Equitable Life of Canada®

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STATEMENT OF HEALTH FOR GROUP INSURANCE (including Optional Life Coverage)

INCLUDED IN THIS APPLICATION

Section 1. Statement of Health for Group Insurance (including Optional Life Coverage)

Section 2. Statement of Health for Dependents Group Insurance

Section 3. Notice to applicants for insurance, Acknowledgement of Notice to application for insurance, applicant to be insured declaration and signatures.

COMPLETION OF THE APPLICATION

a) Make certain that **all questions** are answered clearly and completely to avoid delays in processing your application. If there is not enough room, please continue on an additional blank sheet.

b) Any misrepresentation or misstatement in the answers to these questions shall render any insurance issued in connection with this application voidable by The Equitable Life Insurance Company of Canada.

c) All applicants age 16 and over are to sign in the designated areas in Section 3.

d) Section 3 is to be detached and retained for your records – notice Regarding the Medical Information Bureau

Please complete sections 1 and 3 when applying for any of the following **Member Benefits:**

- Basic Life
- Accidental Death & Dismemberment
- Health
- Long Term Disability
- Short Term Disability
- Optional Life
- Spousal Optional Life

Please complete sections 2 and 3 when applying for either of the following **Dependent Benefits:**

- Dependent Life
- Dependent Health

Section 1 STATEMENT OF HEALTH FOR GROUP INSURANCE

I hereby apply for group insurance coverage for which The Equitable life Insurance Company of Canada requires satisfactory evidence of my insurability. I understand that the insurance coverage shall commence on the date that The Equitable Life of Canada has accepted me for such insurance.

Any misrepresentation or misstatement in the answers to these questions shall render any insurance issued in connection with this application voidable by The Equitable Life Insurance Company of Canada

Applicant (first name, last name)	Policyholder Name/Employer	Group Policy #.

Birth Date: Month Day Year	Place of Birth: Prov. Or State Country	Certificate #.

Preferred Contact

Residence

Address: _____ ❑

Telephone No. (_____) _____ ❑

Email Address _____ ❑

Business

Telephone No. (_____) _____ ext. _____ ❑

Email Address _____ ❑

1. Are you now actively at work on a full time basis? (30 hours per week) ❑ Yes ❑ No
   If no, give details including last day worked and anticipated date of return. _____

2. Height: ft._____ in. _____ cm _____ Weight: lbs._____ kg _____
   Weight changes past year? ❑ Yes ❑ No Amt. of Gain _____ Amt. of Loss _____
   Reason for weight changes: _____

3. Have you smoked any cigarettes or used any other tobacco or nicotine based products within the last 12 months? ❑ Yes ❑ No
   Products_____ Frequency _____ Date last used _____

4. Name & address of your usual medical practitioner: (IF NONE, STATE LAST PHYSICIAN CONTACT– i.e. CLINIC, EMERGENCY ROOM VISIT)

   _____

   Date last consulted:_____ Reason: _____

   Results/Diagnosis: _____ Treatment: _____
   (Include check-up results)

   Any follow-up advised: (e.g. tests, surgery, hospitalization) _____ ❑ Yes ❑ No
   (If yes, provide full details)

   _____

   _____

   _____

Please complete ALL questions below. For any "Yes" answers, provide all details including diagnosis, treatment dates, duration and complete names and addresses of ALL physicians and/or medical facilities below.

1. Has your driver's license ever been suspended and/or have you had 2 or more moving violations within the last year? (If yes, please provide details including current driver's license number) ❑ Yes ❑ No

_____

2. In the last 2 years have you or do you intend to:
a) Make any flights other than as a fare-paying passenger? ❑ Yes ❑ No

_____

b) Engage in a hazardous sport or hobby? (e.g. scuba diving, hang gliding, sky diving, motor racing mountain climbing or other) If scuba diving, complete questionnaire 2c below. Other _____ ❑ Yes ❑ No

2 c) Scuba Diving

Where do you dive? ❑ Inland Waters ❑ Ocean ❑ Other _____

Indicate if you participate in:
❑ Night Diving ❑ Salvage ❑ Wreck ❑ Caves ❑ Under Ice ❑ Search and Rescue ❑ Other _____

Frequency:_____ Location:_____ Date of Last Dive _____

Are you certified? ❑ Yes ❑ No Are you a member of an organized club? ❑ Yes ❑ No
Do you dive alone? ❑ Yes ❑ No

