SUPPLEMENTAL HEALTH INFORMATION

If this form is a supplement to the D-0082 (Insurance Application) or D-0024 (Single Life Term Insurance Application), write the policy number in the box provided at the top of each page.

Policy number

1. LIFE INSURED/OWNER

Name (first, middle, last)	Date of birth (dd/mmm/yy)

2. PERSONAL INFORMATION

Do you have a regular physician/nurse practitioner? ◯ yes ◯ no If yes, please provide the following (If your regular physician/nurse practitioner does not have the most complete and up to date records, advise the name of the physician/nurse practitioner or clinic that does, in Section 2.6.):

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

Physician/nurse practitioner's address/telephone

Reason for last visit to regular physician/nurse practitioner

Results of last visit to regular physician/nurse practitioner

Have you seen any other physician/nurse practitioner at a clinic or hospital other than your regular physician/nurse practitioner?
◯ yes ◯ no If yes, please provide:

Physician/nurse practitioner/clinic/hospital address/telephone

Reason for last visit to other physician/nurse practitioner/clinic/hospital	Date of last visit (dd/mmm/yy)

Results of last visit to other physician/nurse practitioner/clinic/hospital

Height ◯ ft/in ◯ cm	Weight ◯ lb ◯ kg	Weight change in last year ◯ Gain ◯ Loss ◯ lb ________ ◯ kg ________

Reason (if pregnant, provide due date)

2.1 RELATED MEDICAL INFORMATION

Have any of your biological parents, brothers or sisters, whether living or dead, ever suffered from or been diagnosed with, any of the following conditions: (If you answer "YES" to any of the following conditions, complete section below for immediate family member. If unknown, indicate reason in Section 2.6.)

- 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

◯ yes ◯ no ◯ unknown

Relationship to Insured	Illness (If cancer, indicate type)	**Age at onset of illness**	Age if living	Age at death
Relationship to Insured	Illness (If cancer, indicate type)	**Age at onset of illness**	Age if living	Age at death

2.2 MEDICAL INFORMATION

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

A) Head & Respiratory Systems

- 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: ____________________

◯ yes ◯ no

SUPPLEMENTAL HEALTH INFORMATION cont'd

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2.2 MEDICAL INFORMATION cont'd

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

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
- Numbness
- Loss of balance
- Loss of speech
- Cerebral Palsy
- Autism
- Developmental disorder
- ADHD/ADD
- Any other neurological problem/disorder: ____________________

C) Psychological

◯ yes ◯ no

- Anxiety
- Depression
- Bi-polar Disorder
- Panic attacks
- Schizophrenia
- Mental impairment
- 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
- 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: ____________________

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, bone, joint or muscle problem/disorder: ____________________

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2.2 MEDICAL INFORMATION cont'd

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

I) Cancer and Skin Disorders ◯ yes ◯ no

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

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 MEDICAL INFORMATION cont'd

Are you currently under treatment or taking medication, herbal, holistic or prescribed? ◯ yes ◯ no
If yes, provide name, dosage and reason in Section 2.6.

2.4 MEDICAL INFORMATION cont'd

If you answer "YES" to any of the following questions, provide details, **including dates** in Section 2.6.

A) In the last 10 years have you 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 below:** ◯ yes ◯ no

Beer ______ bottles per:	Wine ______ 8 oz glasses per:	Liquor ______ oz/ml per:
◯ day ◯ week ◯ month	◯ day ◯ week ◯ month	◯ day ◯ week ◯ month

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 of Canada? ◯ yes ◯ no
If yes, provide dates of treatment and dates of convictions in Section 2.6.

D) In the last 10 years, have you been charged with or convicted of driving under the influence (DUI), careless or reckless driving, or had your license suspended? **If yes, provide type of violation and dates in Section 2.6** ◯ yes ◯ no

E) Have you had any other moving traffic violations in the last 3 years? ◯ yes ◯ no
If yes, provide details including type and dates in Section 2.6

F) Within the last 15 years, have you used any tobacco, nicotine or non nicotine products such as: cigarettes, cigarillos, pipes, small cigars, large cigars, e-cigarettes, betel nuts, marijuana, hashish, nicotine patch, nicotine gum, chewing tobacco, snuff or other form of tobacco products? **If yes, provide details below.** ◯ yes ◯ no

Type	**Quantity**	**Frequency** (daily, weekly, monthly, yearly)	**Date last used** (or within last 1, 2 or 15 years)	**One time use?** Please provide date:

2.5 MEDICAL INFORMATION cont'd

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

A) In the last 5 years, have you had any injury or illness, surgery, been hospitalized, tested for or treated for anything not listed above? ◯ yes ◯ no

B) In the last 5 years have you 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) If age 50 or less, are you currently pregnant? If yes, provide details of any complications in Section 2.6. ◯ yes ◯ no

SUPPLEMENTAL HEALTH INFORMATION cont

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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. If more space is required, use the D-0056A Supplemental Health Information - Medical History Continuation form.

