GROUP EMPLOYEE HEALTH INFORMATION

INSTRUCTIONS: Please print clearly and ensure all sections are completed.

Name of Group Policyholder (Employer)	Group Policy number	Division number	Certificate number

1. Employee Information

Name (first, middle, last)

Home address (number, street) | City

Province | Postal code | Date of birth (dd/mmm/yy) | ◯ Male ◯ Female

Height ◯ ft/in ◯ cm | Weight ◯ lb ◯ kg | Weight change in last year ◯ Gain ◯ lb ◯ Loss ◯ kg | Reason (if pregnant, provide due date)

Occupation | Personal and confidential e-mail address (optional)

Any further correspondence about this form should be sent to: ◯ Home address ◯ Work address

2. Personal Information

Do you have a regular physician? ◯ Yes ◯ No If yes, please provide:

Physician's name (first, last) | Date of last visit (dd/mmm/yy)

Physician's address/telephone

Reason and results of last visit to regular physician

In the last 12 months have you seen any physician at a clinic or hospital other than your regular physician?
◯ Yes ◯ No If yes, please provide:

Date of last visit (dd/mmm/yy)

Reason for visit: ◯ Consultation/advice ◯ Medication ◯ Annual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

Details (include current medication, dosage, specialist, physician or health care persons name, type of treatment reason for referral, the ER.)

2.1 Related Medical Information

If you answer "Yes," complete section below for immediate family member. If unknown, indicate reason in Section 2.6.

* If cancer, indicate type

Have any of your biological parents, brothers or sisters, whether living or dead, ever suffered from any of the following conditions:

- Diabetes
- Cancer*
- High blood pressure
- Stroke
- Heart disease
- Polycystic Kidney disease
- Kidney disorder
- Huntington's Chorea
- Alzheimer's Disease
- Motor Neuron Disease including but not limited to ALS (Amyotrophic Lateral Sclerosis) or Lou Gehrig's Disease
- Parkinson's Disease
- Mental illness
- Suicide
- Multiple Sclerosis
- Hepatitis
- Any other inherited disease

Relationship	Illness*	Age at onset of illness	Age if living	Age at death

GROUP EMPLOYEE HEALTH INFORMATION cont'd

Employee name

2.2 Medical Information

If you answer "Yes" to any of the following questions, provide details in Section 2.6. Include date, diagnosis, treatment, results, duration and names, addresses of all medical advisors and medical facilities.

Have you ever had or been tested for, treated for, or told you may have any of the following:

A Head & Respiratory Systems ◯ Yes ◯ No

- Optic Neuritis
- Visual disturbance
- Blindness
- Glaucoma
- Deafness
- Tinnitus
- Persistent hoarseness
- Spitting of blood
- Loss of speech
- Sleep Apnea
- Tuberculosis
- Sarcoidosis
- Cystic Fibrosis
- Chronic Obstructive Pulmonary Disease (COPD)
- Bronchitis
- Asthma
- Emphysema

- Any other eye, ear, nose, throat or lung problem/disorder: ______

B Neurological ◯ Yes ◯ No

- Epilepsy or Seizures
- Fainting
- Headaches
- Dizziness
- Transient Ischemic Attack (TIA)
- Stroke
- Tremor
- Parkinson's Disease
- Motor Neuron Disease (Lou Gehrig's Disease/ALS)
- Alzheimer's Disease
- Cognitive impairment
- Dementia
- Weakness of the extremities
- Muscle weakness
- Multiple Sclerosis
- Tingling
- Loss of balance
- Loss of speech
- Cerebral Palsy
- Autism
- Developmental disorder

- Any other neurological problem/disorder: ______

C Psychological ◯ Yes ◯ No

- Anxiety
- Depression
- Bi-polar Disorder
- Stress
- Panic attacks
- Schizophrenia
- Mental impairment
- Burnout
- Attempted suicide or suicidal thoughts
- Eating disorder

