MEDA	VIE		
BLI	JE	CR	OSS <sup>™</sup>

TEL: 1-800-667-4511 FAX: 506-869-9654

PO BOX 220

Date

MONCTON NB E1C 8L3

-	
	550 SHERBROOKE STREET WEST, SUITE L-15

MONTREAL QC H3A 6T6 TEL: 514-286-8454 FAX:514-286-8444

1.	Employee Name:					_0cd	cupation:		
	Name of person applying:	Place of Birtl		rth:		Date of Birth:			
	Address:						MM YY		
							ID No:		
2.							·		
3.	e						y of your parents, brothers or sisters, before attaining age 60, I heart or kidney disease, mental or nervous disorder, colon or		
	Age if Living State of Health	Age at Death	Cause of Death		breas	t can	cer or any inheritable disorder (such as Huntington's chorea or kidney disease)?		
	Father								
	Mother								
	c) What is your height? ft	in	cm <b>d)</b> Have	you l	ost mo	re tha	an 4.5 kg or 10 lbs in the past year?		
	Weight? lbs	kg	If "Yes	s", sta	ate amo	ount a	and reason:		
					1		Remarks		
4.	Have you ever consulted a physician, be indication of diabetes, asthma or bronch arthritis, nervous or mental disorder, bac	nitis, ulcer, o	colitis or Crohn's,	n			If "yes" to any disorder(s) in question 4, please circle applicable condition, refer to the <u>back of this form</u> and complete the applicable section(s).		
5.	Have you ever consulted a physician, be indication of chest pain, heart or circulat blood disorder, thyroid disorder, cancer, convulsions, epilepsy, lung or breathing stomach or gastrointestinal disorder, live or urinary disorder, bone, muscle or join	ory disorde tumours, n disorder, s er disorder,	er, high blood pressure leurological disorder, leep apnea, bowel, kidney disorder, pros	e, tate			Circle condition and provide details. (Date, Duration, Treatment and Current Status)		
6.	Have you used any nicotine or used any any form in the past 12 months?	/ smoking c	cessation products in				Details		
7.	Are you currently taking any prescription indicate the reason, name, strength and		n? If yes, please				Reason, Name, Strength and Dosage		
8.	Have you ever: a) used narcotics, hallucinogens or simil by a physician, or	lar drugs e	xcept as prescribed				Dates and Details		
	b) been advised to reduce your consum treatment for drug or alcohol addiction								
9.	Have you ever requested or received a payment because of an injury, sickness						Date, Reason, Duration and Current Status		
10. Have you ever been tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), or HIV (Human Immunodeficiency Virus) or any other immunological disorder?						Dates and Details			
11.	Do you currently have a referral, testing, pending or contemplated, but not yet co symptoms or problems that require med	mpleted, or	r are you aware of any	у			Dates and Details		
12.	Within the past 5 years, have you had a test results not already mentioned on t		ondition or abnormal				Dates and Details		
1 +	a undersigned dealers the ensurements to the		tions and the question	0.00	the roug	****	if this form are complete and ecourate and form part of an		

I, the undersigned, declare the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada<sup>®</sup> ("Blue Cross Life") and/or Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me, and to manage the Company's business. I hereby authorize any physician, pharmacy, health practitioner, hospital, clinic or other medical or medically related facility, insurance company, government or regulatory authority, MIB, Inc. ("MIB", formerly Medical Information Bureau) or other organization, institute or person that has any records or knowledge of me or my health to give Blue Cross Life, Medavie Blue Cross to its reinsurers any such information. I further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my personal physician or other medical practitioner. I also authorize Blue Cross Life and Medavie Blue Cross to make a brief report of my personal health information to MIB. This consent is valid for as long as the contract is in force, unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and I'm aware of the risks and benefits of consenting or refusing to consent. I have received and read the attached notice form describing the procedures of the MIB. I may contact Medavie Blue Cross at 1-800-667-4511 with any questions related to the collection, use or disclosure of my personal information.

This consent complies with federal and provincial privacy laws. A photocopy of this authorization shall be as valid as the original.

Signature of Applicant \_

FORM-019(E) 01/15

STATEMENT OF

HEALTH

PLEASE DETACH AND RETAIN

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada® or their reinsurer, may, however, make a brief report thereon to MIB, Inc. ("MIB", formerly 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 MIB member company for life, disability or health coverage, or a claim for benefits is submitted to such company, MIB will, on request, supply such company with the information it may have in its files. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's files, you may contact MIB and seek a correction. Information for consumers about MIB may be obtained on its wesite at www.mib.com.

MIB, Inc. 330 University Avenue Toronto, Ontario M5G 1R7 Telephone 416.597.0590 Website www.mib.com

Blue Cross Life Insurance Company of Canada or its reinsurer 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.

