GROUP DEPENDANT(S) 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

Employee's name (first, middle, last)			
Address	City	Province	Postal code
Occupation	Personal and confidential e-mail (optional)		

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

1.1 Dependant(s) Information

To add more dependants, complete an additional Group Dependant(s) Health Information form (GB-0005-ENG).

Dependant's name (first, last)	Relationship to Employee	Gender	Date of birth (dd/mmm/yy)	Height	Weight
		◯ Male ◯ Female		◯ ft/in ◯ cm	◯ lb ◯ kg
		◯ Male ◯ Female		◯ ft/in ◯ cm	◯ lb ◯ kg
		◯ Male ◯ Female		◯ ft/in ◯ cm	◯ lb ◯ kg
		◯ Male ◯ Female		◯ ft/in ◯ cm	◯ lb ◯ kg

1.2 Personal Information

If more space required, complete an additional Group Dependant(s) Health Information form (GB-0005-ENG)

Do the dependant(s) 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

Have the dependant(s) seen any physician at a clinic or hospital other than the 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. Medical Information

If you answer "Yes" to any of the following questions, provide details in Section 2.3. Include date, diagnosis, treatment, results, duration and names, addresses of all medical advisors and medical facilities.

A Have the dependant(s) ever had or been tested for, treated for, or told they may have any of the following:

• Heart trouble • High blood pressure • Diabetes	• Lung, liver or kidney disorders	• Mental or nervous conditions • Cancer or tumors	◯ Yes ◯ No

B Have the dependant(s) ever had any physical or mental disorder not listed above?	◯ Yes ◯ No
C Have the dependant(s) ever had any illness, injury or operation within the past 5 years?	◯ Yes ◯ No

D Immunological Disorder

- 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

◯ Yes ◯ No

GROUP DEPENDANT(S) HEALTH INFORMATION cont'd

Employee name

2.1 Medical Information cont'd

Question	Answer
E Do the dependant(s) consume alcoholic beverages? (If yes, indicate quantity and frequency in section 2.3.)	◯ Yes ◯ No
F Have the dependant(s) 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 ever been convicted of impaired driving or driving "over the legal limit" under s.253 (a) or (b) of the Criminal Code?	◯ Yes ◯ No

G Have the dependant(s) ever used:

• Cocaine • Heroin • LSD • Marijuana	• Hashish • Excitants • Hallucinogens • Amphetamines	• Narcotics • Barbiturates • Tranquilizers, similar drugs or unprescribed drugs	◯ Yes ◯ No

2.2 Additional Information

Question	Answer
A Have the dependant(s) flown in the last 3 years as a pilot, student pilot or crew member (or intend to do so)?	◯ Yes ◯ No
B Have the dependants, in the past 5 years, engaged in or 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
C Have the dependant(s) ever had an application for life, critical illness or disability income insurance declined, rated or restricted?	◯ Yes ◯ No

2.3 Details

Use this area to provide details of answers in Sections 2. - 2.2. Include diagnosis, treatment and results, dates, duration and names and addresses of all medical advisors/clinics and medical facilities.

Question #	Dependant name	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		Signature of Dependant(s)	
X		X	
City		Province	Date (dd/mmm/yy)

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