

GROUP DEPENDANT CHILDREN'S HEALTH INFORMATION

Any reference to testing, tests, test results, or investigations, **excludes genetic tests.**

"Genetic test" means a test that analyzes DNA, RNA, or Chromosomes for purposes such as prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis and "Genetic testing" has a similar meaning. Do not provide any information about genetic tests in this application or on other questionnaires or forms.

Throughout this application, "Empire Life" means The Empire Life Insurance Company.

Please PRINT clearly and ensure all sections are completed.

1.0 Employee Information

Group Policyholder (company name)	Group policy number	Division number	Certificate number
Employee's name (first, middle, last)			
Address	City	Province	Postal code
Occupation	Personal and confidential e-mail (optional)		
Any further correspondence about this form should be sent to: <input type="radio"/> Home address <input type="radio"/> Work address			

1.1 Dependant(s) Information

To add more dependants, complete an additional Group Dependant Children's Health Information form (GB-0005).

Dependant's name (first, last)	Gender	Date of birth (dd/mmm/yy)	Height	Weight
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> ft/in <input type="radio"/> cm	<input type="radio"/> lb <input type="radio"/> kg
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> ft/in <input type="radio"/> cm	<input type="radio"/> lb <input type="radio"/> kg
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> ft/in <input type="radio"/> cm	<input type="radio"/> lb <input type="radio"/> kg

2.0 Personal Information

If more space required, complete an additional Group Dependant Children's Health Information form (GB-0005)

Do the dependant(s) have a regular physician/nurse practitioner? yes no If yes, please provide:

Physician/nurse practitioner's name (first, last)

Physician/nurse practitioner's address/telephone

Date of last visit (dd/mmm/yy)	Reason for visit: <input type="radio"/> Consultation/advice <input type="radio"/> Medication <input type="radio"/> Annual checkup <input type="radio"/> Treatment/therapy <input type="radio"/> Referral <input type="radio"/> Tests/investigations
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Have the dependant(s) seen any physician/nurse practitioner at a clinic or hospital other than the regular physician?
 yes no If yes, please provide:

Date of last visit (dd/mmm/yy)	Reason for visit: <input type="radio"/> Consultation/advice <input type="radio"/> Medication <input type="radio"/> Annual checkup <input type="radio"/> Treatment/therapy <input type="radio"/> Referral <input type="radio"/> Tests/investigations
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Details and results of last visit (include current medication, dosage, specialist, physician/nurse practitioner or health care person's name, type of treatment reason for referral, the ER.)

GROUP DEPENDANT CHILDREN'S HEALTH INFORMATION CONT'D

2.1 Medical Information

If you answer "yes" to any of the following, provide details in section 2.3. Include date(s) of events, duration, treatment, diagnosis, if resolved or continuing, date(s) and results of any testing (excluding genetic testing) and the names and addresses of all medical advisors and medical facilities.

A Have the dependant(s)' biological parents, grandparents, brothers or sisters, whether living or dead, ever suffered from any of the following conditions?

- | | | | |
|----------------------|------------------------|-------------------------------|------------|
| • Kidney disease | • Cystic fibrosis | • Any other inherited disease | ○ yes ○ no |
| • Muscular dystrophy | • Huntington's disease | | |

B Have the dependant(s) ever had been told they had, or received treatment or advice for any of the following?

- | | | | |
|---|------------------------------------|------------------------|------------|
| • Heart trouble | • Cancer, tumors, cysts or nodules | • Down's syndrome | ○ yes ○ no |
| • High blood pressure | • Benign brain tumor | • Kidney failure | |
| • Diabetes | • Blindness/Vision Loss | • Muscular dystrophy | |
| • Major organ disorder, transplant and/or failure | • Cerebral Palsy | • Paralysis | |
| • Mental or nervous conditions | • Cystic Fibrosis | • Spina bifida cystica | |
| • Rheumatoid arthritis | • Deafness/Hearing Loss | | |
| | • Crohn's disease | | |
| | | | |

C Have the dependant(s) ever had any physical, mental or developmental disorder not listed above? ○ yes ○ no

D For any dependant(s) under the age of 2: were the dependant(s) born prematurely (less than 35 weeks)? ○ yes ○ no ○ N/A

E Have the dependant(s) ever had any illness, injury or operation within the past 5 years? ○ yes ○ no

F Have the dependant(s) ever been counselled regarding weight or diet? ○ yes ○ no

G Are the dependant(s) currently under treatment or taking medication, herbal, holistic or prescribed? If yes, provide details in section 2.3. ○ yes ○ no

H Immunological Disorder

- | | |
|---|------------|
| • Any immunological disorder including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) | ○ yes ○ no |
| • Advised to or tested for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) | |
| • Unexplained infection | |

I Do the dependant(s) consume alcoholic beverages? (If yes, indicate quantity and frequency in section 2.3.) ○ yes ○ no

J Have the dependant(s) 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 ever been convicted of impaired driving or driving "over the legal limit" under s.253 (a) or (b) of the Criminal Code? ○ yes ○ no

K Have the dependant(s) ever used:

