GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

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.

Reset Form

Name of Group Policyholder (Employer)

Name of Insured certificate holder (Employee)

1.0 Spousal Applicant Information

Name (first, middle, last)

Home address (number, street)		City	
Province	Postal code	Date of birth (dd/mmm/yyyy)	◯ Male ◯ Female
Height ◯ ft/in ◯ cm	Weight ◯ lb ◯ kg	Weight change in last year ◯ Gain ◯ Loss	◯ lb ◯ kg

Reason for weight change (if pregnant, provide due date)

Occupation

Personal and confidential phone number	Personal and confidential e-mail address

Any further correspondence about this form should be sent to: ◯ Home address ◯ Employee's work address

Do you authorize Empire Life to communicate with you by email regarding this application? ◯ yes ◯ no

2.0 Personal Information

Do you 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/yyyy)	Reason for visit: ◯ Consultation/advice ◯ Medication ◯ Annual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

Details and results of last visit (include current medication, dosage, specialist, physician or health care person's name, type of treatment, reason for referral, the ER.) (Additional space available in section 2.6):

In the last 12 months have you seen any physician/nurse practitioner at a clinic or hospital other than your regular physician?
◯ yes ◯ no If yes, please provide:

Date of last visit (dd/mmm/yyyy)	Reason for visit: ◯ Consultation/advice ◯ Medication ◯ Annual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

Details and results of last visit (include current medication, dosage, specialist, physician or health care person's name, type of treatment, reason for referral, the ER.) (Additional space available in section 2.6):

Empire Life

GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

2.1 Related Medical Information

If you answer "yes", complete section below for immediate family member. If unknown, indicate reason in section 2.6. Do not provide any genetic test information.

Have any of your biological parents, brothers or sisters, whether living or dead, ever suffered from any of the following conditions:

- Diabetes
- Cancer
- High blood pressure
- Stroke
- Heart disease
- Polycystic Kidney disease
- Aplastic anemia
- Kidney disorder
- Huntington's Chorea
- Dementia, including 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
- Progressive systemic Sclerosis
- Hepatitis
- Any other inherited disease or disorder

◯ yes ◯ no

Relationship	Illness - if cancer, indicate type	Age at onset of illness	Age if living	Age at death

2.2 Medical Information

If you answer "yes" to any of the following, provide details in section 2.6. 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.

Have you ever had, been told you had, or received treatment or advice for any of the following:

A Head & Respiratory Systems

◯ yes ◯ no

- Optic Neuritis
- Visual disturbance
- Blindness/Vision Loss
- Glaucoma
- Deafness/Hearing Loss
- 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 disease/disorder:

_____

B Neurological

◯ yes ◯ no

- Epilepsy or Seizures
- Fainting
- Headaches
- Dizziness
- Tremor
- Benign brain tumour
- Numbness or paralysis
- 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
- Loss of balance
- Loss of speech
- Cerebral Palsy
- Autism
- Developmental disorder
- Any other neurological disease/disorder:

_____

C Psychological

◯ yes ◯ no

- Anxiety
- Depression
- Bi-polar Disorder
- Stress
- Panic attacks
- Schizophrenia
- Mental impairment
- Burnout
- 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)
- Stroke
- Bypass or Angioplasty
- Abnormal ECG
- Irregular pulse
- Palpitations
- Heart murmur
- Pacemaker
- High blood pressure
- High cholesterol
- Enlarged heart (cardiomyopathy)
- Heart valve disorder
- Transient Ischemic Attack (TIA)
- Peripheral Vascular Disease
- Swollen ankles
- Blood clot
- Pulmonary embolism
- Primary pulmonary arterial hypertension
- Any other heart, blood vessel or circulatory system disease/disorder:

_____

GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

2.2 Medical Information (cont'd)

If you answer "yes" to any of the following, provide details in section 2.6. 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.

Have you ever had, been told you had, or received treatment or advice for any of the following:

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 stones or Gall bladder disorder
- Pancreatitis
- Kidney disease, stones or Nephritis
- Blood, protein or sugar in the urine
- Prostatitis
- Sexually transmitted disease
- Abnormal pap smear
- Abnormal PSA

Any other disease/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, MRI 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 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
- Progressive systemic sclerosis
- Any other spine, back/neck trouble, bone, joint or muscle injury, disease or disorder:

_____

I Cancer

◯ yes ◯ no

- Tumour
- Polyp
- Cyst
- Nodule
- Enlargement of the lymph nodes
- Dysplastic Nevi Syndrome
- Irregular shaped moles or lesions that have changed in appearance
- Basal Cell Carcinoma
- Malignant Melanoma
- Leukemia
- Lymphoma
- 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

2.3

Are you currently under treatment or taking medication, herbal, holistic or prescribed?
If yes, provide details in section 2.6.