Question #	Details

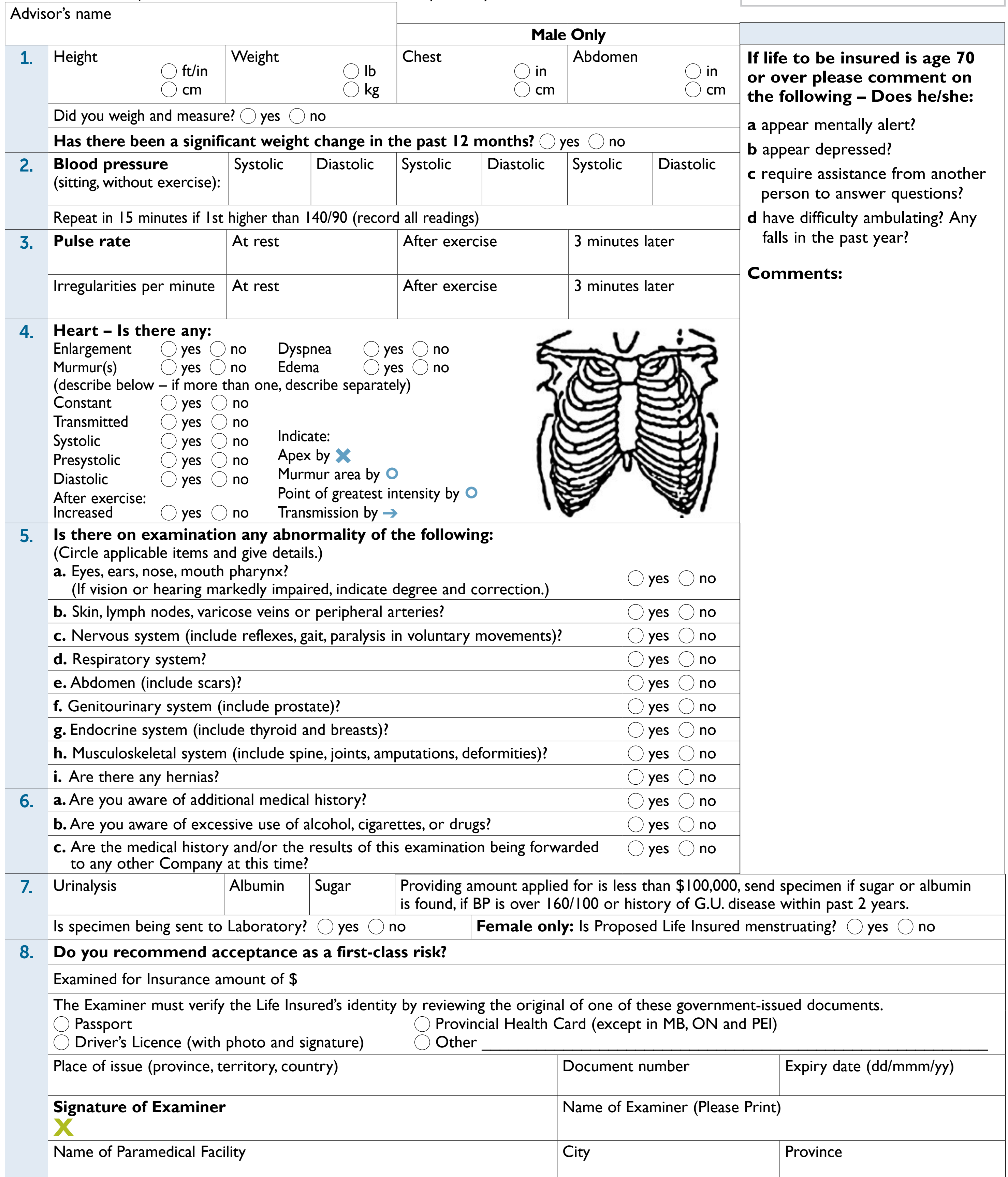
3.0 SIGNATURES

If you answer "YES" to I have read and understood the questions asked above and I have reviewed my answers and confirm them to be full, complete and true to the best of my knowledge and belief. I declare that my answers may be relied upon by Empire Life. I consent to the collection, use and disclosure of my personal information for the purposes set out in the Your Personal Information and Your Privacy notice contained in my Application. I authorize any individual or public or private organizations (including any health care professional or practitioner and any public or private health or social services institution, any insurance company, and the MIB, Inc.) that have personal information about me to release this information to Empire Life, its reinsurers, agents or representatives. I understand that Empire Life may use third party service providers located inside or outside of Canada to process and store my personal information. To access a copy of the most recent Empire Life Privacy Policy, please visit the Empire Life website at www.empire.ca.

