encon

# Critical Illness Insurance Application

## Section 1 Employee Information

**Please print clearly**

| Name of Employer | | | Client No. | |
|---|---|---|---|---|
| Employer's Address | | | | |
| Name of Employee | | | | |
| Employee's Address | | | | |
| Home Telephone | Work Telephone | Email | Occupation | |
| ❑ Male<br>❑ Female | Date of Birth (yyyy/mm/dd) | Place of Birth (City and Country) | Height (ft.in.) | Weight (lbs.) |
| Are you a late applicant? ❑ Yes ❑ No | | If yes, please provide the reason for late application | | |
| Regular Physician or Family Doctor Name and Address | | | | |
| Date and Reason You Last Consulted Any Doctor | | | | |
| Diagnosis, Treatment or Medication Prescribed | | | | |

## Section 2 Applicant Questions

Have any of your natural parents, brothers or sisters ever suffered from any of the following conditions: heart condition, stroke, polycystic kidney disease, cancer (if yes, specify type), diabetes, Alzheimer's, Parkinson's, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntingdon's Chorea, nervous or mental disorder, or any other hereditary disease? If yes, please complete the following table. ❑ Yes ❑ No

| Person to whom it applies | Condition | Age at onset / diagnosis | Age at death (if applicable) |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers/Sisters | | | |

| Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application. | Yes | No |
|---|---|---|
| 1. Have you smoked any cigarettes, cigars, cigarillos, pipe or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the past 12 months? | ❑ | ❑ |
| 2. Have you flown as a pilot, student or crew member in the last two years, or do you have any intention to do so? | ❑ | ❑ |
| 3. Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity? | ❑ | ❑ |
| 4. Do you intend to travel or reside outside Canada or the United States for more than a month? If yes, please provide details. | ❑ | ❑ |
| 5. Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way? If yes, please provide details. | ❑ | ❑ |
| 6. Are you now actively engaged in your occupation on a full-time basis? If no, please provide details, including why you are not working on a full-time basis. | ❑ | ❑ |
| 7. Have you ever had or ever been treated for cancer, tumour, cyst, polyp or other growth, moles, anemia, blood disorder or any form of malignant disease? Any immune system abnormality including AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, enlargement of lymph glands, unusual skin lesions or unexplained infections? | ❑ | ❑ |
| 8. Have you ever had or have you ever been treated for chest pain, angina, heart attack, high blood pressure, abnormal ECG, stroke, paralysis, transient ischemic attack (TIA), elevated cholesterol or other disorders of the heart, blood vessels or circulatory system? Diabetes, pancreatitis, thyroid or other endocrine disorder? Lung or other respiratory disease or disorder? Any disorder of the eyes (excluding near or far sightedness), ears, vocal chords or larynx, including loss of speech? | ❑ | ❑ |
| 9. Have you ever been treated for or diagnosed with kidney, bladder, prostate (including an elevated PSA test result) or breast disorder (including cysts, lumps, biopsy or abnormal mammogram or ultrasound) or other genitourinary disorder, hepatitis B or C (including carrier), cirrhosis or other liver disorder, ulcerative colitis, Crohn's disease or other disorder of the gastrointestinal tract? | ❑ | ❑ |
| 10. Have you ever had or have you ever been treated for dizziness, seizures, epilepsy, tremor, multiple sclerosis, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS), stress, anxiety, depression or other mental or neurological disorder? Disease or disorder of muscles, ligaments, tendons, bones or joints, including but not limited to arthritis, lupus in any form, amputation or deformity? | ❑ | ❑ |
| 11. Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines or any other drug or narcotic, except for as prescribed by your physician? | ❑ | ❑ |
| 12. a. Do you presently drink more than 10 alcoholic beverages per week? If yes, state number, kind and frequency. | ❑ | ❑ |
| b. Have you ever received advice or treatment for, or attended any rehabilitation program for alcohol or drug use? | ❑ | ❑ |
| 13. Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done? | ❑ | ❑ |
| 14. Are you taking any prescribed medication? If yes, state name of medication and reason for use. | ❑ | ❑ |

**Continued on the back**

## Section 2 Applicant Questions (continued)

**Please print clearly**

| Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application. | **Yes** | **No** |
|---|---|---|
| 15. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment? | ❑ | ❑ |
| 16. Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury? | ❑ | ❑ |
| 17. Has there been a variation in your weight in the past year? If yes, state number of pounds/kilograms gained or lost and cause. | ❑ | ❑ |
| 18. Females only: Are you pregnant or have you ever had complications of pregnancy? If pregnant, what is your estimated date of delivery? | ❑ | ❑ |
| 19. During the past 10 years, have you consulted a physician, received treatment or been hospitalized, had surgery or any test (other than routine checkup or minor injury) for any disease, disorder or ailment not already mentioned? | ❑ | ❑ |
| 20. Have you ever received or claimed benefits or a pension for sickness, injury or impairment? | ❑ | ❑ |
| 21. Have you been convicted of a criminal offense, had your driver's license suspended or, within the past three years, been convicted of more than three traffic violations? | ❑ | ❑ |

## Section 3 For every "Yes" answer given above, please provide full details

| Question No. | Nature of disorder | Date of first occurrence | Current status and treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Section 4 Important Notice (Please retain a copy for your records)

**Medical Information Bureau**

Information regarding your insurability will be treated as confidential. Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP"), its reinsurers and ENCON Group Inc. 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 you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply that company with the information it may have in its files.

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: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7, telephone number 416-597-0590.

IAP 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.

## Section 5 Declaration and Authorization

I authorize:

a) any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, any insurance plan sponsor, any agent, broker or market intermediary, any third party administrator, any personal information agents or professional investigation agencies and any government agency, or other organization, institution or person that has any records or knowledge of me or my health, to give to Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP"), its reinsurers or ENCON Group Inc. ("ENCON") any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) IAP, its reinsurers or ENCON to release and exchange any personal information obtained to the above persons and organizations for the purposes of assessment of this application, the administration of any certificate issued and the investigation of any claim.

c) IAP to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing me as an insurance risk. This analysis includes testing for HIV infection.

d) IAP to release any abnormal test results to my personal physician.

I understand that IAP, ENCON, their employees and service providers are subject to strict standards and policies to ensure that my personal information is secure and remains confidential. I understand that IAP and ENCON do not sell, lease, or trade personal information, and that any personal information collected by IAP and ENCON will be kept strictly confidential and is to be used by authorized individuals only. Authorized individuals include employees, agents, or representatives of IAP and ENCON in the performance of their job, persons whom I have authorized, or persons permitted by law to use my personal information. I understand that I have the right to request and receive a copy of my personal information maintained by IAP and ENCON at any time. However, I also acknowledge that where medical information has been provided to IAP through a third party, IAP will release that information to me only through my physician. Further information on IAP's and ENCON's privacy practices can be found at www.iaplife.com and www.encon.ca respectively.

I confirm that the foregoing answers, forming part of an application for Critical Illness insurance to IAP are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. I understand that any coverage arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application or if there is any change in my insurability between the date of this application and the effective date of coverage. I acknowledge that it is my responsibility to notify IAP of any change in my health or insurability. I agree that my insurance will not take effect until my properly completed application has been approved by IAP.

I confirm that I have read and understand the notice in Section 4 regarding the Medical Information Bureau.

A copy of this authorization shall be as valid as the original.

*Please sign here*

Employee Signature | Date (yyyy/mm/dd)