- Any other emotional, behavioral or psychiatric problem/disorder: ______

D Heart & Circulatory System ◯ Yes ◯ No

- Chest pain
- Angina
- Shortness of breath
- Heart attack (Myocardial Infarction)
- Bypass or Angioplasty
- Abnormal ECG
- Irregular pulse
- Palpitations
- Heart murmur
- Pacemaker
- High blood pressure
- High cholesterol
- Enlarged heart
- Transient Ischemic Attack (TIA)
- Stroke
- Peripheral Vascular Disease
- Swollen ankles
- Blood clot

- Any other heart, blood vessel or circulatory system problem/disorder: ______

E Liver, Stomach, Bladder, Kidney, or Reproductive Systems ◯ Yes ◯ No

- Hepatitis
- Hepatitis carrier
- Cirrhosis
- Jaundice
- Ulcer
- Irritable bowel
- Crohn's Disease
- Colitis
- Diverticulitis
- Bleeding from the rectum
- Chronic diarrhea
- Blood in the stool
- Gall bladder
- Pancreatitis
- Kidney disease, stones or Nephritis
- Blood, protein or sugar in the urine
- Prostatitis
- Sexually transmitted disease
- Abnormal pap smear

Any other problem/disorder of the:

- Stomach
- Pancreas
- Liver
- Intestines
- Kidneys
- Bladder or Ureters
- Prostate or male reproductive organs
- Uterus, Ovaries or Cervix

Specify: ______

F Breast (male or female) ◯ Yes ◯ No

- Abnormal biopsy, mammogram or breast ultrasound
- Fibrocystic disease
- Cysts or lumps

- Any other breast changes or abnormalities: ______

GROUP EMPLOYEE HEALTH INFORMATION cont'd

Employee name

2.2 Medical Information cont'd

If you answer "Yes" to any of the following questions, provide details in Section 2.6.

Have you ever had or been tested for, treated for, or told you may have any of the following:

G Blood, Glandular or Endocrine Systems ◯ Yes ◯ No

- Abnormalities of the Thyroid, Pituitary, Lymph or Adrenal glands
- Goiter
- Diabetes
- Abnormal blood sugar
- Anemia
- Bleeding disorder
- Hemophilia
- Any other blood or glandular problem/disorder: ____________________

H Any injury or disorder of Muscle & Skeletal Systems ◯ Yes ◯ No

- Rheumatism
- Gout
- Rheumatoid Arthritis
- Osteoarthritis or any other type of Arthritis
- Fibromyalgia
- Chronic fatigue
- Chronic pain
- Systemic Lupus Erythematosus (SLE) or Lupus in any form
- Muscular Dystrophy
- Paralysis
- Amputation
- Any other spine, back/neck trouble, bone, joint or muscle problem/disorder: ____________________

I Cancer ◯ Yes ◯ No

- Tumour
- Polyp
- Cyst
- Enlargement of the lymph nodes
- Dysplastic Nevi Syndrome
- Irregular shaped moles or lesions that have changed in appearance
- Basal Cell Carcinoma
- Malignant Melanoma
- Any other form of malignant disease or growth: ____________________

J Immunological Disorder ◯ Yes ◯ No

- Any immunological disorder including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
- Advised to or tested for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
- Unexplained infection

2.3

Are you currently under treatment or taking medication, herbal, holistic or prescribed? If yes, provide details in 2.6. ◯ Yes ◯ No

2.4

If you answer "Yes" to any of the following questions, provide details in Section 2.6.

A Have you ever used: ◯ Yes ◯ No

- Cocaine
- Heroin
- LSD
- Marijuana
- Hashish
- Excitants
- Hallucinogens
- Amphetamines
- Narcotics
- Barbiturates
- Tranquilizers, similar drugs or unprescribed drugs

B Do you consume alcoholic beverages? If yes, provide details in 2.6. ◯ Yes ◯ No

C Have you ever decided to or been advised to decrease consumption of alcohol or drugs; or been treated for or joined an organization because of alcohol or drug use; or have you ever been convicted of impaired driving or driving "over the legal limit" under s.253 (a) or (b) of the Criminal Code? ◯ Yes ◯ No

D In the last 12 months, have you used: ◯ Yes ◯ No

- Cigarettes
- Cigarillos
- Large cigars
- Small cigars
- Hashish
- Chewing tobacco
- Snuff
- Nicotine substitutes (including gum or patches)
- Marijuana
- Betel nuts
- Pipes

2.5 Additional Information

If you answer "Yes" to any of the following questions, provide details in Section 2.6.

