GROUP DEPENDANT CHILD 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)

1.0 Employee Information

Name (first, middle, last)

Address	City	Province	Postal code

Occupation	Personal and confidential e-mail

Any further correspondence about this form should be sent to: ◯ Home address ◯ Work address

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

1.1 Dependant Information

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

Dependant's name (first, last)	◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)	Height ◯ ft/in ◯ cm	Weight ◯ lb ◯ kg

2.0 Personal Information

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

Does the dependant 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):

Has the dependant 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/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 DEPENDANT CHILD HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

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

• Kidney disease • Muscular dystrophy	• Cystic fibrosis • Huntington's disease	• Any other inherited disease	◯ yes ◯ no

B Has the dependant ever had, been told they had, or received treatment or advice for any of the following?

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

C Has the dependant ever had any physical, mental or developmental disorder not listed above?	◯ yes ◯ no
D If under the age of 2: was the dependant born prematurely (less than 35 weeks)?	◯ yes ◯ no ◯ N/A
E Has the dependant had any illness, injury or operation within the past 5 years?	◯ yes ◯ no
F Has the dependant ever been counselled regarding weight or diet?	◯ yes ◯ no
G Is the dependant 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) • Advised to or tested for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) • Unexplained infection	◯ yes ◯ no
I Does the dependant consume alcoholic beverages? (If yes, indicate quantity and frequency in section 2.3.)	◯ yes ◯ no
J Has the dependant 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 Has the dependant 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

2.2 Required Additional Information

A Has the dependant flown in the last 3 years as a pilot, student pilot or crew member (or intend to do so)?	◯ yes ◯ no
B Has the dependant, 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 Has the dependant ever had an application for life, critical illness or disability income insurance rated, restricted or declined?	◯ yes ◯ no

GROUP DEPENDANT CHILD HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

2.3 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

3.0 Declaration and Authorization

Collection, Use and Access to My Personal Information

I (being the employee, dependant child or the dependant child's parent/legal guardian acting on behalf of the dependant child) 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 and my dependant child in order to assess this application and/or the administration of the group benefits plan ("Personal Information").

If I am a dependant child or the dependant child's parent/legal guardian, acting on behalf of the dependant child, 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.

This authorization applies to the employee and dependant child (or the dependant child's parent/legal guardian acting on behalf of the dependant child), as applicable.

GROUP DEPENDANT CHILD HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

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, LLC (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:

- 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 **https://www.empire.ca/group-privacy-information**. 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 this declaration may render my coverage voidable; and
- the meaning of the statements contained in the Pre-Notice MIB, LLC 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 DEPENDANT CHILD HEALTH INFORMATION

Group #	Division #	Employee last name, first initial

4.0 Signatures

Signature of Employee **X**	Date (dd/mmm/yyyy)
Employee name (first, middle, last)	
Signature of Dependant or parent/legal guardian if a minor **X**	Date (dd/mmm/yyyy)
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.