Dive Particulars	Past 12 months			Expected – next 12 months	
Depth of dive	Number of Dives	Average Time per dive		Number of Dives	Average Time per dive
0 – 75 feet					
76-100 feet					
Other – specify depth _____ ft					

3. Has any immediate family member (whether living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Mental Illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease?
(If yes, indicate family member, age at diagnosis and condition). ❑ Yes ❑ No

_____

_____

4. Within the past 5 years, have you received disability benefits from any source or missed 5 or more consecutive days from work due to illness or injury or had any company decline, modify, cancel or rescind any life, disability income or critical illness insurance? (If yes, please provide full details) ❑ Yes ❑ No

_____

_____

Have you ever had symptoms of, been treated for or been advised to receive treatment or have any investigations of any of the following:

5 . Heart Attack, Angina, Chest pain, Rheumatic Fever, Stroke, TIA, Elevated Blood Pressure – (include last Blood Pressure reading known and date) Cholesterol (include last known levels) Heart Murmur or other Heart or Blood Vessel disease or disorder? (If yes, please provide details) ❑ Yes ❑ No

_____

_____

_____

_____

6. Asthma, Respiratory, Sleep Apnea or other Lung disorder? ❑ Yes ❑ No
(If yes, complete Respiratory Questionnaire 6a below.)

6 a) Respiratory Disorder

Do you have a history of: ❑ Asthma ❑ Recurrent Bronchitis ❑ Emphysema ❑ Other _____

Date of first episode: _____ Date of last episode: _____ Frequency of episodes: _____

Do you consider severity of episodes ❑ Mild ❑ Moderate ❑ Severe

Have you ever been hospitalized or been seen in Emergency: ❑ Yes ❑ No (If "Yes", details)

_____

Have you ever undergone tests (Pulmonary Function Tests, Chest X-rays, other)? ❑ Yes ❑ No (If "Yes", details)

_____

Indicate all medications used (inhalers, oral, other):

	At time of flare-up	Maintenance Medications
Type		
Dosage		
Frequency		

7. Diabetes (include age at diagnosis, date and last known Hemoglobin (A1C), Colitis, Bowel Disorder, Hepatitis, or Hepatitis carrier state, Kidney, Bladder or Prostate, Gout or Urinary disorder, Blood or Endocrine abnormality? (If yes, please provide details) ❑ Yes ❑ No

_____

8. Any Visual or Hearing Impairment, Dizziness, Fainting, Convulsions, Stroke, Blurred Vision etc.? (If yes, please provide full details) ❑ Yes ❑ No

_____

9. Thyroid, or Glandular disorder, Lupus, Multiple Sclerosis, Amytrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Epilepsy, Muscle or Bone disorder? (If yes, please provide full details) ❑ Yes ❑ No

_____

10. Cancer, Tumour, Cyst, Polyp, Mole, Lump or other growth, Breast disorder or abnormal Mammogram or Ultrasound (include pathology results, malignant or benign). (If yes, please provide full details) ❑ Yes ❑ No

_____

11. Anxiety, Stress, Depression, Fatigue, Attempted Suicide, Nervous Breakdown, Eating Disorder, or other Nervous System disorder? (if yes, complete Nervous Disorder Questionnaire 11a below) ❑ Yes ❑ No

11 a) Nervous Disorder

Have you ever had any indication of the following:

Depression ❑ Yes ❑ No Eating Disorder ❑ Yes ❑ No Weight Loss ❑ Yes ❑ No

Insomnia ❑ Yes ❑ No Suicidal Thoughts/attempt ❑ Yes ❑ No Other e.g-anxiety, stress ❑ Yes ❑ No

(If yes, provide details) _____

When did you first consult a doctor/therapist and what was the diagnosis?

