GROUP EMPLOYEE HEALTH INFORMATION

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)	Group policy number	Division number	Certificate number

1. Employee Information

Name (first, middle, last)

Home address (number, street)	City

Province	Postal code	Date of birth (dd/mmm/yy)	◯ Male ◯ Female

Height	Weight	Weight change in last year	Reason (if pregnant, provide due date)
◯ ft/in ◯ cm	◯ lb ◯ kg	◯ Gain ◯ Loss ◯ lb ◯ kg	

Occupation

Personal and confidential phone number (optional)	Personal and confidential e-mail address (optional)

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

2. 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/yy)	Reason for visit: ◯ Consultation/advice ◯ Medication ◯ A nnual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

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/yy)	Reason for visit: ◯ Consultation/advice ◯ Medication ◯ A nnual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

Details and results (include current medication, dosage, specialist, physician or health care person's name, type of treatment reason for referral, the ER.)

2.1 Related Medical Information

If you answer "yes," complete section below for immediate family member. If unknown, indicate reason in section 2.6.

*If cancer, indicate type

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*	Age at onset of illness	Age if living	Age at death

Empire Life

GROUP EMPLOYEE HEALTH INFORMATION

Employee name

2.2 Medical Information

If you answer "yes" to any of the following questions, provide details in section 2.6. Include date, diagnosis, treatment, results, duration, current status and names, addresses of all medical advisors and medical facilities.

Have you ever had or been tested for, treated for, or told you may have 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: _____

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: _____

GROUP EMPLOYEE HEALTH INFORMATION

Employee name

2.2 Medical Information cont'd

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

Have you ever had or been tested for, treated for, or told you may have any of the following:

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

2.4

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

A Have you ever used: ◯ yes ◯ no

- Cocaine
- Heroin
- LSD
- Marijuana
- Hashish
- Excitants
- Hallucinogens
- Amphetamines
- Narcotics
- Barbiturates
- Tranquilizers
- Any other illicit drugs or drugs taken other than as prescribed

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: ◯ yes ◯ no

- Cigarettes
- Cigarillos
- Large cigars
- Small cigars
- Hashish
- Chewing tobacco
- Nicotine substitutes (including gum or patches)
- Snuff
- Marijuana
- Betel nuts
- Pipes

2.5 Additional Information

If you answer "yes" to questions A, B, C, D, E, F, G, H, I or J, provide details in section 2.6.

If you answer "no" to question D, 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? ◯ 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? ◯ yes ◯ no

C Are you aware of any symptoms or complaints regarding your health for which a health professional has not yet been consulted? ◯ yes ◯ no

D Are you currently actively at work performing all the usual duties of your job with your employer? ◯ yes ◯ no

E Have you ever been disabled or received disability income payments? ◯ yes ◯ no

F Are you currently pregnant? If yes, provide details of any complications in section 2.6. ◯ yes ◯ no

G 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

GROUP EMPLOYEE HEALTH INFORMATION

Employee name

2.5 Additional Information

H	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
I	Have you ever had an application for life, critical illness or disability income insurance rated, restricted or declined?	◯ yes ◯ no
J	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 area to provide details of answers in sections 2.1 - 2.5. Include diagnosis, treatment and results, dates, duration, current status and names and addresses of all medical advisors/clinics and medical facilities.

Question #	Details

GROUP EMPLOYEE HEALTH INFORMATION

3. 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).

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 and/or the group plan administrator;
- 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; 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 that:

- the statements in this application form part of the application in consideration for the insurance applied for; and
- I also understand and agree that any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable.

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. Signature

Signature of Employee X	Date (dd/mmm/yy)
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
E-mail: groupmedicalunderwriting@empire.ca