- | | | | |
|-------------|-----------------|---|------------|
| • Cocaine | • Hashish | • Narcotics | ○ yes ○ no |
| • Heroin | • Excitants | • Barbiturates | |
| • LSD | • Hallucinogens | • Tranquilizers | |
| • Marijuana | • Amphetamines | • Any other illicit drugs or drugs taken other than as prescribed | |
| | | | |

2.2 Additional Information

A Have the dependant(s) flown in the last 3 years as a pilot, student pilot or crew member (or intend to do so)? ○ yes ○ no

B Have the dependants, in the past 5 years, engaged in or plan to engage in any of the following: skin or scuba diving, mountain climbing, hang-gliding, heli-skiing, back-country skiing, CAT skiing, parachute jumping, ultralight aircraft flying; racing any motorized vehicle; or any other hazardous extreme sport or activity? ○ yes ○ no

C Have the dependant(s) ever had an application for life, critical illness or disability income insurance rated, restricted or declined? ○ yes ○ no

GROUP DEPENDANT CHILDREN'S HEALTH INFORMATION CONT'D

3.0 Declaration and Authorization (cont'd)

Collection:

I authorize Empire Life to collect Personal Information from any person or organization that has information relevant to this application and/or the employee's group benefits plan.

I authorize the following persons or organizations that have Personal Information to disclose such information to Empire Life:

- the employee's employer and the group plan administrator;
- the employee's employer's insurance broker and/or advisor (to the extent permitted by the employer);
- my doctor and other health professionals and practitioners (e.g. pharmacist dentists);
- hospitals, clinics, social service agencies and other similar agencies that have provided services to me;
- professional regulatory bodies (e.g. College of Pharmacists);
- investigative and government agencies (e.g. Canada Revenue Agency);
- other insurance companies with which I have or have had coverage;
- the MIB, Inc. (a cooperative data exchange formed by the life and health insurance industry); and
- third party service providers that provide services related to the benefit plan (e.g. payroll, enrolment, claims handling services, travel emergency assistance benefits providers, paramedical service providers).

I also authorize the collection of Personal Information by third party service providers for purposes of assessing this application and administering claims made by me, my dependants or my beneficiary(ies).

I understand that Empire Life will not require applicants to undergo a genetic test or provide any genetic test information as part of this application or any claim for benefits under the group benefits plan.

Use:

I authorize Empire Life to keep the Personal Information on file and use it for the following purposes:

- to assess this application, eligibility for coverage, and the nature and amounts of such coverage;
- to assess the risk on a continuing basis and consider whether to issue or renew a group policy of insurance under which I might be or become insured;
- to determine the premium payable for such insurance;
- to administer the group benefits plan, including conducting audits and investigations;
- to provide benefits and assess any claim(s) made by the employee, dependants, or beneficiary(ies); and
- to comply with applicable law.

Access/Disclosure:

I understand that:

- the Personal Information will be kept on file by Empire Life;
- authorized Empire Life employees, representatives, its reinsurers and third party service providers will have access to this file, for the purposes listed above;
- Personal Information may be exchanged with the persons and organizations listed above if required for the purposes listed above. However, specific details relating to medical conditions will not be disclosed to the employee's employer;
- in all cases, Empire Life restricts its collection, use, disclosure and retention of Personal Information to what is reasonably required for the purposes listed above;
- Empire Life may use third party service providers located inside or outside Canada to process and store the Personal Information; and
- I have the right to request access to the Personal Information in the file, as permitted or required by law, and, where appropriate, to have any inaccurate information corrected. I can access Empire Life's most recent Privacy Policy at www.empire.ca.

Other:

I understand:

- the statements in this application form part of the application in consideration for the insurance applied for; and
- the meaning and importance of all the questions asked on this application form, and agree that any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable; and
- the meaning of the statements contained in the Pre-Notice MIB, Inc. on the following page and I authorize Empire Life and the other parties referred to in the Pre-Notice to collect, use and disclose my Personal Information (including financial and medical information but excluding genetic test information) for the purposes set out in the Pre-Notice.

I certify that the information given in this and other supporting documents is true, full and complete.

A photocopy or electronic copy of this authorization will be as valid as the original.

4.0 Signatures

Signature of Employee

X

Employee name (print)

Signature of Dependant(s) or parent/legal guardian if minor(s)

X

City

Province

Date (dd/mmm/yy)

GROUP DEPENDANT CHILDREN'S HEALTH INFORMATION CONT'D

Please return to:

Empire Life
Group Medical Underwriting
Personal and Confidential
259 King Street East, Kingston, ON K7L 3A8
Group Customer Service: 1 800-267-0215 Fax: 1-888-220-2717
Email: groupmedicalunderwriting@empire.ca

Pre-Notice MIB, Inc.

Except as required by law, information regarding your insurability will be treated as confidential. Empire Life or its reinsurers may, however, make a brief report to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member for life, health or disability coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may contact MIB and seek a correction. The address of the bureau's information office is:

MIB, Inc.
330 University Avenue, Suite 501
Toronto ON M5G 1R7
Telephone (416) 597-0590
Website www.mib.com

Empire Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life, health or disability coverage, or to whom a claim for benefits may be submitted.

Please make a copy of this Pre-Notice and form for your records.

Insurance & Investments – Simple. Fast. Easy.®

www.empire.ca info@empire.ca

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