

GROUP EMPLOYEE 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.

Name of Group Policyholder (Employer)

1.0 Employee Information

Name (first, middle, last)				
Home address (number, street)		City	Province	Postal code
<input type="radio"/> Male <input type="radio"/> Female	Date of birth (dd/mmm/yy)	Height <input type="radio"/> ft/in <input type="radio"/> cm	Weight <input type="radio"/> lb <input type="radio"/> kg	Weight change in last year <input type="radio"/> Gain <input type="radio"/> Loss
Reason for weight change (if pregnant, provide due date)			Occupation	
Are you currently actively at work performing all the usual duties of your job with your employer? <input type="radio"/> yes <input type="radio"/> no - if no, provide details in section 2.6.				
Personal and confidential phone number			Personal and confidential e-mail address	
Any further correspondence about this form should be sent to: <input type="radio"/> Home address <input type="radio"/> Work address				
Do you authorize Empire Life to communicate with you by email regarding this application? <input type="radio"/> yes <input type="radio"/> no				

2.0 Personal Information

Do you have a regular physician/nurse practitioner? <input type="radio"/> yes <input type="radio"/> 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
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? <input type="radio"/> yes <input type="radio"/> 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
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):	

GROUP EMPLOYEE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial
---------	------------	-----------------------------------

2.1 Related Medical Information

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

<ul style="list-style-type: none"> • Diabetes • Cancer (indicate type below) • High blood pressure • Stroke • Heart disease • Polycystic Kidney disease • Aplastic anemia 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Mental illness • Suicide • Multiple Sclerosis • Progressive systemic Sclerosis • Hepatitis • Any other inherited disease or disorder 	<input type="radio"/> yes <input type="radio"/> no
--	---	---	--

If you answer "yes," provide details below, but do not provide any genetic test information.

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

<ul style="list-style-type: none"> • Optic Neuritis • Visual disturbance • Blindness/Vision Loss • Glaucoma • Deafness/Hearing Loss • Tinnitus • Persistent hoarseness • Any other eye, ear, nose, throat or lung disease/disorder: _____ 	<ul style="list-style-type: none"> • Spitting of blood • Loss of speech • Sleep Apnea • Tuberculosis • Sarcoidosis • Cystic Fibrosis 	<ul style="list-style-type: none"> • Chronic Obstructive Pulmonary Disease (COPD) • Bronchitis • Asthma • Emphysema 	<input type="radio"/> yes <input type="radio"/> no
---	--	---	--

B Neurological

<ul style="list-style-type: none"> • Epilepsy or Seizures • Fainting • Headaches • Dizziness • Tremor • Benign brain tumour • Numbness or paralysis • Any other neurological disease/disorder: _____ 	<ul style="list-style-type: none"> • Parkinson's Disease • Motor Neuron Disease (Lou Gehrig's Disease/ALS) • Alzheimer's Disease • Cognitive impairment • Dementia • Weakness of the extremities 	<ul style="list-style-type: none"> • Muscle weakness • Multiple Sclerosis • Tingling • Loss of balance • Loss of speech • Cerebral Palsy • Autism • Developmental disorder 	<input type="radio"/> yes <input type="radio"/> no
--	--	--	--

C Psychological

<ul style="list-style-type: none"> • Anxiety • Depression • Bi-polar Disorder • Any other emotional, behavioral or psychiatric problem/disorder: _____ 	<ul style="list-style-type: none"> • Stress • Panic attacks • Schizophrenia • Mental impairment 	<ul style="list-style-type: none"> • Burnout • Attempted suicide or suicidal thoughts • Eating disorder 	<input type="radio"/> yes <input type="radio"/> no
--	---	--	--

D Heart & Circulatory System

<ul style="list-style-type: none"> • Chest pain • Angina • Shortness of breath • Heart attack (Myocardial Infarction) • Stroke • Bypass or Angioplasty • Abnormal ECG • Any other heart, blood vessel or circulatory system disease/disorder: _____ 	<ul style="list-style-type: none"> • Irregular pulse • Palpitations • Heart murmur • Pacemaker • High blood pressure • High cholesterol • Enlarged heart (cardiomyopathy) • Heart valve disorder 	<ul style="list-style-type: none"> • Transient Ischemic Attack (TIA) • Peripheral Vascular Disease • Swollen ankles • Blood clot • Pulmonary embolism • Primary pulmonary arterial hypertension 	<input type="radio"/> yes <input type="radio"/> no
---	--	---	--