_____

Name of medications both prescription or non-prescription with dates, dosage and frequency:

_____

Have you ever been hospitalized or seen in Emergency? ❑ Yes ❑ No If "Yes", details:

_____

Are your symptoms: ❑ Resolved ❑ Unchanged ❑ Less Severe ❑ More Severe

Any time off work? ❑ Yes ❑ No If "Yes" details:

_____

Describe any current symptoms:

_____

12. The Skin, Muscles, Bones and Joints, e.g. Arthritis, Back or Neck pain, Paralysis, Deformity, unusual Skin Lesions or unexplained Infections. (If yes, complete Pain Questionnaire 12a if applicable). ❑ Yes ❑ No

12 a) Pain Questionnaire ❑ Headaches ❑ Back ❑ Neck ❑ Arthritis ❑ Other Pain Disorder

Location of Pain _____ Radiating to (if applicable) _____

Duration of Pain _____

First Episode _____ Most recent Episode _____ How often does pain occur _____

Longest duration of discomfort _____

If back or neck involved check box: ❑ Neck (Cervical) ❑ Middle (Thoracic) ❑ Low (Lumbo sacral)

Diagnosis/Cause: _____

Name(s) of doctor(s) consulted with dates and full addresses:

_____

_____

1. History of medications (list names, dates, dosage and frequency of use): ❑ Yes ❑ No
2. History of treatment (i.e. physiotherapy, massage)? ❑ Yes ❑ No
3. Have you been advised to undergo any tests, investigations or surgery? ❑ Yes ❑ No
4. Have you ever been hospitalized, unable to work or restricted? ❑ Yes ❑ No
5. Do you have associated symptoms or signs? ❑ Yes ❑ No

If yes, provide full details

_____

_____

13. a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder? (If yes, please provide details) ❑ Yes ❑ No

_____

b) Have you ever had a positive test result indicating exposure to the AIDS Virus (Positive HIV)? (If yes, please provide details) ❑ Yes ❑ No

_____

c) Within the past 5 years, have you had any indication of a sexually transmitted disease? (If yes, please provide details) ❑ Yes ❑ No

_____

14. Do you regularly take any medication? (If yes, specify type, dosage, when and by whom prescribed, if not previously indicated on this form) ❑ Yes ❑ No

_____

15. Do you have any symptoms or are you aware of any problems for which you have not yet consulted a doctor or other health practitioner, or that has not already been listed above? (If yes, please provide details) ❑ Yes ❑ No

_____

16. a) Do you drink alcoholic beverages and/or used marijuana, cocaine or any illegal or addictive drugs? (If yes, complete Alcohol and Drug use questionnaire 16d) ❑ Yes ❑ No

b) Have you ever received advice or treatment pertaining to your use of alcohol? (If yes, complete Alcohol and Drug Use questionnaire 16d). ❑ Yes ❑ No

c). Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs? (If yes, complete Alcohol and Drug Use questionnaire 16 d). ❑ Yes ❑ No

16 d) Alcohol and Drug Use

1) Alcohol ❑ Yes ❑ No
2) Cocaine (includes Crack) ❑ Yes ❑ No
3) Marijuana and/or Hashish ❑ Yes ❑ No
4) Amphetamines (Ecstasy etc) ❑ Yes ❑ No
5) Barbiturates type:_____ ❑ Yes ❑ No
6) Heroin, Morphine, Demerol, Methadone ❑ Yes ❑ No
7) Hallucinogens (LSD) ❑ Yes ❑ No
8) Other similar narcotics ❑ Yes ❑ No

Give details regarding "Yes" answers: ("TYPE" REFERS TO ALCOHOL AND/OR DRUGS)

	Type	Daily Amount	Type	Weekly Amount	Type	Monthly Amount
Use at Present						
Previous 1-2 yrs.						
Previous 3-5 Yrs.						
Other (include dates)						

Have you been treated for or joined an organization (i.e. AA) for alcoholism or drug use? ❑ Yes ❑ No
Have you ever been advised to reduce consumption of alcohol and/or drugs? ❑ Yes ❑ No

If yes, please provide details:

_____
_____
_____
_____

Section 2 STATEMENT OF HEALTH FOR DEPENDENTS

If coverage for Dependent is not required please proceed to Section 3 Legal Information

I hereby apply for Dependent group insurance for which The Equitable Life Insurance company of Canada requires satisfactory evidence of insurability of my Dependents. I understand that the Dependent insurance coverage shall commence only after The Equitable Life has accepted my Dependents, as listed below, for such insurance. I understand if this is a late application the Dental coverage (if applicable) will be restricted.

Plan Member: (e.g - employee) _____ _____
First Name Last Name

Policyholder: _____ Policy No. _____

Certificate No. _____

Complete the following information for all Dependents TO BE INSURED

Name of Dependent	Relationship to Plan member	Birthdate			Sex	Height	Weight	Name and address of doctor
		MM	DD	YY				
1.								
2.								
3.								
4.								

