Fill this form on screen

MEDAVIE BLUE CROSS™

EVIDENCE OF HEALTH – GROUP INSURANCE

NOTICE: Any incomplete request or unanswered question shall delay the study of your file.

Ⓐ CONTRACT NO.	SECTION NO	IDENTIFICATION NO.

Ⓑ SUBSCRIBER

NAME: | PLACE OF BIRTH:

GIVEN NAME: | OCCUPATION:

ADDRESS No. Street Apt.

City Province Postal Code

TEL.: HOME: OFF.:

SOCIAL INSURANCE NUMBER | DATE OF BIRTH Day Month Year

HEIGHT ft. in./cm	PRESENT WEIGHT lb./kilo	SEX	AGE
		☐ M ☐ F	

Ⓒ PLEASE COMPLETE IF THE INSURANCE REQUESTED IS FOR DEPENDENTS

SPOUSE

NAME: | PLACE OF BIRTH:

GIVEN NAME: | OCCUPATION:

SEX: ☐ M ☐ F | DATE OF BIRTH Day Month Year | AGE | HEIGHT ft. in./cm | PRESENT WEIGHT lb./kilo

CHILD / CHILDREN

NAME	GIVEN NAME	SEX M	SEX F	DATE OF BIRTH Day	Month	Year	AGE	HEIGHT ft. in./cm	PRESENT WEIGHT lb./kilo
		☐	☐						
		☐	☐						
		☐	☐						

FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION H.

Ⓓ IN YOUR LIFETIME, HAVE YOU BEEN TREATED FOR, OR SHOWN SYMPTOMS OF THE FOLLOWING DISEASES?	SUBSCRIBER Yes	SUBSCRIBER No	DEPENDENT/S Yes	DEPENDENT/S No
1. **Cardiovascular system**: Chest pain, palpitations, high blood pressure, acute rheumatoid arthritis, heart murmur, heart seizure, or any impairment of the heart or blood vessels.	☐	☐	☐	☐
2. **Respiratory system**: Asthma, chronic bronchitis, spitting of blood, tuberculosis, emphysema or any impairment of the respiratory system.	☐	☐	☐	☐
3. **Digestive system**: Colitis, ulcer, bleeding from stomach or bowel, or other impairment of the stomach, gall-bladder, liver (hepatitis, cirrhosis), or the intestines.	☐	☐	☐	☐
4. **Genito-urinary system:** Sugar, albumine, blood or pus in the urine, or any impairment of the kidneys, bladder, prostate or reproductive organs.	☐	☐	☐	☐
5. **Endocrine system:** Diabetes, impairment of the thyroid or any other impairment of endocrine system.	☐	☐	☐	☐
6. **Musculo-skeletal system**: Rheumatism, arthritis, gout, muscle or bone disease including spinal chord, back and joints.	☐	☐	☐	☐
7. **Nervous system:** Convulsions, epilepsy, cephalea, paralysis, degenerative disease, depression or other mental or nervous disorder.	☐	☐	☐	☐
8. **Immunological system:** Have you ever had or been told that you had one of the following ailment, or have you undergone tests or received medical counsel for these:				
a) AIDS (Acquired Immune Deficiency Syndrome), Para-AIDS (ARC) or any other immunological disorder?	☐	☐	☐	☐
b) Hypertrophy of lymphatic ganglions (glands), chronic diarrhea, less common or persistent lesions, infections of unknown origins?	☐	☐	☐	☐
9. **General:** Alcohol or drug abuse, anemia or other blood disease, cyst, tumor, cancer, or other physical or mental disorder not mentioned previously.	☐	☐	☐	☐

Ⓔ DETAILS OF "YES" ANSWERS

Question number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in an outpatient clinic or in a doctor's office.

MEDAVIE BLUE CROSS™

AUTHORIZATION

PLEASE DO NOT DETACH

01COL0131A (Rev.: 03-06)

PERSONAL INFORMATION REPORT AND EXCHANGE NOTICE

DETACH AND GIVE TO THE SUBSCRIBER

FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION G.