A photocopy of this authorization shall be as valid as the original.

Signature of Life Insured/Owner X	Name of Life Insured/Owner (please print)
Signature of Witness X	Name of Witness (please print)
Signed at (City and Province)	Date (dd/mmm/yy)

SUPPLEMENTAL HEALTH INFORMATION cont'd



If Life Insured is subject to examination, this form must be completed by the examiner.

Advisor's name		Policy number

Male Only (Chest, Abdomen)

	Height	Weight	Chest	Abdomen
1.	◯ ft/in ◯ cm	◯ lb ◯ kg	◯ in ◯ cm	◯ in ◯ cm

Did you weigh and measure? ◯ yes ◯ no

Has there been a significant weight change in the past 12 months? ◯ yes ◯ no

2.	**Blood pressure** (sitting, without exercise):	Systolic	Diastolic	Systolic	Diastolic	Systolic	Diastolic

Repeat in 15 minutes if 1st higher than 140/90 (record all readings)

3.	**Pulse rate**	At rest	After exercise	3 minutes later
	Irregularities per minute	At rest	After exercise	3 minutes later

4. **Heart – Is there any:**

Enlargement ◯ yes ◯ no Dyspnea ◯ yes ◯ no
Murmur(s) ◯ yes ◯ no Edema ◯ yes ◯ no
(describe below – if more than one, describe separately)
Constant ◯ yes ◯ no
Transmitted ◯ yes ◯ no
Systolic ◯ yes ◯ no
Presystolic ◯ yes ◯ no
Diastolic ◯ yes ◯ no
After exercise:
Increased ◯ yes ◯ no

Indicate:
Apex by ✖
Murmur area by ○
Point of greatest intensity by ○
Transmission by →

5. **Is there on examination any abnormality of the following:**
(Circle applicable items and give details.)

a. Eyes, ears, nose, mouth pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	◯ yes ◯ no
b. Skin, lymph nodes, varicose veins or peripheral arteries?	◯ yes ◯ no
c. Nervous system (include reflexes, gait, paralysis in voluntary movements)?	◯ yes ◯ no
d. Respiratory system?	◯ yes ◯ no
e. Abdomen (include scars)?	◯ yes ◯ no
f. Genitourinary system (include prostate)?	◯ yes ◯ no
g. Endocrine system (include thyroid and breasts)?	◯ yes ◯ no
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	◯ yes ◯ no
i. Are there any hernias?	◯ yes ◯ no

6.

a. Are you aware of additional medical history?	◯ yes ◯ no
b. Are you aware of excessive use of alcohol, cigarettes, or drugs?	◯ yes ◯ no
c. Are the medical history and/or the results of this examination being forwarded to any other Company at this time?	◯ yes ◯ no

If life to be insured is age 70 or over please comment on the following – Does he/she:

a appear mentally alert?
b appear depressed?
c require assistance from another person to answer questions?
d have difficulty ambulating? Any falls in the past year?

Comments:

7.	Urinalysis	Albumin	Sugar	Providing amount applied for is less than $100,000, send specimen if sugar or albumin is found, if BP is over 160/100 or history of G.U. disease within past 2 years.

Is specimen being sent to Laboratory? ◯ yes ◯ no **Female only:** Is Proposed Life Insured menstruating? ◯ yes ◯ no

8. **Do you recommend acceptance as a first-class risk?**

Examined for Insurance amount of $

The Examiner must verify the Life Insured's identity by reviewing the original of one of these government-issued documents.
◯ Passport ◯ Provincial Health Card (except in MB, ON and PEI)
◯ Driver's Licence (with photo and signature) ◯ Other ______________________

Place of issue (province, territory, country)	Document number	Expiry date (dd/mmm/yy)
Signature of Examiner X	Name of Examiner (Please Print)	
Name of Paramedical Facility	City	Province

This examination is to be forwarded in a sealed envelope to The Empire Life Insurance Company, Kingston, Ontario. Fees are paid by cheque from Head Office. Please do not accept payment from any other source.

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