

PARAMEDICAL

Policy number

1. LIFE INSURED

Name (first, middle, last)

Date of birth

| d | d | - | m | m | m | - | y | y | y | y |

Name and address of personal physician/nurse practitioner

2. HEALTH INFORMATION

1. I understand I must answer all questions truthfully. yes

2. What is your height? cm ft/in
 What is your weight? kg lb

If you answer “yes” to any of the following questions, please provide details in the Additional Information section, on page 3. Please include date(s) of event(s), duration, treatment, diagnosis, if resolved or continuing, date(s) and result(s) of any testing (excluding genetic testing) and the names and address of all medical Advisors and facilities.

3. Have you ever had, been told you had, or received treatment or advice for:

- a) Heart attack, heart surgery, heart murmur, heart valve disorder, cardiomyopathy, irregular heart rhythm, a pacemaker, chest pain, shortness of breath or any other disease or disorder of the heart? yes no
- b) Aneurysm, stroke, transient ischemic attack (TIA), Alzheimer’s disease, dementia, cognitive impairment, memory loss, tremor, Parkinson’s disease, Huntington disease, seizures, convulsions, cerebral palsy, head injury, hydrocephalus, loss of consciousness, loss of speech, loss of hearing, or loss of vision? yes no
- c) Cancer, tumour, polyp, cyst, growth, malignancy, dysplastic nevus syndrome or a mole that changed in appearance, colour or size? yes no
- d) Diabetes, high blood sugar, sugar in the urine, or any disorder of the endocrine or thyroid glands? yes no
- e) Blood clot, circulation disorder, peripheral vascular disease, high blood pressure, high cholesterol, swollen ankles or legs, anemia, hemophilia or any blood disorder? yes no
- f) Multiple sclerosis, amyotrophic lateral sclerosis (ALS), muscle weakness, tingling or numbness of the extremities, or any motor neuron disease? yes no
- g) Sleep apnea, emphysema, tuberculosis, asthma, chronic bronchitis, or any other lung disease or disorder? yes no
- h) Hepatitis, hepatitis carrier, cirrhosis, pancreatitis, or any disorder of the liver, bladder, kidney, pancreas or gall bladder? yes no
- i) Arthritis, rheumatoid arthritis, osteoarthritis, Lupus, muscular dystrophy, paralysis, or any other disease or disorder of the joints, muscles, or connective tissue (not including injuries)? yes no
- j) Acquired Immunodeficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? yes no

4. In the past 5 years, have you had, been told you had, or received treatment or advice for:

- a) An abnormal mammogram or breast imaging test, abnormal Pap test, abnormal PSA test, or any prostate disorder? yes no
- b) Ulcer, ulcerative colitis, Crohn’s disease, diverticulitis, intestinal or rectal bleeding, jaundice, or any disorder of the stomach, bowel or digestive system? yes no
- c) Depression, anxiety disorder, post-traumatic stress disorder, bipolar disease, psychosis, been hospitalized for these or any other psychological/nervous disorders, and/or have you ever contemplated or attempted suicide? yes no
- d) Chronic pain, chronic fatigue, fibromyalgia, or any injury of the back, spine, neck or musculoskeletal system? yes no

5. In the past 5 years, excluding genetic tests, have you:

- a) had surgery, been admitted to a hospital (other than for childbirth), been referred to a physician or other health care provider, or had any clinical test for which the results are not yet known? yes no
- b) been advised to have any diagnostic test or receive treatment or surgery that has not yet been completed, or had any symptoms for which you have not yet consulted a health care provider? yes no

2. HEALTH INFORMATION cont'd

6. a) What best describes your tobacco and nicotine history? Note: nicotine and tobacco includes use of cigarette, e-cigarette, cigarillo, small cigar, large cigar, pipe, chewing tobacco, nicotine patch or gum, betel nut, any other tobacco or nicotine products?		Last used : <input type="radio"/> in past 12 months <input type="radio"/> 12-24 months ago <input type="radio"/> 2-15 yrs ago <input type="radio"/> more than 15yrs ago <input type="radio"/> no past usage
b) If used within the last 12 months please specify: Product _____ frequency/amount of usage _____		
7. Alcohol and drug use		
a) How many drinks of alcohol do you consume per week? Note: 1 drink of alcohol is considered to be 1 glass of wine, 1 bottle/can of beer or 1.5 oz of hard liquor.		<input type="radio"/> less than 1 <input type="radio"/> 1-14 <input type="radio"/> 15-21 <input type="radio"/> 22-28 <input type="radio"/> 29-35 <input type="radio"/> more than 35 <input type="radio"/> None
b) In the past 10 years have you used marijuana, cocaine, heroin, unprescribed opiates, ecstasy, amphetamines, or any other drug not prescribed to you, other than over the counter medication?		<input type="radio"/> yes <input type="radio"/> no
c) In the past 10 years have you been prescribed marijuana by a health care provider?		<input type="radio"/> yes <input type="radio"/> no
d) Have you ever had, sought, or been advised to seek treatment or counselling for alcohol or drug use and/or have you been admitted to any facility because of alcohol or drug use?		<input type="radio"/> yes <input type="radio"/> no

