Life or its reinsurers for underwriting and claims adjudication purposes. • In the event of a claim, I authorize any coroner, police force and any other agency that holds information regarding my death to communicate such information to Assumption Life and its reinsurers. • I have retained a copy of this Statement of Health. • I acknowledge that a copy of this authorization shall be as valid as the original.

_____ _____

Signature of the employee **Date** (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
770 Main St. / P.O. Box 160, Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 506-853-5434 Email : group@assumption.ca

Assumption Life
Group Insurance

New Nouveau Brunswick

Employee's name: _____

11. ALCOHOL AND DRUG CONSUMPTION

a. Name the drugs that you have consumed _____
b. Quantity _____ Frequency _____ Date last consumed _____
c. Have you consulted a physician or received treatment due to your drug consumption? ☐ Yes ☐ No
If yes, state the date of the consultation or treatment _____
d. Have you consulted a physician or received treatment due to your alcohol consumption? ☐ Yes ☐ No
If yes, state the date of the consultation or treatment _____
e. Date of your last: Alcohol consumption _____ Drug consumption _____

12. HYPERTENSION

a. Date of onset _____ Cause (if known) _____
b. Your blood pressure is: ☐ Controlled ☐ Not controlled Date and result of your last blood pressure reading _____

13. HIGH CHOLESTEROL

a. Date of onset _____
b. Your cholesterol is: ☐ Controlled ☐ Not controlled

14. ASTHMA OR RESPIRATORY DISORDER

a. Type ☐ asthma ☐ acute bronchitis ☐ chronic bronchitis ☐ emphysema ☐ other (specify) _____
b. Frequency of episodes _____ Date of last episode _____
c. Hospitalization ☐ Yes ☐ No Date _____ Time of work? ☐ Yes ☐ No Dates _____
d. Type of treatment _____ Emergency visits? ☐ Yes ☐ No Dates _____

15. DIABETES

a. Date of onset _____ b. Type of treatment ☐ insulin ☐ oral medication ☐ diabetic diet _____
c. Date and result of your last glucose level _____ and HbA1c _____
d. Have you had any complications related to your diabetes (eye, kidney, circulation, neurological)? ☐ Yes ☐ No
Specify _____

16. BACK, NECK OR SPINAL DISORDER

a. What area of your back was involved? ☐ neck ☐ middle (thoracic) ☐ lower (lumbosacral) ☐ other (specify) _____
b. What was the cause? _____ Diagnosis (if known) _____
c. Date of first episode _____ Date of last episode _____
d. Hospitalization required? ☐ Yes ☐ No Dates _____ Time off work? ☐ Yes ☐ No Dates _____
e. Type of treatment _____ Date of last treatment _____
f. Have you had any X-rays or other tests on your back? ☐ Yes ☐ No If yes, date and results _____
g. Did you consult with a specialist? ☐ Yes ☐ No If yes, specify date and name of specialist _____
h. Do you have any restrictions in your activities or limitations of movement? ☐ Yes ☐ No
Specify _____

17. ARTHRITIS

a. Type ☐ rheumatoid ☐ osteoarthritis ☐ other (specify) _____
b. Date of onset _____ Frequency of episodes _____ Date of last episode _____
c. Time off work? ☐ Yes ☐ No Dates _____
d. Type of treatment _____ Date of last treatment _____
e. Did you consult with a specialist? ☐ Yes ☐ No If yes, specify date and name of specialist _____
f. Do you have any restrictions in your activities or limitations of movement? ☐ Yes ☐ No
Specify _____

18. DEPRESSION, ANXIETY OR OTHER NERVOUS DISORDER

a. Type of symptoms ☐ insomnia ☐ anxiety ☐ nervousness ☐ fatigue ☐ suicidal thoughts ☐ suicide attempt ☐ phobia ☐ depression
☐ other (specify) _____
b. Date of onset _____ Cause _____
c. Frequency of episodes _____ Date of last episode _____
d. Hospitalization? ☐ Yes ☐ No Dates _____ Time of work? ☐ Yes ☐ No Dates _____
e. Type of treatment _____ Date of last treatment _____
f. Did you consult with a psychiatrist? ☐ Yes ☐ No
If yes, specify date and name of psychiatrist _____

19. ULCER, COLITIS OR CROHN'S DISEASE

a. Type ☐ ulcer ☐ colitis ☐ ulcerative colitis ☐ Crohn's disease ☐ other (specify) _____
b. Frequency of episodes _____ Date of last episode _____
c. Hospitalization? ☐ Yes ☐ No Dates _____ Complications? ☐ Yes ☐ No Specify _____
d. Type of treatment _____ Date of last treatment _____

20. IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS IN NUMBER 9 OR 10, ON THE PREVIOUS PAGE, PROVIDE DETAILS BELOW.

QUESTION NO.	CONDITION, DISORDER, DIAGNOSIS	DATE BEGAN	DATE ENDED	TREATMENT
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			

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NOTICE FOR RECORDS AND PERSONAL INFORMATION

Ref. Group Policy 954 - Supplementary Life

Retain for your personal records

For the purpose of administering your group insurance plan, Assumption Life, the insurance underwriter, collects personal information about you.

In order to protect the confidentiality of your personal information, Assumption Life is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of Assumption Life or third parties acting on our behalf, in Canada or elsewhere, in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed. This personal information may be medical in nature or related to your lifestyle. We, our service providers or our reinsurers may consult any insurance file that we hold or that is held by other insurers or reinsurers with respect to any other insurance application or statement you may have made in the past.

We may, for medical underwriting purposes, ask you to seek the assistance of a physician or a paramedical organization or a clinic in order to have you undergo a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. You would have to consent to such medical examinations, electrocardiograms, blood, urine and saliva tests. You are responsible for fees incurred in providing any underwriting requirement. The analyses will be used to determine the existence of various abnormalities such as diabetes, hepatic, kidney, or liver disorder, bone disease, immune disorder, infections caused by the AIDS virus, and the presence of medication, drugs, nicotine or their metabolites and to determine cholesterol and any related blood lipid levels.

In the event of a claim, we could retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your health, finances and lifestyle. We may also require a copy of your medical records, of the police investigation report, of the coroner's report, or any information explaining the circumstances of your death. In the event of a disputed death claim, we may have to share some of your personal information with your beneficiaries or personal representative.

Only those employees or agents (including any reinsurer, health care professional or service provider) who need the personal information for the performance of their duties will have access to your file. The group insurance policyholder (your employer or plan administrator, as applicable) will have access to the personal information required to carry out administrative tasks.

Your personal information may be securely used, stored or accessed in Canada and other countries where our service providers are located and may be subject to the laws of these countries.

Assumption Life shall not communicate your personal information to a third party without your consent unless required to do so by law or ordered to do so by a court.

You are entitled to consult any personal information held in your file and, if applicable, to have it corrected by submitting a written request to the following address:

ASSUMPTION LIFE, c/o Underwriting Department
P.O. Box 160/770 Main Street
Moncton NB E1C 8L1

IMPORTANT

Send your completed application (page 1; and if applicable, page 2 of the Statement of Health form) along with your request for the additional coverage (Employee Benefits Program Enrolment/Change Form) to:

Vestcor Pension Services Corporation (VPSC)
P.O. Box 6000
Fredericton, NB E3B 5H1

Telephone: 506-453-2296 or 1-800 561-4012 Fax: 506-457-7388

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