the co-operators®
A Better Place For You®

GROUP BENEFITS HEALTH EVIDENCE QUESTIONNAIRE

To avoid delays, please complete the required information by printing clearly in ink.
All questions must be answered or form will be returned.

Reason for Medical Underwriting
(To be completed by the Plan Sponsor)

☐ Late Applicant
☐ Excess Coverage
☐ Salary Increase > 15%
☐ Evidence From 1st Dollar (0 NEM)

PLAN MEMBER INFORMATION **To be completed by the Plan Member**

Group _____ Account _____ Certificate _____ Group Name _____

Plan Member _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth _____ ☐ Male ☐ Female Height _____ Weight _____
MMM/DD/YYYY

Occupation _____ Are you actively at work? ☐ Yes ☐ No If no, why? _____

HEALTH EVIDENCE

1. Have any family members been diagnosed with MS, diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?	☐ Yes ☐ No	If yes, specify condition/relationship/age at diagnosis: _____
2. Have any of your parents, brothers or sisters had any hereditary disorder (i.e.: Huntington's chorea, polycystic kidney disease, etc.)?	☐ Yes ☐ No	If yes, specify: _____
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):		**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.
a) Disorder of eyes, ears, nose or throat?	☐ Yes ☐ No	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?	☐ Yes ☐ No	
c) Nervous disorders, including depression, anxiety or suicidal thoughts?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
g) Hepatitis A, B, C, or "type unknown"?	☐ Yes ☐ No	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	☐ Yes ☐ No	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, pituitary, adrenals or other glands or unexplained infections?	☐ Yes ☐ No	
l) Thyroid or other endocrine disorders?	☐ Yes ☐ No	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	☐ Yes ☐ No	
n) Other than previously listed, have you had any other conditions, illnesses, ailments, diseases, injuries, operations, visited any other doctor or had any diagnostic tests?	☐ Yes ☐ No	
4. In the past 10 years have you:		
a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions?	☐ Yes ☐ No	
b) Received advice or treatment in connection with any of the categories mentioned in (4a)?	☐ Yes ☐ No	
c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	☐ Yes ☐ No	

HEALTH EVIDENCE (CONTINUED) To be completed by the Plan Member

5. Has an application for insurance on your life/health ever been declined, rated or modified in any way?	☐ Yes ☐ No	When? _____ Why? _____ Company? _____
6. Do you currently have an individual life policy with The Co-operators that has been issued within the last year?	☐ Yes ☐ No	If yes, Policy # _____
7. Have you applied for or received a pension or Workers' Compensation or disability benefits because of illness or injury?	☐ Yes ☐ No	When? _____ Why? _____
8. Have you lost any time from work during the last 12 months because of illness or injury?	☐ Yes ☐ No	When? _____ Amount of time? _____ Why? _____
9. Do you have any condition for which future hospitalization or surgery has been advised or is contemplated? If yes, give details and dates.	☐ Yes ☐ No	
10. Are you receiving any treatment/medication from any physician or alternative healthcare provider previously not disclosed? If yes, state type and frequency.	☐ Yes ☐ No	
11. Female Applicant a) Have you ever had any disease of the breasts, ovaries, cervix or uterus?	☐ Yes ☐ No	If yes, 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.
b) Have any pregnancies or labours been abnormal?	☐ Yes ☐ No	
c) Are you pregnant?	☐ Yes ☐ No	If yes, give expected delivery date: _____
12. Do you now or have you ever used alcohol?	☐ Yes ☐ No	If Yes, complete the following: Frequency of use: ☐ # ____ Daily ☐ # ____ Week ☐ # ____ Month Date last used: _____
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	☐ Yes ☐ No	If yes, give details and dates: _____
14. Do you now or have ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)?	☐ Yes ☐ No	If Yes, complete the following: Type of drug: _____ Frequency of use: ☐ Daily ☐ # _____Week ☐ # _____Month Date last used: _____
15. Have you ever used any form of tobacco, nicotine products or substitutes (including nicotine patch and gum)?	☐ Yes ☐ No	If yes, for how long and how many per day? _____

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

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason/**Outcome** _____

APPLICANT DECLARATION AND AUTHORIZATION

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 AUTHORIZATION AND CONSENT

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Plan Member Signature _____ Date _____ (MMM/DD/YYYY)

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

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DEPENDENT HEALTH EVIDENCE QUESTIONNAIRE

To be completed ONLY if applying for coverage for dependents.
To avoid delays, please complete the required information by printing clearly in ink.
All questions must be answered or form will be returned.