1. Has any application for Life Insurance on any of the Dependents been declined, postponed or modified in any way? ❑ Yes ❑ No
2. Do any of the Dependents have any **physical or mental** impairment or have they had **any illness, impairment or injury** that has required treatment, surgery, and/or hospitalization? ❑ Yes ❑ No
3. Are any of the Dependents on **medication or medical treatment of any kind** or has any treatment or diagnostic test been advised that has not been completed? ❑ Yes ❑ No
4. Do any of the Dependents to be insured NOT live with the employee? Please state below place of residence, date last seen and frequency of visits. ❑ Yes ❑ No

If yes to any of the above questions provided full details.

Dependent	Question #	Date	Reason for consultation	Diagnosis and Treatment

Additional Information:

_____

_____

_____

_____

_____

Please provide information for contact if further details are required: i.e. telephone number, email address etc.

Section 3 LEGAL INFORMATION

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER, DECLARE, AGREE AND CERTIFY THAT:

1. All the statements, information and answers provided in all sections of this Application are true, complete, accurate and correctly recorded.
2. The personal information willingly provided by the member to the member's employer, the independent broker/sales advisor and The Equitable Life Insurance Company of Canada (Equitable), collected on this Application and held in their files, will be used by Equitable for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Policy and all benefits under the Policy, and any supplementary documents. The member understands and authorizes that for the above purposes the personal information on file is accessible to and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable, participating reinsurer(s), other insurance companies, investigative parties, health care providers, including, but not limited to pharmacies, physicians and dentists, and any other person or party whom the member authorizes. If applying for the member's spouse and/or dependents, the member confirms that the member is authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. The member understands that all claims made under the Policy are submitted through the member as insured plan member. The member therefore authorizes Equitable to exchange information about these claims with the member or any person acting on the member's behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing a claim.

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER:

1. Agree that the insurance being applied for in this Application or such insurance as issued by Equitable shall not take effect until the first premium for the insurance coverage has been paid by the plan sponsor .
2. Acknowledge receiving the Notice regarding the Medical Information Bureau and authorize Equitable to obtain information from the Medical Information Bureau;
3. Authorize Equitable to perform all tests, including, without limitation, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this Application. Such tests may include tests to determine the presence of various diseases including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS). Equitable may disclose to its reinsurer(s), your attending physician(s), health service providers, and the Medical Information Bureau, the results of all such tests and personal information necessary to fulfill any of the identified purposes in this Application. I/we understand and agree that any positive results for HIV, hepatitis, or any other communicable diseases will be reported to the appropriate Public Health Authority. Your personal information collected by the testing facility may be processed and stored by such facility in Canada and/or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
4. Authorize the Motor Vehicle Division in any province requiring such authorization to permit Equitable or any investigative agency on behalf of Equitable, to be given a copy of all driving record information relevant to this Application.
5. Authorize any physician, practitioner, hospital, clinic, or other medical-related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any record or knowledge of the person(s) this insurance is applied for, or their health, to give full particulars of such information, including any prior medical history, to Equitable or its reinsurers.
6. Agree that this Application may be transmitted to Equitable electronically and received by Equitable as the Applicant's original application for insurance.
7. A photostatic copy of these authorizations shall be as valid as the original.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT MEMBER'S KNOWLEDGE AND WITHIN THE KNOWLEDGE OF THE PERSON(S) AGED 16 YEARS OR OLDER, THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY AND HEALTH OF ALL PERSON(S) TO BE INSURED OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY EQUITABLE.

Signed at _____ this _____ day of _____ 20 _____

Signature of Member (Employee)	Witness
Signature of Spouse of Member (when applicable)	Witness
Signature of Dependent Child(ren) (when applicable) age 16 or older	Witness

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU – **Please read carefully and detach for your records.**

Information regarding the insurability of the Person(s) to be Insured with be treated as confidential. We, or our reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another Bureau member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau 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 the Bureau and seek a correction. The address of the Bureau's Information Office is 330 University Avenue, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590.

We or our reinsurer(s) may also release information in our file to other Life Insurance Companies to whom a Person to be Insured may apply for life, critical illness or health insurance, or to whom a claim for benefits may be submitted.

Equitable Life of Canada®