◯ yes ◯ no

GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

2.4 If you answer "yes" to any of the following questions, provide details in section 2.6.

A Have you ever used: • Cocaine • Heroin • LSD • Marijuana • Hashish • Excitants • Hallucinogens • Amphetamines • Narcotics • Barbiturates • Tranquilizers • Any other illicit drugs or drugs taken other than as prescribed	◯ yes ◯ no
B Do you consume alcoholic beverages? If yes, provide details in section 2.6.	◯ yes ◯ no
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?	◯ yes ◯ no
D In the last 12 months, have you used: • Cigarettes • Cigarillos • e-cigarette • Large cigars • Small cigars • Chewing tobacco • Snuff • Nicotine substitues (including gum or patches) • Hashish • Marijuana • Betel nuts • Pipes	◯ yes ◯ no

2.5 Required Additional Information

If you answer "yes" to any of the following questions, provide details in section 2.6.

A Have you ever had any disorder, injury or illness, surgery, been hospitalized, tested for or treated for anything not listed above (excluding genetic testing)?	◯ yes ◯ no
B Have you ever had, or been advised to have, any consultation, medical exam or diagnostic test, such as MRI, CT scan, ECG, X-ray, or blood test (excluding genetic testing)?	◯ yes ◯ no
C Are you aware of any symptoms or complaints regarding your health for which a healthcare professional has not yet been consulted?	◯ yes ◯ no
D Have you ever been disabled or received disability income payments?	◯ yes ◯ no
E Are you currently pregnant? If yes, provide details of any complications in section 2.6.	◯ yes ◯ no
F Have you flown in the last 3 years as a pilot, student pilot or crew member (or do you intend to do so)?	◯ yes ◯ no
G Have you, in the past 5 years, engaged in or do you 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
H Have you ever had an application for life, critical illness or disability income insurance rated, restricted or declined?	◯ yes ◯ no
I In the last 5 years, have you been absent from work for 15 consecutive days for sickness or injury?	◯ yes ◯ no

2.6 Details

Use this section to provide details of the Medical Information questions, including date(s) of events, duration, treatment, diagnosis, if resolved or continuing, date(s) and result(s) of any testing (excluding genetic testing) and the names and addresses of all medical advisors and medical facilities.

Question #	Details

GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

3.0 Declaration and Authorization

Collection, Use and Access to My Personal Information

I (being the employee or spouse ("Dependant")) am applying for group benefits coverage with The Empire Life Insurance Company (Empire Life) and understand that Empire Life needs medical, financial, employment and other information about me in order to assess this application and/or the administration of the group benefits plan ("Personal Information").

If I am a spouse, I understand that the group benefits coverage is provided through the employee plan member and that Empire Life may exchange Personal Information with the employee.

The authorization below applies to the employee and spouse, as applicable.

Collection:

I authorize Empire Life to collect Personal Information from any person or organization that has information relevant to this application and/or the 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. pharmacists, 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 who 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 my 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:

- my Personal Information will be kept on file by Empire Life;
- access to my file is restricted to Empire Life employees, agents, representatives, reinsurers, third party service providers and other persons who require it to perform their duties, and to persons to whom I have granted access. Empire Life may store my personal information outside my province of residence but within Canada;
- Empire Life may also disclose my personal information to organizations outside my province of residence or outside Canada who process or store my personal information as part of their duties. Therefore, my personal information may be subject to the laws of other jurisdictions, which may allow disclosure to courts, law enforcement, or other government authorities of those jurisdictions under certain circumstances; and
- I can access a copy of the most recent privacy policy, by visiting the Empire Life website at www.empire.ca. I am entitled to consult my file and, when applicable, have it corrected. To exercise my rights, I must send written notification to: Chief Privacy Officer, The Empire Life Insurance Company, 259 King Street East, Kingston, ON K7L 3A8.

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 the declaration may render the 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.

GROUP SPOUSE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

4.0 Signatures

Signature of Spousal Applicant **X**	Date (dd/mmm/yyyy)
Signature of Employee **X**	Date (dd/mmm/yyyy)
Employee name (first, middle, last)	
City	Province

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, LLC

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 thereon to MIB, LLC (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance 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. Please contact MIB by emailing **Canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is :

MIB, LLC
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Empire Life or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com.**

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