Please complete applicable section if you answered "Yes" to Question #4

If "test give defaults.       for these conditions.         If "test give defaults.       for these conditions.         If These give default and the use of oral steroids (ie. Preduisone)?       for these conditions.         If These give default and the use of oral steroids (ie. Preduisone)?       for these condition regarding pain.         If These give default and the use of oral steroids (ie. Preduisone)?       for these condition regarding pain.         If These fore default and the or pleodes:       for these condition regarding pain.         If These fore default houghts I Fatigue I Nerousness I Anxiety I Photain and these of physician(s) consuted: </th <th>1.</th> <th>DIABETES</th> <th>d)</th> <th>Do you follow a diabetic diet?  Yes No</th>	1.	DIABETES	d)	Do you follow a diabetic diet?  Yes No	
a) Type: Asthma Bronchilis   b) Severity: Mild Moderata   c) Date of nest: Mild   d) Frequency of symptoms or episodes (ie. weekly, monthly):   e) Date of any hospitalization or emergency room visits:   3. ULCER. COLITIS OR CROMN'S   a) Type: 1. Ulcert   c) Date of any hospitalization or emergency room visits:   a) Type: 1. Ulcert   c) Date of nergency of attacks or episodes:   c) Date of nest:   c) Date of nest:   c) Frequency of attacks or episodes:   c) Date of nest:   d) Type of symptoms:   d) Type of symptoms:   What you's dealed and present condition regarding pain, deformuly. limitations of movement:   d) Type of symptoms:   d) Type of the back was involved:   d) Date of nest:   d) Date of nest:   d) Date of the back	b)	Type of treatment:  Insulin  Oral medication  Diet Any history of diabetic comas or insulin reactions?  Yes No		<ul> <li>Eye trouble</li> <li>Albumin in the urine</li> <li>Numbness or a tingling sensation in the limbs.</li> <li>Give full details including name and address of doctor(s) consulted</li> </ul>	
a) Type: Asthma Bronchilis   b) Severity: Mild Moderata   c) Date of nest: Mild   d) Frequency of symptoms or episodes (ie. weekly, monthly):   e) Date of any hospitalization or emergency room visits:   3. ULCER. COLITIS OR CROMN'S   a) Type: 1. Ulcert   c) Date of any hospitalization or emergency room visits:   a) Type: 1. Ulcert   c) Date of nergency of attacks or episodes:   c) Date of nest:   c) Date of nest:   c) Frequency of attacks or episodes:   c) Date of nest:   d) Type of symptoms:   d) Type of symptoms:   What you's dealed and present condition regarding pain, deformuly. limitations of movement:   d) Type of symptoms:   d) Type of the back was involved:   d) Date of nest:   d) Date of nest:   d) Date of the back					
c) Date of onset of this condition: (a)   (b) Date of onset of this condition: (b)   (c) Date of any hospitalization or emergency room visits: (c)   (c) Date of any hospitalization or emergency room visits: (c)   (c) Date of any hospitalization or emergency room visits: (c)   (c) Date of any hospitalization or emergency room visits: (c)   (c) Date of any hospitalization or emergency room visits: (c)   (c) Date of last attack or episodes: (c)   (c) Date of last attack or episode: (c)   (c) Date of nest: (c)   (c) Date of nest: (c)   (c) Frequency of attacks or episodes: (c)   (c) Type: Rheumatoid   (c) Date of onset: (c)   (c) Frequency of attacks or episodes: (c)   (c) Type of treatment: (c)   (c) Type of surgeny file   (c) Date of nest:   (c) Date of nest:  <	,	Type: 🗆 Asthma 🗆 Bronchitis	f)		
d)       Frequency of symptoms or episodes (ie. weekly, monthly):         e)       Date of any hospitalization or emergency room visits:         3.       ULCER, COLITIS OR CROHN'S         a)       Type:         a)       Type:         2.       Colitis         3.       Ulcerative         3.       Cronn's         b)       Frequency of attacks or episodes:         c)       Date of last attack or episode:         c)       Date of last attack or episode:         c)       Any hemorrhage (bleeding)?         4.       ARTHRITS         a)       Type:         a)       Type:         b)       Frequency of attacks or episodes:         c)       Frequency of attacks or episodes:         d)       Type:         c)       Frequency of attacks or episodes:         d)       Type of treatment:         f)       What joints are affected and present condition regarding pain, deformity, limitations of movement:         f)       Type and duration of reatment:         f)       Type and duration of reatment:         f)       Ype of treatment:         g)       Any hospitalization required?         f)       Ype of treatment: <t< td=""><td></td><td>•</td><td>g)</td><td>Have you ever been referred to a specialist or have you ever had a</td></t<>		•	g)	Have you ever been referred to a specialist or have you ever had a	