A Have you ever had any injury or illness, surgery, been hospitalized, tested for or treated for anything not listed above? ◯ Yes ◯ No

B Have you ever had, or been advised to have, any consultation, medical exam or diagnostic test, including MRI, CT scan, ECG, X-ray, or blood test? ◯ Yes ◯ No

C Are you aware of any symptoms or complaints regarding your health for which a doctor has not yet been consulted? ◯ Yes ◯ No

D Have you ever been disabled or received disability income payments? ◯ Yes ◯ No

E Are you currently pregnant? If yes, provide details of any complications in Section 2.6. ◯ Yes ◯ No

F Have you flown in the last 3 years as a pilot, student pilot or crew member (or do you intend to do so)? ◯ Yes ◯ No

G Have you, in the past 5 years, engaged in or do you plan to engage in any of the following: skin or scuba diving; mountain climbing; hang-gliding, heli-skiing, parachute jumping, ultralight aircraft flying; racing cars, boats, motorcycles or other motorized vehicles; or any other hazardous extreme sport or activity? ◯ Yes ◯ No

H Have you ever had an application for life, critical illness or disability income insurance declined, rated or restricted? ◯ Yes ◯ No

I In the last 5 years, have you been absent from work for 15 consecutive days for sickness or injury? ◯ Yes ◯ No

GROUP EMPLOYEE HEALTH INFORMATION cont'd

2.6 Details

Use this area to provide details of answers in Sections 2.1 - 2.5. Include diagnosis, treatment and results, dates, duration and names and addresses of all medical advisors/clinics and medical facilities.

Employee name	
Question #	Details

3. Declaration and Authorization

Declaration

- I declare the statements contained in this form were accurately recorded and they are true and complete. I understand these statements form part of the application in consideration for the insurance applied for. I also understand and agree that any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable.

Authorization

- I authorize the following individuals or groups to collect, use and disclose information with The Empire Life Insurance Company (Empire Life), its reinsurers, their agents or representatives and third party service providers: any health care professional or practitioner and any public or private health or social services institution; any insurance company or financial institution; Medical Information Bureau; personal information agents and agencies; organizations whose purpose is the prevention, detection or repression of crime or statutory offences; my current or my former employers; and any other public or private organization that has information concerning me or any of my eligible dependants.
- I understand Empire Life may collect and disclose this information for the purpose of: assessing the risk on a continuing basis and considering whether to issue or renew a group policy of insurance under which I might be or become insured; determining the premium payable for such insurance; and assessing my eligibility for coverage and the nature and amounts of such coverage; assessing any claim made by me or my beneficiaries.
- I understand this information will be maintained by Empire Life in a file and only authorized individuals will have access to the file for achieving the purpose outlined above. My file will be kept at the Head Office of Empire Life. Empire Life may use third party service providers located outside of Canada to process and store my personal information. To access a copy of the most recent Privacy Policy, I may visit www.empire.ca. I also understand I am entitled to consult the file and, when applicable, have it corrected. I can exercise this right by contacting the Empire Life Head Office in writing.
- I agree a photocopy of this authorization shall be as valid as the original.

4. Signature

Signature of Employee X	Date (dd/mmm/yy)
City	Province

Please return to: Empire Life
Group Medical Underwriting
259 King Street East Kingston, ON K7L 3A8
Group Customer Service: 1 800-267-0215 Fax: 613-548-8402
E-mail: groupmedicalunderwriting@empire.ca

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