3. FAMILY HISTORY INFORMATION

8. Have any of your biological mother, father, sister(s) or brother(s) been diagnosed before their 65th birthday with cancer, tumour, leukemia, lymphoma, Hodgkin's disease, heart disease, heart attack, coronary artery disease, stroke, cardiomyopathy, diabetes, polycystic kidney disease, Alzheimer's disease, dementia, Huntington's disease, Parkinson's disease, multiple sclerosis, motor neuron disease or Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease)? If you answer "yes" to this question, provide details below, but do not provide any genetic test information.				<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unknown	
Relationship to Insured	Illness (if cancer, indicate type)	Age at onset of illness	Age if living	Age at death	
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4. PERSONAL INFORMATION

9. In the past 10 years, have you been charged with driving a vehicle while impaired, or with reckless or careless driving, or have you had your driver's license suspended?	<input type="radio"/> yes <input type="radio"/> no
10. In the past 3 years, have you:	
a) had more than 1 moving violations while driving a motor vehicle?	<input type="radio"/> yes <input type="radio"/> no
b) flown as a private pilot, student pilot or crew member, or do you have plans to do so?	<input type="radio"/> yes <input type="radio"/> no
c) participated in SCUBA diving, sky diving, hang gliding, motor vehicle racing, mountain climbing, heli-skiing, back country skiing, extreme sports, or do you have plans to engage in these or any other hazardous activities?	<input type="radio"/> yes <input type="radio"/> no
11. a) Within the next 12 months, do you have any plans to travel outside of Canada, USA, Mexico, UK, Europe, or the Caribbean?	<input type="radio"/> yes <input type="radio"/> no
b) Do you have any plans to change your country of residency in the next 12 months?	<input type="radio"/> yes <input type="radio"/> no
12. Other than previously mentioned, have you ever been charged with any criminal offense, or are there any charges pending?	<input type="radio"/> yes <input type="radio"/> no
13. In the past 5 years, have you been off work for more than 2 weeks due to a medical condition or injury and/or have you applied for or received disability benefits?	<input type="radio"/> yes <input type="radio"/> no

6. DECLARATION, ACKNOWLEDGEMENT, AGREEMENT AND CONSENT

By signing below, I confirm that:

I have understood the questions asked above and I was present when the answers and statements were recorded.

I have reviewed the answers recorded and confirm them to be complete and true, to the best of my knowledge and belief, as of the date I signed below and in the event that any answers or statements recorded above contain a misrepresentation or non-disclosure of a material fact, Empire Life may void any policy issued based on my application.

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 (including medical information, but excluding genetic test information) 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.

I further understand Empire Life will not require Life Insureds to undergo a genetic test or provide any genetic test information as part of the application.

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

Signature of Life Insured

X

First name of Life Insured

Last name

Signature of witness

X

First name of witness

Last name

Signed at (city and province)

Date

d | d | - | m | m | m | - | y | y | y | y |

PARAMEDICAL cont'd

Name of Life Insured (first, middle, last)	Policy number
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To be completed by a Health Professional

1.	Height <input type="radio"/> ft/in <input type="radio"/> cm	Weight <input type="radio"/> lb <input type="radio"/> kg	Chest (male only) <input type="radio"/> in <input type="radio"/> cm	Abdomen (male only) <input type="radio"/> in <input type="radio"/> cm
Did you weigh? <input type="radio"/> yes <input type="radio"/> no Did you measure? <input type="radio"/> yes <input type="radio"/> no				
Has there been a significant weight change in the past 12 months? <input type="radio"/> yes <input type="radio"/> no				
2.	Blood pressure (sitting, without exercise):			
Systolic	1st reading:	2nd reading:	3rd reading:	
Diastolic	1st reading:	2nd reading:	3rd reading:	
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.	<input type="radio"/> Specimen has been sent to Dynacare laboratory.			
PLACE LAB BAR CODE STICKER HERE				
Female only: Is the proposed Life Insured menstruating? <input type="radio"/> yes <input type="radio"/> no				
5.	If the proposed Life Insured is age 70 or over, does he/she:			
a appear mentally alert? <input type="radio"/> yes <input type="radio"/> no				
b appear depressed? <input type="radio"/> yes <input type="radio"/> no				
c require assistance from another person to answer questions? <input type="radio"/> yes <input type="radio"/> no				
d have difficulty ambulating? Any falls in the past year? <input type="radio"/> yes <input type="radio"/> no				
Comments:				
6.	The Examiner must verify the Life Insured's identity by reviewing the original of one of these government-issued documents:			
<input type="radio"/> Passport <input type="radio"/> Driver's Licence (with photo and signature) <input type="radio"/> Provincial Health Card (except in MB, ON and PEI)				
<input type="radio"/> Other _____				
Place of issue		Document number		Expiry date (dd/mmm/yy)
Signature of Examiner X			Name of Examiner (please print)	
Name of paramedical company, city and 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.