RWAM Insurance Administrators Inc.
49 Industrial Drive
Elmira, Ontario N3B 3B1

# GROUP HEALTH EVIDENCE FORM

Group # _____

Div # _____

Certificate # _____

the co-operators
A Better Place For You™

Underwritten by
Co-operators Life Insurance Company

**Entire application to be completed in ink. PLEASE PRINT.**
**Copies not acceptable**

**TO BE COMPLETED BY EMPLOYEE**

| Name of employee<br><br>Address of employee City Prov. Postal Code | Phone<br>Work ( )<br>Home ( ) |
|---|---|

| Name of policyholder/employer | Occupation | Are you Actively at Work? ☐ Yes ☐ No<br>If No, why? |
|---|---|---|

| Date of Birth<br>Day Month Year | Height | Weight | Sex |
|---|---|---|---|
| | | | |

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ☐ Yes ☐ No
   If "Yes", specify:

2. Have any of your parents, brothers or sisters had any hereditary disorder? ☐ Yes ☐ No If "Yes", specify:
   (ie: Huntington's chorea, polycystic kidney disease, etc.)

| | | Yes | No |
|---|---|---|---|
| 3. | Have you ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which): | | |
| a) | Disorder of eyes, ears, nose or throat? | ☐ | ☐ |
| b) | Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system? | ☐ | ☐ |
| c) | Nervous disorders, including depression, severe anxiety or suicidal thoughts? | ☐ | ☐ |
| d) | High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels? | ☐ | ☐ |
| e) | Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs? | ☐ | ☐ |
| f) | Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system? | ☐ | ☐ |
| g) | Hepatitis A, B, C, or "type unknown"? | ☐ | ☐ |
| h) | Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder? | ☐ | ☐ |
| i) | Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome? | ☐ | ☐ |
| j) | Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood? | ☐ | ☐ |
| k) | Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of thyroid, pituitary, adrenals or other glands or unexplained infections? | ☐ | ☐ |
| l) | Thyroid or other endocrine disorders? | ☐ | ☐ |
| m) | Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs? | ☐ | ☐ |
| n) | Any other conditions, illnesses, diseases, injuries or operations not mentioned above? | ☐ | ☐ |

**Details of "Yes" answers:**
Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.



*continued . . .*

| | Yes | No | Details of "Yes" answers: |
|---|---|---|---|
| 4. In the past 10 years have you:<br>a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions?<br>b) Received advice or treatment in connection with any of the categories mentioned in (4a)?<br>c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus? | ☐ | ☐ | Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted. |
| 5. Has an application for insurance on your life/health ever been declined, rated or modified in any way? | ☐ | ☐ | When?<br>Why?<br>Company? |
| 6. Do you currently have an individual life policy with The Co-operators that has been issued within the last five years? | ☐ | ☐ | |
| 7. Have you applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury? | ☐ | ☐ | When?<br>Why? |
| 8. Have you lost any time from work during the last 12 months because of illness or injury? | ☐ | ☐ | When?<br>Amount of time?<br>Why? |
| 9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? | ☐ | ☐ | If "Yes", give details and dates. |
| 10. Are you receiving any treatment/medication from any physician or alternative healthcare provider as previously not defined? | ☐ | ☐ | State type and frequency. |
| 11. Female Applicant<br>a) Have you ever had any disease of the breasts, ovaries, cervix or uterus?<br>b) Have any pregnancies or labours been abnormal?<br>c) Are you pregnant? If "Yes", give expected delivery date. | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |
| 12. Do you now or have you ever used alcohol? If "Yes", complete the following:<br>a) Frequency of use (daily, weekly, monthly) _____<br>b) Amount consumed on each occasion _____<br>c) Date last used _____ | ☐ | ☐ | |
| 13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership) | ☐ | ☐ | |
| 14. Do you now or have ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If "Yes", complete the following:<br>a) Type of drug _____<br>b) Frequency of use (daily, weekly, monthly) _____<br>c) Date last used _____ | ☐ | ☐ | |
| 15. Have you ever used any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)? If "Yes", for how long and how often? _____<br>How long have you been smoking? _____ | ☐ | ☐ | |

16. Who is your regular family physician? (If none, Walk In Clinic visited) _____

Address: _____

Approximate date last seen: _____ Reason/Outcome _____

**Co-operators Life Insurance Company Privacy Statement**

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

**Applicant Declaration and Authorization Note:**

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with Co-operators and/or RWAM Insurance Administrators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite my Application for insurance coverage, evaluate my eligibility for coverage and adjudicate all claims.

I authorize the release by Co-operators and/or RWAM Insurance Administrators of information obtained duirmg the underwriting process to my personal physician and to the Co-operator's re-insurers, and when required toPublic Health Authorities.

I further authorize Co-operators and/or RWAM Insurance Administrators, the group plan administrator or their representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of my Application. I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

This authorization shall remain valid until revoked in writing by me. Any copy of this authorization shall be as valid as the original.