Reason for Medical Underwriting

☐ Late Applicant (check all that apply)
☐ Spouse ☐ Child
☐ Dependent application for incapacitated status

DEPENDENT INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Phone Number: Home (_____) _____ Cell (_____) _____

Spouse _____ (First Name) _____ (Initial) _____ (Last Name) ☐ Male ☐ Female Date of Birth _____ (MMM/DD/YYYY) Height_____ Weight_____

Child _____ (First Name) _____ (Initial) _____ (Last Name) ☐ Male ☐ Female Date of Birth _____ (MMM/DD/YYYY) Height_____ Weight_____

Child _____ (First Name) _____ (Initial) _____ (Last Name) ☐ Male ☐ Female Date of Birth _____ (MMM/DD/YYYY) Height_____ Weight_____

Child _____ (First Name) _____ (Initial) _____ (Last Name) ☐ Male ☐ Female Date of Birth _____ (MMM/DD/YYYY) Height_____ Weight_____

DEPENDENT HEALTH EVIDENCE

1. Is the Plan Member actively at work?	☐ Yes	☐ No	If no, why? _____
2. Do all the dependents named above reside with the employee?	☐ Yes	☐ No	If no, give details, identify child: _____
3. 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):			**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.
a) Disorder of eyes, ears, nose or throat?	☐ Yes	☐ No	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?	☐ Yes	☐ No	
c) Nervous disorders, including depression, anxiety or suicidal thoughts?	☐ Yes	☐ No	
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?	☐ Yes	☐ No	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	☐ Yes	☐ No	
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?	☐ Yes	☐ No	
g) Hepatitis A, B, C, or "type unknown"?	☐ Yes	☐ No	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	☐ Yes	☐ No	
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?	☐ Yes	☐ No	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	☐ Yes	☐ No	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, pituitary, adrenals or other glands or unexplained infections?	☐ Yes	☐ No	
l) Thyroid or other endocrine disorders?	☐ Yes	☐ No	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	☐ Yes	☐ No	
n) An application for insurance declined, postponed or modified in any way?	☐ Yes	☐ No	When? _____ Why? _____ Company? _____
o) Advice that future surgery is required?	☐ Yes	☐ No	
p) Other than previously listed, have you had any other conditions, illnesses, ailments, diseases, injuries, operations, visited any other doctor, had any diagnostic tests or receiving any medication?	☐ Yes	☐ No	

DEPENDENT HEALTH EVIDENCE (CONTINUED)

4. Female Applicant
   a) Have you ever had any disease of the breasts, ovaries, cervix or uterus? ☐ Yes ☐ No
   b) Have any pregnancies or labours been abnormal? ☐ Yes ☐ No
   c) Are you pregnant? ☐ Yes ☐ No — If yes, give expected delivery date: ____________
5. 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? ☐ Yes ☐ No
   b) Received advice or treatment in connection with any of the categories mentioned in (5a)? ☐ Yes ☐ No
   c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus? ☐ 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.

6. Spouse: Who is your regular family physician?(If none, Walk In Clinic visited) ____________

Address ____________ (Street) ____________ (City) ____________ (Province) ____________ (Postal Code)

Approximate Date Last Seen ____________ (MMM/DD/YYYY) Reason/**Outcome** ____________

Child: Who is your regular family physician?(If none, Walk In Clinic visited) ____________

Address ____________ (Street) ____________ (City) ____________ (Province) ____________ (Postal Code)

Approximate Date Last Seen ____________ (MMM/DD/YYYY) Reason/**Outcome** ____________

Child: Who is your regular family physician?(If none, Walk In Clinic visited) ____________

Address ____________ (Street) ____________ (City) ____________ (Province) ____________ (Postal Code)

Approximate Date Last Seen ____________ (MMM/DD/YYYY) Reason/**Outcome** ____________

Child: Who is your regular family physician?(If none, Walk In Clinic visited) ____________

Address ____________ (Street) ____________ (City) ____________ (Province) ____________ (Postal Code)

Approximate Date Last Seen ____________ (MMM/DD/YYYY) Reason/**Outcome** ____________

DECLARATION AND AUTHORIZATION

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 AUTHORIZATION AND CONSENT

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

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 confirm that I am authorized to act on behalf of my spouse and dependents. I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Plan Member Signature ____________ Date ____________ (MMM/DD/YYYY)

Spouse Signature ____________ Date ____________ (MMM/DD/YYYY)

Child Signature ____________ (if age 16 years or more.) Date ____________ (MMM/DD/YYYY)

Child Signature ____________ (if age 16 years or more.) Date ____________ (MMM/DD/YYYY)

Child Signature ____________ (if age 16 years or more.) Date ____________ (MMM/DD/YYYY)

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