GROUP DEPENDANT CHILDREN'S 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

Employee's name (first, middle, last)			
Address	City	Province	Postal code
Occupation	Personal and confidential e-mail (optional)		

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

1.1 Dependant(s) Information

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

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

2.0 Personal Information

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

Do the dependant(s) have a regular physician? ◯ 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 ◯ Annual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

Have the dependant(s) 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/yy)	Reason for visit: ◯ Consultation/advice ◯ Medication ◯ Annual checkup ◯ Treatment/therapy ◯ Referral ◯ Tests/investigations

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

2.1 Medical Information

If you answer "yes" to any of the following questions, provide details in section 2 .3. Include date, diagnosis, treatment, results, duration, current status and names and addresses of all medical advisors and medical facilities.

A Have 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 Have the dependant(s) ever had or been tested for, treated for, or told they may have 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 Have the dependant(s) ever had any physical, mental or developmental disorder not listed above?	◯ yes ◯ no
D For any dependant(s) under the age of 2: were the dependant(s) born prematurely (less than 35 weeks)?	◯ yes ◯ no ◯ N/A
E Have the dependant(s) ever had any illness, injury or operation within the past 5 years?	◯ yes ◯ no

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Employee name

2.1 Medical Information cont'd

F Have the dependant(s) ever been counselled regarding weight or diet?	◯ yes ◯ no
G Are the dependant(s) 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 Do the dependant(s) consume alcoholic beverages? (If yes, indicate quantity and frequency in section 2.3.)	◯ yes ◯ no
J Have the dependant(s) 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 Have the dependant(s) 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 Additional Information

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

2.3 Details

Use this area to provide details of answers in sections 2.1 - 2.2. Include diagnosis, treatment and results, dates, duration, current status and names and addresses of all medical advisors/clinics and medical facilities.

Question #	Dependant name	Details

GROUP DEPENDANT CHILDREN'S HEALTH INFORMATION

3. 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(ren) 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.

The authorization below applies to the employee and dependant child(ren) (or the dependant child's parent/legal guardian acting on behalf of the dependant child), 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 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, Inc. (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).

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:

- 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 this 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 the employee's employer and/or 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 the 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

Signature of Dependant(s) or parent/legal guardian if minor(s)

X

City	Province	Date (dd/mmm/yy)

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