STATEMENT OF HEALTH
LATE APPLICATION FOR :

New Nouveau Brunswick

❑ **Health & Travel Coverage** **OR** ❑ **Participation Long Term Disability Plan**

Employer (department, hospital, school district or agency)	Social Insurance No.	Policy No.

Name of Applicant	Sex	Address	Postal Code

Date of Birth — Day | Mo. | Yr.

Exact Height _____ ❑ cm ❑ ft. & in.

Exact Weight _____ ❑ kg ❑ lb.

Weight loss of more than 10 lbs. (4.5 kgs.) in past 12 months ❑ Yes ❑ No

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?

	Yes	No	Give details of "yes" answers. Identify question number and circle applicable items. Include diagnosis, dates and treatment.
2. Have you ever consulted a physician or practitioner for or ever had any indication of (please specify which)			
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, kidney stone 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?	❑	❑	
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 (including AA membership)
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.

Date _____ Signature of Applicant (in ink) _____

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