X _____ X _____

Employee Signature Date

**This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted**

RWAM Insurance Administrators Inc.
49 Industrial Drive
Elmira, Ontario N3B 3B1

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Group # _____

DIV # _____

Certificate# _____

# DEPENDENT GROUP HEALTH EVIDENCE FORM

Employee Name: _____

| Proposed lives to be insured | Date of Birth | | | Height | Weight |
|---|---|---|---|---|---|
| | Day | Month | Year | | |
| Spouse: | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| Child: | | | | | |

| | | Yes | No |
|---|---|---|---|
| 1. | Is the employee actively at work? If No, why? _____ | ☐ | ☐ |
| 2. | Do all the dependents named above reside with the employee? If "No", give details. Identify child. | ☐ | ☐ |
| 3. | Was any child born prematurely? If "Yes", identify child and state how many months. _____ | | |
| 4. | If any child is less than one year old, give name and birth weight: _____ | ☐ | ☐ |
| 5. | Has any dependent ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which): | | |
| a) | Disorder of eyes, ears, nose or throat? | ☐ | ☐ |
| b) | Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders paralysis, stroke, disorder of brain or nervous system? | ☐ | ☐ |
| c) | Nervous disorders, including depression, severe anxiety or suicidal thoughts? | ☐ | ☐ |
| d) | High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels? | ☐ | ☐ |
| e) | Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs? | ☐ | ☐ |
| f) | Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system? | ☐ | ☐ |
| g) | Hepatitis A, B, C, or "type unknown"? | ☐ | ☐ |
| h) | Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder? | ☐ | ☐ |
| i) | Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome? | ☐ | ☐ |
| j) | Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood? | ☐ | ☐ |
| k) | Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of thyroid, pituitary, adrenals or other glands or unexplained infections? | ☐ | ☐ |
| l) | Thyroid or other endocrine disorders? | ☐ | ☐ |
| m) | Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs? | ☐ | ☐ |
| n) | An application for insurance declined, postponed or modified in any way? When, why and what company? | ☐ | ☐ |
| o) | Advice that surgery is required? | ☐ | ☐ |
| p) | Any other conditions, illnesses, diseases, injuries or operations not mentioned above? | ☐ | ☐ |
| 6. | Female Dependents: | | |
| a) | Has any dependent ever had any disease of the breasts, ovaries or uterus? | ☐ | ☐ |
| b) | Have any pregnancies or labours been abnormal? | ☐ | ☐ |
| c) | Is any dependent pregnant? If "Yes", give expected delivery date. | ☐ | ☐ |

**Details of "Yes" answers:**
Identify question number, circle applicable items. Include name of dependent, date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/ result, as well as name and address of doctor consulted.

*continued . . .*

| | Yes | No |
|---|---|---|
| 7. In the past 10 years has any dependent: | | |
| a) Had or been told they had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions? | ☐ | ☐ |
| b) Received advice or treatment in connection with any of the categories mentioned above in (7a)? | ☐ | ☐ |
| c) Tested positive for antibodies to the AIDS (Human T-cell Lymphotrophic, TYPE III); HIV virus? If "Yes", give details. | ☐ | ☐ |

SPOUSE:

8. Who is your regular family physician? (If none, Walk In Clinic visited) _____

Address: _____

Approximate date last seen: _____ Reason/Outcome: _____

CHILD:

8. Who is your regular family physician? (If none, Walk In Clinic visited) _____

Address: _____

Approximate date last seen: _____ Reason/Outcome: _____

CHILD:

8. Who is your regular family physician? (If none, Walk In Clinic visited) _____

Address: _____

Approximate date last seen: _____ Reason/Outcome: _____

CHILD:

8. Who is your regular family physician? (If none, Walk In Clinic visited) _____

Address: _____

Approximate date last seen: _____ Reason/Outcome: _____

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## Applicant Declaration and Authorization

I declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me, my spouse or dependent(s) to release to and exchange with Co-operators and/or RWAM Insurance Administrators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite this Application for insurance coverage, evaluate the eligibility for coverage and adjudicate all claims.

I confirm that I am authorized to act on behalf of my spouse and dependants.

I authorize the release by Co-operators and/or RWAM Insurance Administrators of information obtained during the underwriting process to my personal physician and to Co-operator's re-insurers, and when required to Public Health Authorities.

I further authorize Co-operators and/or RWAM Insurance Administrators, the group plan administrator or their representatives and/or agents to request me or my dependents to undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes.

I understand that my refusal or withdrawal of consent may result in the delay or denial of this Application.

I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete and accurate.

I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

DATE _____ SIGNATURE OF EMPLOYEE _____

DATE _____ SIGNATURE OF SPOUSE _____

DATE _____ SIGNATURE OF CHILD _____
(if age 16 years or more.)

DATE _____ SIGNATURE OF CHILD _____
(if age 16 years or more.)

DATE _____ SIGNATURE OF CHILD _____
(if age 16 years or more.)

**Any expense incurred in providing this or additional information is the responsibility of the employee.**
**This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.**