(F) WITHIN THE PAST 5 YEARS, HAVE YOU:

	SUBSCRIBER		DEPENDENT/S	
	Yes	No	Yes	No
1. Consulted, or been examined or treated by a physician or other practitioner?	☐	☐	☐	☐
2. Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐	☐	☐
3. Been submitted to an electrocardiogram?	☐	☐	☐	☐
4. Been submitted to a chest x-ray?	☐	☐	☐	☐
5. Been submitted to laboratory tests or other tests for diagnostic purposes?	☐	☐	☐	☐
6. Requested or received a pension for disability or injury?	☐	☐	☐	☐
7. Been advised to submit to an examination, hospitalization or operation which has not yet taken place?	☐	☐	☐	☐

(G) DETAILS OF "YES" ANSWERS OF SECTION F

Question number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in an outpatient clinic or in a doctor's office.

(H) AT PRESENT:

	SUBSCRIBER		DEPENDENT/S	
	Yes	No	Yes	No
1. Are you under medical treatment?	☐	☐	☐	☐
2. Name and address of physician who has your medical records.				
3. Are you taking any drugs?	☐	☐	☐	☐
4. If yes, name of medication, strength, daily dosage and how long you have been using them.				

(I) 1. Do you or did you ever smoke cigarettes, cigars, pipe, alcoholic beverages, narcotics or other drugs? ☐ Yes ☐ No

If yes, indicate the quantity per week	Cigarettes		Cigars		Pipe		Alcoholic beverages		Narcotics of other drugs	
	Now	In the past	Now	In the past	Now	In the past	Now	In the past	Now	In the past
SUBSCRIBER										
DEPENDENTS										

2. If it is the case, give the date on which you have stopped smoking:

(J) ADDITIONAL REMARKS

(K) DECLARATION

I, the undersigned, hereby declare that I have read all of the above questions and that the answers and explanations given have been accurately reproduced. Moreover, I agree that they form the basis of the contract applied for. I certify having received and read the Personal Information Report and Exchange Notice.

Signature of witness _____ Date _____ Signature of subscriber _____

PLEASE COMPLETE THIS SECTION AT ALL TIMES

A photocopy of this authorization is as valid as the original

AUTHORIZATION

I/We hereby authorize any licensed physician, surgeon, medical practitioner, hospital, institution, clinic or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (M.I.B.), any other organization, institution or person that currently possesses or may have any records or knowledge of my health or of the health of my spouse or any of my children to give such information in full to Blue Cross Group Benefits and Blue Cross Life Insurance Company of Canada or its reinsurers upon request, and I hereby expressly waive, in my name and on behalf of any other person having or claiming any interest in any policy issued, reinstated or amended following any statement made hereby, any right to invoke any legal provision forbidding such licensed physician, surgeon, medical practitioner, hospital, institution, clinic or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau, or any other person to give such records or information.

Signature of witness _____ Date _____ Signature of subscriber _____

PERSONAL INFORMATION REPORT AND EXCHANGE NOTICE

The main objective of Medavie Blue Cross and Blue Cross Life Insurance Company of Canada is to offer its customers financial security at the lowest possible cost. In order to meet this objective in a manner that is fair and equitable towards all its policyholders, the Company must assess the risk involved in each application received.

The examination of your application shall be made on the basis of information from various sources such as: data which you have supplied in your medical history, findings of any medical examination and any analysis deemed necessary, reports from physicians having attended you, hospitals where you have been confined, as well as information on the subscriber's character, financial reputation, personal characteristics and mode of living.

All information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report of such information to the Medical Information Bureau (M.I.B.), a non-profit organization made of life insurance companies, which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, the M.I.B. will supply such company with whatever information it may have concerning you.

Should you so request, the M.I.B. will arrange disclosure of any information it may have concerning you. If you question the accuracy of any information in your file, you may contact the M.I.B. and seek a correction at the following address:

MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, SUITE 501, TORONTO (ONTARIO) M5G 1R7, TELEPHONE: (416) 597-0590, FAX: (416) 597-1193

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.