PACIFIC BLUE CROSS® BC Life

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-8055

APPLICANTS — Please complete BLACK portions of this application.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete RED portions of this application.
See page 4 for tips for completing this form.

PART 1 — EMPLOYMENT INFORMATION

Name of company/organization	Policy number	ID number	Division	Sub-division (if applicable)	Class

Type of insurance and amount applying for

☐ Life/Accidental death & dismemberment $ _____ ☐ Short-term disability $ _____ ☐ Long-term disability $ _____
☐ Dependent life $ _____ ☐ Extended health care ☐ Critical illness $ _____

PART 2 — APPLICANT INFORMATION

First name	Last name		Middle initial

Street address	City	Province	Postal code

Email address	Daytime phone number (10 digits)

PART 3 — INDIVIDUALS TO BE COVERED

Please provide the information requested in the table below.
List any additional children in *Part 7 — Additional Information*.

	FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	HEIGHT	WEIGHT
Applicant				(mm-dd-yyyy)	☐M ☐F		
Spouse				(mm-dd-yyyy)	☐M ☐F		
First child				(mm-dd-yyyy)	☐M ☐F		
Second child				(mm-dd-yyyy)	☐M ☐F		
Third child				(mm-dd-yyyy)	☐M ☐F		
Fourth child				(mm-dd-yyyy)	☐M ☐F		
Fifth child				(mm-dd-yyyy)	☐M ☐F		

1. Have you or your spouse ever applied for or received benefits, compensation or pension due to sickness or injury? ☐Yes ☐No
2. Have you or your spouse been absent from work because of sickness or injury during the last six months? ☐Yes ☐No
3. Do you or your spouse now have or are you applying for other life or disability income insurance? ☐Yes ☐No
   If yes, type of insurance:

   _____

   Amount:

   _____

   Benefit and elimination periods (where applicable):

   _____

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PART 4 — MEDICAL DECLARATION: Complete questions 1–6

1. Have you or any dependent ever consulted a doctor or practitioner because of, suffered from, been treated for or had any indication of any medical condition? If you are unsure how to answer any of these questions, please consult your doctor.

- **Chest or heart conditions** ☐ Yes ☐ No
  Including circulatory, heart or vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke), blood disorders.
- **Diabetes and gland disorders** ☐ Yes ☐ No
  Including diabetes (IDDM-Type 1) or (NIDDM-Type 2), hormonal or thyroid conditions.
- **Gastrointestinal conditions** ☐ Yes ☐ No
  Including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), colitis, Crohn's disease, irritable bowel syndrome, diverticulitis, colon polyps, ulcers, hernia, GERD (acid reflux or persistent heartburn).
- **Musculoskeletal conditions** ☐ Yes ☐ No
  Including osteoarthritis or rheumatoid arthritis, osteoporosis, bone density loss or back, neck, joint or muscle pain (including fibromyalgia).
- **Immunological conditions** ☐ Yes ☐ No
  Including acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or any other immunological disorder, or any positive test results indicating exposure to the AIDS virus.
- **Genitourinary conditions** ☐ Yes ☐ No
  Including kidney, bladder, infertility or reproductive disorders, menopause, endometriosis, sexually transmitted disease(s) or recurring infections (cold sore/herpes/shingles).
- **Neurological/nervous conditions** ☐ Yes ☐ No
  Including Alzheimer's, dementia, Parkinson's, epilepsy, multiple sclerosis, seizures, paralysis, chronic headaches or migraines, or chronic fatigue syndrome.
- **Mental health conditions** ☐ Yes ☐ No
  Including anxiety, depression, emotional disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD).
- **Cancer** ☐ Yes ☐ No
  Including tumors (malignant or benign), leukemia.
- **Lifestyle** ☐ Yes ☐ No
  Including use of marijuana, cocaine, narcotics, hallucinogens, or similar drugs not prescribed by a physician and/or used tobacco products (cigarettes, chewing tobacco, snuff and nicotine replacement products) and/or undergone treatment for alcoholism or a drug habit.

2. Have you, your spouse or your dependents had any physical impairments, deformities, hospitalization or illness not covered in question 1? ☐ Yes ☐ No

3. If yes to either question 1 or 2, please give details:

NAME	CONDITION/ DISORDER	DIAGNOSIS DATE	RECOVERY DATE	MEDICATION/ TREATMENT	PHYSICIAN NAME, ADDRESS AND PHONE NUMBER
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		

4. Are you, your spouse or dependents taking any prescribed medication? ☐ Yes ☐ No
   If yes, provide name of medication(s) and reason for use in space provided below.

NAME	TYPE OF DRUG/TOBACCO	AMOUNT USED	FREQUENCY
			(mm-dd-yyyy)
			(mm-dd-yyyy)
			(mm-dd-yyyy)

5. Have you or your spouse had any weight change within the last 12 months? ☐ Yes ☐ No
   If yes, please provide details.

Applicant	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason
Spouse	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason

6. Please provide your family's medical history.
Have your parents or siblings had cancer, high blood pressure, heart or kidney disease, alcoholism or mental illness?

Applicant: ☐ Yes ☐ No	Spouse: ☐ Yes ☐ No

FAMILY MEMBER	AGE OR AGE AT DEATH	DETAILS OF ANY HEALTH DISORDER	CAUSE OF DEATH (IF APPLICABLE)
Applicant's father			
Applicant's mother			
Applicant's sibling			
Applicant's sibling			
Applicant's sibling			
Spouse's father			
Spouse's mother			
Spouse's sibling			
Spouse's sibling			
Spouse's sibling			

PART 5 — DECLARATION AND AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health or my dependents' health to give Pacific Blue Cross/BC Life and its reinsurers any such information. I understand this information will be used by Pacific Blue Cross/BC Life to determine my eligibility or my dependents' eligibility for coverage and may be used in connection with any claim filed with Pacific Blue Cross/BC Life. A photocopy of this authorization shall be as valid as the original.

I authorize Pacific Blue Cross/BC Life or its reinsurers to make a brief report of my personal health information to the Medical Information Bureau.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

Applicant's signature **X**	Date (mm-dd-yyyy)

PART 6 — NOTIFICATION

IMPORTANT: Please read carefully.

Information regarding your insurability will be treated as confidential. Pacific Blue Cross/BC Life or its reinsurers may, however, make a brief report 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 a company, the Bureau, upon request, will supply such company with the information in its file.

The Bureau receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Therefore, the Bureau has agreed to protect such information in a manner that is substantially similar to the company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, the Bureau is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about the Bureau's commitment to the confidentiality and security of your personal information, you may contact the Bureau's Privacy department at privacy@mib.com.

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. Their address is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7.

Pacific Blue Cross/BC Life 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.

PART 7 — ADDITIONAL INFORMATION

CHECK LIST TO COMPLETE THIS FORM

1. Have you provided full details to all the medical questions, including dates and present condition of any illnesses or injuries?
2. Have you provided the full name and addresses of any doctors consulted?
3. Have you indicated your height and weight and your date of birth in the spaces provided?
4. Have you signed and dated the authorization?

IF ALL THE REQUESTED INFORMATION IS NOT PROVIDED, THIS FORM WILL BE RETURNED TO YOU.

PACIFIC BLUE CROSS

BC Life

MAIL YOUR FORM
Attn: Medical Underwriting
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT
604 419-8055

QUESTIONS?
604 419-2100
Toll-free: 1 877 275-4768

www.pac.bluecross.ca