

EMPIRE LIFE VITALS FORM

Policy number(s)

To be completed by a health professional.

Life Insured Information		
Life Insured first name	Last name	Date of birth (dd/mmm/yy)
The health professional must verify the Life Insured's identity by reviewing the original of one of these government-issued documents: <input type="radio"/> Passport <input type="radio"/> Driver's Licence (with photo and signature) <input type="radio"/> Other _____		
Place of issue	Document number	Expiry date (dd/mmm/yy)

Vital Statistics	
Height (without shoes) _____ <input type="radio"/> ft.in <input type="radio"/> cm	Weight (measured) _____ <input type="radio"/> lbs <input type="radio"/> kg

Blood Pressure Readings							
	1	2	3		1	2	3
Systolic				Diastolic			
Pulse rate (sitting at rest) _____ Was the pulse regular? <input type="radio"/> yes <input type="radio"/> no							
Was a large blood pressure cuff used? <input type="radio"/> yes <input type="radio"/> no							

Supplemental Information
In the last 12 months, have you used any of the following tobacco or nicotine products? <input type="radio"/> no <input type="radio"/> yes - specify the type: <input type="radio"/> cigarettes <input type="radio"/> e-cigarettes <input type="radio"/> cigarillos <input type="radio"/> pipes <input type="radio"/> chewing tobacco <input type="radio"/> snuff <input type="radio"/> marijuana <input type="radio"/> nicotine substitutes (including gum or patches) <input type="radio"/> betel nuts <input type="radio"/> small cigars <input type="radio"/> more than 12 large cigars
In the last 12 months, have you used any prescription medications? <input type="radio"/> yes <input type="radio"/> no - if yes, list the medications:
Specify if you have a personal history of any of the following: <input type="radio"/> high blood pressure <input type="radio"/> diabetes <input type="radio"/> heart disease <input type="radio"/> none

Health Professional Information		
Signature of health professional X	Name (please print clearly)	Date and time of data collection
Name of paramedical company	City and province	

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 the application with the number noted above (the "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 the Application. 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.	
Signature of Life Insured X	Date (dd/mmm/yy)

Fees are paid by cheque from Head Office. Please do not accept payment from any other source.

The completed form is to be forwarded in a sealed envelope to :

Empire Life
259 King Street East
Kingston ON K7L 3A8