

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN PLAN MEMBER GROUP HEALTH FORM

Group Health form to be used
when Plan Member is applying for:
- Basic Life, AD&D, & Disability
- Optional Group Life Insurance
- Optional Long Term Disability

3**CONTACT INFORMATION**

Mail: Co-operators Life Insurance Company
Group Medical Underwriting
1900 Albert Street Regina, SK S4P 4K8

Email: group_client_services@cooperators.ca

Phone: 1-800-667-8164

Fax: 1-866-889-9924

INSTRUCTIONS

To avoid delays, please complete all information.

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

PLAN MEMBER INFORMATION (To be completed by the Plan Member)

Group **6414** Account **1** Certificate _____

Plan Member _____
First Name Initial Last Name

Address _____
Street City Province Postal Code

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

Email _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_client_services@cooperators.ca

Date of Birth _____ Sex ☐ M ☐ F ☐ X Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg
MMM/DD/YYYY

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

IF APPLYING FOR ADDITIONAL EMPLOYEE GROUP LIFE COVERAGE, PLEASE COMPLETE THE FOLLOWING SECTION:

Amount of Additional Employee Group Life Insurance being applied for \$ _____ (coverage is available in Units of \$10,000 to a maximum of \$500,000).

Beneficiary _____
First Name Initial Last Name Relationship _____

HEALTH EVIDENCE To be completed by the Plan Member

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):

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

Details of "Yes" answers

Identify question number, indicate 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.

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"/> Yes <input type="checkbox"/> No	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, cysts or growths, pituitary, adrenals or other glands or unexplained infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
l) Thyroid or other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Received advice or treatment in connection with any of the categories mentioned in (4a)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Has an application for insurance on your life/health ever been declined, rated or modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____ Why? _____ Company? _____
6. Do you currently have an individual life policy with Co-operators that has been issued within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Policy # _____
7. Have you applied for or received a pension or Workers' Compensation or disability benefits because of illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____ Why? _____
8. Have you lost any time from work during the last 12 months because of illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____ Amount of time? _____ Why? _____
9. Do you have any condition for which future hospitalization or surgery has been advised or is contemplated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give details and dates. _____ _____
10. Are you under observation, taking treatment/medication or receiving advice from any physician or alternative healthcare provider, for any medical or physical condition/symptom not previously disclosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details _____ _____
11.a) Have you ever had any disease of the breasts, ovaries, cervix or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Have any pregnancies or labours been abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate 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. _____ _____
c) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give expected delivery date _____
12. Do you now or have you ever used alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following: Frequency of use <input type="checkbox"/> #_____Daily <input type="checkbox"/> #_____Week <input type="checkbox"/> #_____Month Date last used _____
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following: Type of drug _____ Frequency of use <input type="checkbox"/> Daily <input type="checkbox"/> #_____ Week <input type="checkbox"/> #_____ Month Date last used: _____

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

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** _____**PRIVACY STATEMENT****Co-operators Privacy Statement**

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of your province of residence or Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

PLAN MEMBER DECLARATION AND AUTHORIZATION**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.