EXAM BY M.D.

Policy number

1. LIFE INSURED

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 2.7.):

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	Weight	Weight change in last year
◯ ft/in ◯ cm	◯ lb ◯ kg	◯ 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, but do not provide any genetic test information. If unknown, indicate reason in Section 2.7.

• 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 2.7, but do not provide any genetic test information. Include date, diagnosis, treatment, results, duration and names, addresses of all medical advisors and medical facilities.

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: _____

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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 2.7 but do not provide any genetic test information. 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: _____

I) Cancer and Skin Disorders — ◯ yes ◯ no

- Tumour
- Polyp
- Cyst or lumps
- 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

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2.3 MEDICAL INFORMATION cont'd

Are you currently under treatment or taking medication, herbal, holistic or prescribed? **If yes, provide name, dosage and reason in Section 2.7.**	◯ yes ◯ no

2.4 MEDICAL INFORMATION cont'd

If you answer "YES" to any of the following questions, provide details, **including dates** in Section 2.7.

A) In the last 10 years have you used: • Cocaine • Hashish • Narcotics • Heroin • Excitants • Barbiturates • LSD • Hallucinogens • Tranquilizers, similar drugs or unprescribed drugs • Marijuana • Amphetamines	◯ yes ◯ no
B) Do you consume alcoholic beverages? **If yes, provide details below:**	◯ yes ◯ no

Beer _____ bottles per: ◯ day ◯ week ◯ month	Wine _____ 8 oz glasses per: ◯ day ◯ week ◯ month	Liquor _____ oz/ml per: ◯ 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? **If yes, provide dates of treatment and dates of convictions in Section 2.7.**	◯ yes ◯ no
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 2.7**	◯ yes ◯ no
E) Have you had any other moving traffic violations in the last 3 years? **If yes, provide details including type and dates in Section 2.7**	◯ yes ◯ no
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, 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 2.7.

A) In the last 5 years, have you had any injury or illness, surgery, been hospitalized, tested (excluding genetic tests) for or treated for anything not listed above?	◯ yes ◯ no
B) In the last 5 years (excluding genetic tests) 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 2.7.	◯ yes ◯ no

2.6 Answer the following questions if the Life Insured is age 75 or older, otherwise proceed to Section 2.7.

In the past 5 years or are you currently:

a) in need of home care such as a personal support worker or do you reside in a home for the aged, nursing home other facility or have been recommended to receive this type of care?	◯ yes ◯ no
b) unable to perform activities of daily living on your own, such as bathing, dressing, toileting, eating, transferring from bed to chair, or controlling bladder or bowel function?	◯ yes ◯ no
c) in need of any medical equipment such as a walker, wheelchair, cane, oxygen tank or any other device?	◯ yes ◯ no
d) Have you had a fall or injury in the past year?	◯ yes ◯ no

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2.7 DETAILS

Use this area to provide details of answers in Sections 2.1 - 2.6. Include diagnosis, treatment and results (excluding any genetic testing), dates, duration and names and addresses of all medical advisors/clinics and medical facilities. If more space is required, use the D-0057A Paramedical Additional Information Supplement form.

Question #	Details

3.0 SIGNATURES

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	Name of Life Insured (please print)
Signature of witness X	Name of witness (please print)
Signed at (city and province)	Date (dd/mmm/yy)

EXAM BY M.D. cont'd

Name of Life Insured	Policy number

To be completed by a Medical Examiner

1.

Height	Weight	Chest (male only)	Abdomen (male only)
○ ft/in ○ cm	○ lb ○ kg	○ in ○ cm	○ in ○ cm

Did you weigh? ○ yes ○ no Did you measure? ○ yes ○ no

Has there been a significant weight change in the past 12 months?
○ yes ○ 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. ○ **Specimen has been sent to Dynacare labratory**

PLACE LAB BAR CODE STICKER HERE

Female only: Is the proposed Life Insured menstruating? ○ yes ○ no

5. If the proposed Life Insured is age 70 or over, does he/she:

a appear mentally alert? ○ yes ○ no
b appear depressed? ○ yes ○ no
c require assistance from another person to answer questions? ○ yes ○ no
d have difficulty ambulating? Any falls in the past year? ○ yes ○ no

Comments:

6. The Examiner must verify the Life Insured's identity by reviewing the original of one of these government-issued documents:

○ Passport ○ Driver's Licence (with photo and signature)
○ Provincial Health Card (except in MB, ON and PEI)
○ Other _____

Place of issue	Document number	Expiry date (dd/mmm/yy)

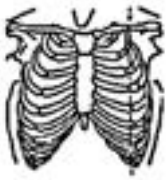
7. Heart – Is there any:

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 6
Murmur area by O
Point of greatest intensity by O
Transmission by →



8. 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 and hernias)?	○ 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

9.

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

Signature of Examiner
X

Name of Examiner (please print)

Name, city and province of paramedical facility

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.