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New Nouveau Brunswick CANADA

STATEMENT OF HEALTH - GROUP INSURANCE

NOTICE: ANY UNANSWERED OR INCOMPLETE QUESTIONS WILL DELAY YOUR APPLICATION

SECTION A

Policy No.: _____ Section No.: _____ ID No.: _____

I'm applying for: ❑ Health & Travel Coverage ❑ Optional Life - Policy #19800-000 ❑ Participation Long Term Disability Plan - Policy #6666

SECTION B - EMPLOYEE INFORMATION

First Name: _____ Last Name: _____

Place of Birth (City/Country): _____ Occupation: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Daytime Phone Number: _____ Email: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____

What is your height? _____ ft _____ in ***or*** _____ cm

Weight? _____ lbs ***or*** _____ kg

Have you lost more than 4.5 kg or 10 lbs in the past year? ❑ Yes ❑ No

If "Yes", state amount and reason: _____
Ex: Diet, exercise, illness)

SECTION C - PLEASE COMPLETE IF THE INSURANCE REQUESTED IS FOR SPOUSE OR DEPENDENTS

SPOUSE:

First Name: _____ Last Name: _____

Place of Birth (City/Country): _____ Occupation: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____

What is their height? _____ ft _____ in ***or*** _____ cm

Weight? _____ lbs ***or*** _____ kg

Have they lost more than 4.5 kg or 10 lbs in the past year? ❑ Yes ❑ No

If "Yes", state amount and reason: _____
Ex: Diet, exercise, illness)

CHILD / CHILDREN:

First Name	Last Name	Date of Birth			Age	Height			Weight	
		Day	Month	Year		feet	inches	cm	lbs	kg

SECTION D - FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION E.

In your lifetime, have you been treated for, or shown symptoms of any of the following diseases?	**Employee**		**Dependent(s)**	
	Yes	**No**	**Yes**	**No**
1. Cardiovascular system: Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or any impairment of the heart or blood vessels.	❑	❑	❑	❑
2. Respiratory system: Asthma, sleep apnea, chronic bronchitis, spitting of blood, tuberculosis, emphysema or any impairment of the respiratory system.	❑	❑	❑	❑
3. Digestive system: Colitis, Crohn's disorder, ulcer, bleeding from stomach or bowel, or other impairment of the stomach, gallbladder, liver (hepatitis, cirrhosis), or the intestines.	❑	❑	❑	❑
4. Genito-urinary system: Sugar, albumin, blood or pus in the urine, or any impairment of the kidneys, bladder, prostate or reproductive organs.	❑	❑	❑	❑
5. Endocrine system: Diabetes, impairment of the thyroid or any other impairment of the endocrine system.	❑	❑	❑	❑
6. Musculo-skeletal system: Rheumatism, arthritis, gout, muscle or bone disease including spinal cord, back, neck and joints.	❑	❑	❑	❑
7. Nervous system: Convulsions, epilepsy, migraine, paralysis, degenerative disease, depression or other mental or nervous disorder.	❑	❑	❑	❑
8. Immunological system: Have you ever had or been told that you had one of the following ailments, or have you undergone tests or received medical counsel for any of these:				
a) HIV (Human Immunodeficiency Virus) or any other immunological disorder?	❑	❑	❑	❑
b) Hypertrophy of lymph nodes (glands), chronic diarrhea, persistent lesions, infections of unknown origins?	❑	❑	❑	❑

Continued on Page 2

STOP! BEFORE CONTINUING PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS ABOVE!

SECTION D - (continued)

In your lifetime, have you been treated for, or shown symptoms of any of the following diseases?	Employee Yes	Employee No	Dependent(s) Yes	Dependent(s) No
9. **General:** Anemia or other blood disease, cyst, tumor, cancer, or other physical or mental disorder, sight or hearing disorder, not mentioned previously.	❑	❑	❑	❑
10. Within the past 5 years, have you had a medical condition or abnormal test results not already mentioned on this form?	❑	❑	❑	❑
11. Have you ever been advised to reduce your consumption of alcohol, received treatment for alcohol addiction (including Alcoholics Anonymous), consumed 5 or more alcoholic drinks per day on average, or have any other history of alcohol dependency, alcohol abuse, or frequent binge drinking?	❑	❑	❑	❑
12. Have you ever used narcotics, stimulants, hallucinogens or other recreational drugs (including cannabis) except as prescribed by a physician, received treatment for drug addiction, or have any history of drug dependency or abuse?	❑	❑	❑	❑
13. In the past 12 months, have you used any nicotine or smoking cessation products of any kind (including e-cigarettes)?	❑	❑	❑	❑
14. 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?	❑	❑	❑	❑

SECTION E - DETAILS OF "YES" ANSWERS OF SECTION D

Question Number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in outpatient clinic or in a doctor's office.

