



GROUP HEALTH EVIDENCE



Underwritten by
Co-operators Life Insurance Company

Group # _____
DIV # _____
Certificate # _____

Entire application to be completed in ink. PLEASE PRINT.
Fax copies not acceptable

TO BE COMPLETED BY EMPLOYEE

Name of employee			Phone		
Address of employee			City	Prov.	Postal Code
			Work ()		Home ()
Name of policyholder/employer			Salary per month \$ _____		Occupation
Date of Birth		Height	Weight		Sex
Day	Month	Year			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify:					
2. Have any of your parents, brothers or sisters had any hereditary disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify: (ie: Huntington's chorea, polycystic kidney disease, etc.)					
			Yes	No	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.
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?			<input type="checkbox"/>	<input type="checkbox"/>	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?			<input type="checkbox"/>	<input type="checkbox"/>	
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?			<input type="checkbox"/>	<input type="checkbox"/>	
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?			<input type="checkbox"/>	<input type="checkbox"/>	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?			<input type="checkbox"/>	<input type="checkbox"/>	
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?			<input type="checkbox"/>	<input type="checkbox"/>	
g) Hepatitis A, B, C, or "type unknown"?			<input type="checkbox"/>	<input type="checkbox"/>	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?			<input type="checkbox"/>	<input type="checkbox"/>	
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?			<input type="checkbox"/>	<input type="checkbox"/>	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?			<input type="checkbox"/>	<input type="checkbox"/>	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of thyroid, pituitary, adrenals or other glands or unexplained infections?			<input type="checkbox"/>	<input type="checkbox"/>	
l) Thyroid or other endocrine disorders?			<input type="checkbox"/>	<input type="checkbox"/>	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?			<input type="checkbox"/>	<input type="checkbox"/>	
n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above?			<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Details of "Yes" answers:
4. In the past 10 years have you: a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions? b) Received advice or treatment in connection with any of the categories mentioned in (4a)? c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	When? Why? Company?
6. Do you currently have an individual life policy with The Co-operators that has been issued within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	When? Why?
8. Have you lost any time from work during the last 12 months because of sickness or illness?	<input type="checkbox"/>	<input type="checkbox"/>	When? Amount of time? Why?
9. Are you in need of surgical operation or do you expect to receive any health care (including attention due to pregnancy) in the future? If "Yes" give details and dates.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you receiving any treatment/medication from any physician or alternative healthcare provider as previously defined?	<input type="checkbox"/>	<input type="checkbox"/>	State type and frequency.
11. Female Applicant a) Have you ever had any disease of the breasts, ovaries, cervix or uterus? b) Have any pregnancies or labours been abnormal? c) Are you pregnant? If "Yes", give expected delivery date.	<input type="checkbox"/>	<input type="checkbox"/>	
12. Do you now or have you ever used alcohol? If "Yes", complete the following: a) Frequency of use (daily, weekly, monthly) _____ b) Amount consumed on each occasion _____ c) Date last used _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)	<input type="checkbox"/>	<input type="checkbox"/>	
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: a) Type of drug _____ b) Frequency of use (daily, weekly, monthly) _____ c) Date last used _____	<input type="checkbox"/>	<input type="checkbox"/>	
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? How long have you been smoking? _____	<input type="checkbox"/>	<input type="checkbox"/>	
16. Who is your regular physician or family doctor? _____ Address: _____ Date Last Seen: _____ Reason/Outcome: _____			

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company ("Co-operators") 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:

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 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 _____
Employee Signature

X _____
Date

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

DEPENDENT GROUP HEALTH EVIDENCE FORM

COMPLETE IF LATE APPLICANT for EHC & Dependent Group Life

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

	Yes	No	
			<p>Details of "Yes" answers: Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment, outcome/result, as well as name and address of doctor consulted.</p>
1. Do all the dependents named above reside with the employee? If "No", give details. Identify child.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was any child born prematurely? If "Yes", identify child and state how many months.	<input type="checkbox"/>	<input type="checkbox"/>	
3. If any child is less than one year old, give name and birth weight:			
4. Has any dependent ever had			
a) Rheumatic fever, arthritis or any disorder of the bones, muscles, joints or spine?	<input type="checkbox"/>	<input type="checkbox"/>	
b) High blood pressure, chest pain or any heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Tuberculosis, pleurisy, asthma, bronchitis, or any other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Ulcers, recurrent indigestion, chronic diarrhea, stomach or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Sugar, albumin, pus or blood in urine, diabetes, nephritis, kidney stone; or any disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
f) Cancer, tumour, enlarged glands (nodes) or skin lesions?	<input type="checkbox"/>	<input type="checkbox"/>	
g) Convulsions, epilepsy, nervous breakdown; or any disorder of the brain or nervous system	<input type="checkbox"/>	<input type="checkbox"/>	
h) An application for insurance declined, postponed or modified in any way? When, why and what company?	<input type="checkbox"/>	<input type="checkbox"/>	
i) Within the past 5 years an electrocardiogram, x-ray, blood test or any surgical operation? State results.	<input type="checkbox"/>	<input type="checkbox"/>	
j) Advice that surgery is required?	<input type="checkbox"/>	<input type="checkbox"/>	
k) Venereal disease or any sexually transmitted disease or disorder of reproductive organs or prostate?	<input type="checkbox"/>	<input type="checkbox"/>	
l) Any other disease, conditions, or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Female Dependents:			
a) Has any dependent ever had any disease of the breasts, ovaries or uterus?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have any pregnancies or labours been abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Is any dependent pregnant? If "Yes", give expected delivery date.	<input type="checkbox"/>	<input type="checkbox"/>	

continued . . .

	Yes	No
6. 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?	<input type="checkbox"/>	<input type="checkbox"/>
b) Received advice or treatment in connection with any of the categories mentioned above in (6a)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Tested positive for antibodies to the AIDS (Human T-cell Lymphotropic, TYPE III); HIV virus? If "Yes", give details.	<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE:		
7. Who is your regular physician or family doctor? _____		
Address: _____		
Date Last Seen: _____ Reason/Outcome: _____		
CHILD:		
7. Who is your regular physician or family doctor? _____		
Address: _____		
Date Last Seen: _____ Reason/Outcome: _____		
CHILD:		
7. Who is your regular physician or family doctor? _____		
Address: _____		
Date Last Seen: _____ Reason/Outcome: _____		
CHILD:		
7. Who is your regular physician or family doctor? _____		
Address: _____		
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 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.

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

DATE _____ SIGNATURE OF EMPLOYEE (in ink) _____

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.)

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