GROUP EMPLOYEE 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

<ul style="list-style-type: none"> • Hepatitis • Hepatitis carrier • Cirrhosis • Jaundice • Ulcer • Irritable bowel • Crohn's Disease • Colitis 	<ul style="list-style-type: none"> • Diverticulitis • Bleeding from the rectum • Chronic diarrhea • Blood in the stool • Gall stones or Gall bladder disorder • Pancreatitis 	<ul style="list-style-type: none"> • Kidney disease, stones or Nephritis • Blood, protein or sugar in the urine • Prostatitis • Sexually transmitted disease • Abnormal pap smear • Abnormal PSA 	<input type="radio"/> yes <input type="radio"/> no
Any other disease/disorder of the: <ul style="list-style-type: none"> • Stomach • Pancreas • Liver Specify: _____	<ul style="list-style-type: none"> • Intestines • Kidneys • Bladder or Ureters 	<ul style="list-style-type: none"> • Prostate or male reproductive organs • Uterus, Ovaries or Cervix 	

F Breast (male or female)

<ul style="list-style-type: none"> • Abnormal biopsy, mammogram, MRI or breast ultrasound • Fibrocystic disease • Cysts or lumps • Any other breast changes or abnormalities: _____ 	<input type="radio"/> yes <input type="radio"/> no
---	--

G Blood, Glandular or Endocrine Systems

<ul style="list-style-type: none"> • Abnormalities of the Thyroid, Pituitary, Lymph or Adrenal glands • Goiter • Diabetes • Any other blood or glandular problem/disorder: _____ 	<ul style="list-style-type: none"> • Abnormal blood sugar • Anemia 	<ul style="list-style-type: none"> • Bleeding disorder • Hemophilia 	<input type="radio"/> yes <input type="radio"/> no
--	--	---	--

H Muscle & Skeletal Systems

<ul style="list-style-type: none"> • Rheumatism • Gout • Rheumatoid Arthritis • Osteoarthritis or any other type of Arthritis • Any other spine, back/neck trouble, bone, joint or muscle injury, disease or disorder: _____ 	<ul style="list-style-type: none"> • Fibromyalgia • Chronic fatigue • Chronic pain • Systemic Lupus Erythematosus (SLE) or Lupus in any form 	<ul style="list-style-type: none"> • Muscular Dystrophy • Paralysis • Amputation • Progressive systemic sclerosis 	<input type="radio"/> yes <input type="radio"/> no
---	--	---	--

I Cancer

<ul style="list-style-type: none"> • Tumour • Polyp • Cyst • Nodule • Enlargement of the lymph nodes • Any other form of malignant disease or growth: _____ 	<ul style="list-style-type: none"> • Dysplastic Nevi Syndrome • Irregular shaped moles or lesions that have changed in appearance 	<ul style="list-style-type: none"> • Basal Cell Carcinoma • Malignant Melanoma • Leukemia • Lymphoma 	<input type="radio"/> yes <input type="radio"/> no
---	---	--	--

J Immunological Disorder

<ul style="list-style-type: none"> • 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 	<input type="radio"/> yes <input type="radio"/> no
---	--

2.3 Are you currently under treatment or taking medication, herbal, holistic or prescribed? If yes, provide details in section 2.6. yes no

2.4 A Have you ever used: (If you answer "yes" to any of the following questions, provide details in section 2.6.)

<ul style="list-style-type: none"> • Cocaine • Heroin • LSD • Marijuana 	<ul style="list-style-type: none"> • Hashish • Excitants • Hallucinogens • Amphetamines 	<ul style="list-style-type: none"> • Narcotics • Barbiturates • Tranquilizers • Any other illicit drugs or drugs taken other than as prescribed 	<input type="radio"/> yes <input type="radio"/> no
---	---	---	--

B Do you consume alcoholic beverages? If yes, provide quantity and frequency in section 2.6. yes no

GROUP EMPLOYEE HEALTH INFORMATION

Group #	Division #	Employee last name, first initial
---------	------------	-----------------------------------

3.0 Declaration and Authorization

Collection, Use and Access to My Personal Information

I am applying for group benefits coverage to The Empire Life Insurance Company (Empire Life) and understand that Empire Life needs medical, financial, employment and other information about me relevant to my application and/or the administration of my group benefits plan ("Personal Information").

Collection:

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

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

- my employer and the group plan administrator;
- my employer's insurance broker and/or advisor (to the extent permitted by my employer);
- my doctor and other health professionals and practitioners (e.g. pharmacists, dentists);
- professional regulatory bodies (e.g. College of Pharmacists);
- hospitals, clinics, social service agencies and other similar agencies that have provided services to me;
- investigative and governmental 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 my 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 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 me, my dependants, or my 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 the 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 my 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 Personal Information. Personal information that is processed or stored outside Canada may be subject to the laws of the jurisdiction outside Canada where the information is processed or stored, which may allow disclosure to courts, law enforcement or other government authorities of that jurisdiction under certain circumstances; 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 Signature

Employee name (print)

Signature of Employee

X

City

Date (dd/mm/yy)

____ / ____ / 20____

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
E-mail: 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

® Registered trademark of The Empire Life Insurance Company. Policies are issued by The Empire Life Insurance Company.