EXAM BY M.D.

Policy number

1. Life Insured Information

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? What is your weight?	_____ ◯ cm ◯ ft/in _____ ◯ 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) Depression, anxiety disorder, post-traumatic stress disorder, bipolar disease, psychosis, eating disorder, been hospitalized for these or any other psychological/nervous disorders, and/or have you ever contemplated or attempted suicide?	◯ yes ◯ no
e) Diabetes, high blood sugar, sugar in the urine, or any disorder of the endocrine or thyroid glands?	◯ yes ◯ no
f) Blood clot, circulation disorder, peripheral vascular disease, high blood pressure, high cholesterol, swollen ankles or legs, anemia, hemophilia or any blood disorder?	◯ yes ◯ no
g) Multiple sclerosis, amyotrophic lateral sclerosis (ALS), muscle weakness, tingling or numbness of the extremities, or any motor neuron disease?	◯ yes ◯ no
h) Sleep apnea, emphysema, tuberculosis, asthma, chronic bronchitis, or any other lung disease or disorder?	◯ yes ◯ no
i) Hepatitis, hepatitis carrier, cirrhosis, pancreatitis, or any disorder of the liver, bladder, kidney, pancreas or gall bladder?	◯ yes ◯ no
j) 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
k) 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) 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

Empire Life®

EXAM BY M.D. cont'd

Policy number

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 :
- ◯ in past 12 months
- ◯ 12-24 months ago
- ◯ 2-15 yrs ago
- ◯ more than 15 yrs ago
- ◯ 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.

- ◯ less than 1
- ◯ 1-14 ◯ 15-21
- ◯ 22-28 ◯ 29-35
- ◯ more than 35
- ◯ 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?
Note: If yes, provide frequency of use (number of times per day/week/month). ◯ yes ◯ no

c) In the past 10 years have you been prescribed marijuana by a health care provider?
Note: If yes, provide frequency of use (number of times per day/week/month). ◯ yes ◯ 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? ◯ yes ◯ 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)? ◯ yes ◯ no ◯ unknown
If you answer "yes" to this question, provide details below, but do not provide any genetic test information.

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

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? ◯ yes ◯ no

10. In the past 3 years, have you:

a) had more than 1 moving violations while driving a motor vehicle? ◯ yes ◯ no

b) flown as a private pilot, student pilot or crew member, or do you have plans to do so? ◯ yes ◯ 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? ◯ yes ◯ no

11. a) Do you intend to travel outside of Canada or the United States in the next 12 months? ◯ yes ◯ no

b) Do you have any plans to change your country of residency in the next 12 months? ◯ yes ◯ no

12. Other than previously mentioned, have you ever been charged with any criminal offense, or are there any charges pending? ◯ yes ◯ 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? ◯ yes ◯ no

EXAM BY M.D. cont'd

Policy number

4. Personal Information (cont'd)

Answer the following questions if the Life Insured is age 75 or older, otherwise proceed to Section 5.

14. 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
15. Have you had a fall or injury in the past year?	◯ yes ◯ no

5. Additional Information

Use this section to provide details of the Health and Personal questions. 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.

Question #	Details

EXAM BY M.D. cont'd

Policy number

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

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):

	1st reading:	2nd reading:	3rd reading:
Systolic			
Diastolic			

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

3.

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

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)

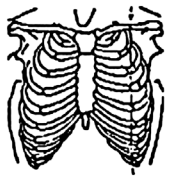
7. **Heart – Is there any:**

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.