SECTION F - IF YOU ARE CURRENTLY PRESCRIBED MEDICATION, PLEASE COMPLETE THE SECTION BELOW

Name of person	Name of medication and reason *ex: "ventolin, for asthma" or "anaprox, backpain"*	Strength, quantity and frequency *ex: "50mg, twice daily" or "10mg, as needed"*	Date treatment started, or approximate duration if unknown? *ex: "June 2015" or "about 5 years"*	Is treatment effective? Yes	No
				❍	❍
				❍	❍
				❍	❍
				❍	❍
				❍	❍

SECTION G - NICOTINE AND DRUG CONSUMPTION

In the past 12 months, have you or your spouse used any nicotine, narcotics or other drugs? ❍ Yes ❍ No
If yes, please specify weekly consumption below. If you have stopped using these products in the last 12 months, indicate usage before you stopped.

	Employee, Spouse or both?	*ex: "7 packs per week"*
Cigarettes	❍ **E** ❍ **S** ❍ **B**	
Cigars	❍ **E** ❍ **S** ❍ **B**	
Narcotics or other drugs	❍ **E** ❍ **S** ❍ **B**	

SECTION H - FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION I.

Within the past 5 years, have you:	Employee Yes	Employee No	Dependent(s) Yes	Dependent(s) No
1. Consulted or been examined or treated by a physician or other practitioner, aside from regular check-ups?	❑	❑	❑	❑
2. Been a patient in a hospital, clinic, sanatorium or other medical facility?	❑	❑	❑	❑
3. Undergone an electrocardiogram, chest x-ray, laboratory tests or other tests for diagnostic purposes?	❑	❑	❑	❑
4. Requested or received a pension for disability or injury?	❑	❑	❑	❑

PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS ABOVE BEFORE CONTINUING!

SECTION I - DETAILS OF "YES" ANSWERS OF SECTION H

Question Number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in outpatient clinic or in a doctor's office.

SECTION J - CURRENT MEDICAL RECORDS

If "Yes" for dependent(s), indicate their name(s)

1. Are you under medical treatment? Employee: ❍ Yes ❍ No Dependent(s): ❍ Yes ❍ No Name: _____

2. Please give the name and address of physician who has your medical records.

_____

_____

SECTION K - FAMILY HISTORY

For the employee or spouse, have any of your parents, brothers or sisters, before attaining age 60, ever had cancer, heart or kidney disease, mental or nervous disorder, or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease)? ❍ Yes ❍ No If yes, provide the following details:

Family Member (Mother, Father, Brother, Sister)	Related to employee or spouse?	Age at onset of condition	Name of Condition (type of cancer, heart or kidney disease etc.)	If you have been investigated for this condition, indicate date and results (if no investigation done, state "none")

I, the undersigned, declare the answers to the above questions and the questions on the 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, to recommend suitable products and services to me, and to manage the Company's business. I hereby authorize any physician, pharmacy, health practitioner, hospital, clinic or other medical or medically related facility, insurance company, government or regulatory authority, 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 its reinsurers 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 I'm aware of the risks and benefits of consenting or refusing to consent. I may contact Medavie Blue Cross at 1-800-667-4511 with any questions related 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.

Signature of Applicant

Signature of Spouse (if spouse is applying)

Signature of Child (if over 18 years)

Date

**Blue Cross Life Insurance Company of Canada underwrites all life and disability benefits.*

If you require any space to complete the form, attach additional pages as necessary.

Before submitting this form, please ensure you have answered all questions and signed and dated it. FAILURE TO DO SO WILL DELAY YOUR APPLICATION

Please note that we may follow up with you to collect more details if required. If necessary, a representative from our third party service provider may contact you in the days following receipt of your Statement of Health to collect more medical information.

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