

ADULT-FULL QUESTION SET

Policy number

Use this question set for adults insurance age 18+, applying for all amounts of insurance coverage.

| | | |
|----------------------------------|--------------------|---------------|
| First name of Life Insured 1 | Middle initial | Last name |
|----------------------------------|--------------------|---------------|

Date of birth of Life Insured 1: | d | d | - | m | m | m | - | y | y | y | y |

| | | |
|----------------------------------|--------------------|---------------|
| First name of Life Insured 2 | Middle initial | Last name |
|----------------------------------|--------------------|---------------|

Date of birth of Life Insured 2: | d | d | - | m | m | m | - | y | y | y | y |

Name and address of the personal physician/nurse practitioner for Life Insured 1

Name and address of the personal physician/nurse practitioner for Life Insured 2

| Health Information | Life Insured 1 | Life Insured 2 |
|--------------------|----------------|----------------|
|--------------------|----------------|----------------|

| | | |
|---|---------------------------|---------------------------|
| 1. I understand I must answer all questions truthfully. | <input type="radio"/> yes | <input type="radio"/> yes |
|---|---------------------------|---------------------------|

| | | |
|---|---|---|
| 2. What is your height? What is your weight? | _____ <input type="radio"/> cm <input type="radio"/> ft/in _____ <input type="radio"/> kg <input type="radio"/> lb | _____ <input type="radio"/> cm <input type="radio"/> ft/in _____ <input type="radio"/> kg <input type="radio"/> lb |
|---|---|---|

If you answer “yes” to any of the following questions, please provide details in the Additional Details 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| c) Cancer, tumour, polyp, cyst, growth, malignancy, dysplastic nevus syndrome or a mole that changed in appearance, colour or size? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| e) Diabetes, high blood sugar, sugar in the urine, or any disorder of the endocrine or thyroid glands? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| f) Blood clot, circulation disorder, peripheral vascular disease, high blood pressure, high cholesterol, swollen ankles or legs, anemia, hemophilia or any blood disorder? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| g) Multiple sclerosis, amyotrophic lateral sclerosis (ALS), muscle weakness, tingling or numbness of the extremities, or any motor neuron disease? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| h) Sleep apnea, emphysema, tuberculosis, asthma, chronic bronchitis, or any other lung disease or disorder? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| i) Hepatitis, hepatitis carrier, cirrhosis, pancreatitis, or any disorder of the liver, bladder, kidney, pancreas or gall bladder? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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)? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |
| k) Acquired Immunodeficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no |



| Health Information (cont'd) | Life Insured 1 | Life Insured 2 | | |
|--|--|--|----------------------|----------------------|
| 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no | | |
| b) Ulcer, ulcerative colitis, Crohn's disease, diverticulitis, intestinal or rectal bleeding, jaundice, or any disorder of the stomach, bowel or digestive system? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no | | |
| c) Chronic pain, chronic fatigue, fibromyalgia, or any injury of the back, spine, neck or musculoskeletal system? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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? | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> no | | |
| 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 | 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 and 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 | <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? Note: If yes, provide frequency of use (number of times per day/week/month). | <input type="radio"/> yes <input type="radio"/> no | <input type="radio"/> yes <input type="radio"/> 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). | <input type="radio"/> yes <input type="radio"/> no | <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 | <input type="radio"/> yes <input type="radio"/> no | | |
| Family History Information | Life Insured 1 | Life Insured 2 | | |
| 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 | <input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unknown | | |
| Related to: <input type="radio"/> Life Insured 1 <input type="radio"/> Life Insured 2 | | | | |
| Relationship to Insured | Illness (if cancer, indicate type) | Age at onset of illness | Age if living | Age at death |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Related to: <input type="radio"/> Life Insured 1 <input type="radio"/> Life Insured 2 | | | | |
| Relationship to Insured | Illness (if cancer, indicate type) | Age at onset of illness | Age if living | Age at death |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Related to: <input type="radio"/> Life Insured 1 <input type="radio"/> Life Insured 2 | | | | |
| Relationship to Insured | Illness (if cancer, indicate type) | Age at onset of illness | Age if living | Age at death |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

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 this application.

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

Signature of Life Insured 1

X

First name of Life Insured 1

Last name

Signature of Life Insured 2

X

First name of Life Insured 2

Last name

Signature of Owner (if not a Life Insured)

X

First name of Owner

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 |