3. ULCER. COLITIS OR CROHN'S       e)       Type of surgery (if required)?         3. ULCER. COLITIS OR CROHN'S       Closentive       Gastric         2. Collits       Ulcerative       Mucus       Spastic         3. Type:       1       Ulcerative       Mucus       Spastic         b)       Frequency of attacks or episodes:       ()       Any loss of time from work?       Yes       No         c)       Date of last attack or episode:       ()       ()       Any loss of time from work?       Yes       No         ()       ARTHRITS       ()       ()       Any loss of time from work?       Yes       No         ()       Type:       BReumatid       Osteoarthritis       Gout       Rheumatism       ()       H"'Yes' give dates and duration         ()       Type of symptoms:       Gout       Rheumatism       ()       What joints are affected and present condition regarding pain, deformity, limitations of movement:         ()       Type of symptoms:       Weight Loss       Depression       Insomnia         ()       Type of symptoms:       Weight Loss       Depression       Insomnia         ()       Type of symptoms:       Weight Loss       Anxiety       Phobia         ()       Date of last attack or episode:       <	d)	Frequency of symptoms or episodes (ie. weekly, monthly) :			
a) Type:       1. Ulcer       Duodenal       Gastric         2. Colitis       Ulcerative       Mucus       Spastic         b) Frequency of attacks or episodes:       ()       ()         c) Date of last attack or episode:       ()         d) Any hemorrhage (bleeding)?       ()         4. ARTHRITIS       ()         a) Type:       Rheumatoid       Osteoarthritis         b) Type of treatment:       ()         a) Type:       Rheumatoid       Osteoarthritis         c) Date of onset:       ()         c) Frequency of attacks or episodes:       ()         d) Type of treatment:       ()         d) Type of treatment:       ()         d) Type of symptoms:       Ovelogenetic ()         d) Type of symptoms:       Ovelogenetic ()         f) Type and duration of treatment:       ()         m) Type of symptoms:       Ovelogenetic ()         c) Date of onset:       ()         d) Date of last attack or episo	e)	Date of any hospitalization or emergency room visits:			
2. Colitis       Ulcerative       Mucus       Spastic       9)       Any loss of time from work?       Yes       No         b)       Frequency of attacks or episodes:	3.	ULCER, COLITIS OR CROHN'S	e)	Type of surgery (if required)?	
3. Crohn's	a)	51	f)	Type of treatment:	
c) Date of last attack or episode:   d) Any hemorrhage (bleeding)?   4. ARTHRITIS   a) Type:   heumatoid   Osteoarthritis   Gout   Bate of onset:   C) Frequency of attacks or episodes:   Type of treatment:   Type of treatment:   S. NERVOUS OR MENTAL DISORDER   a) Type of symptoms:   Weight Loss   Date of onset:   () Type of symptoms:   Weight Loss   Date of onset:   () Type of symptoms:   Weight Loss   Depression   Insomnia   Suicidal thoughts   Date of onset:   () Date of last attack or episode:   () Date of first attack or episode:   () Date of first attack or episode:   () Date of last attack or episode:   () Date of last attack or episode:   () Date of last attack or episode:   () Date of first attack or episode:   () Date of last attack or episode:   () Date of last attack or episode:   () Date of first attack or episode:   () Date of last attack or episode:   () Date of first attack or episode:   () Date of last attack or episode:   () Date of last attack or episod		•	g)	,	
d) Any hemorrhage (bleeding)?	b)	Frequency of attacks or episodes:			
4. ARTHRITIS         a) Type:       Rheumatoid       Osteoarthritis       Gout       Rheumatism         b) Date of onset:	C)	Date of last attack or episode:			
a) Type: Rheumatoid Osteoarthritis Gout Rheumatism   b) Date of onset:	d)	Any hemorrhage (bleeding)?			
a) Type: Rheumatoid Osteoarthritis Gout Rheumatism   b) Date of onset:	4.	ARTHRITIS	e)	Any loss of time from work?	
c) Frequency of attacks or episodes: i)   d) Type of treatment:   d) Type of symptoms:   a) Type of symptoms:   b) What was the cause?   b) What was the cause?   c) Date of onset:   d) Date of last attack or episode:   a) What area of the back was involved:   b) What area of the back was involved:   c) Date of first attack or episode:   c) Date of first attack or episode:   c) Date of first attack or episode:   c) Date of alsat attack or episode:   c) Date of alsat attack or episode:   c) Date of first attack or episode:   c) Date of alsat attack or episode:   c) Date of first attack or episode:   c) Date of alsat attack or episode:   c) Date of alsat attack or episode:   c) Date of alsat attack or episode:   c) Date of first attack or episode:   c) Date of alsat attack or episode:   c) Date of alsat attack or episode:   c) Date of first attack or episode:   c) Date of alsat			0)		
d) Type of treatment:   d) Type of treatment:   d) Type of treatment:   d) Type of treatment:   d) Type of symptoms:   weight Loss   Depression   l) Name and duration of treatment:   f) Any hospitalization required?   g) Date and duration of any time off work:   h) Name and address of physician(s) consulted:   c) Date of noset:   d) Date of last attack or episode:   a) What area of the back was involved:   b) What was the cause?   i) Any loss of time from work:   l) Yes   No   li May loss of time from work:   li Yes   lost of first attack or episode:   c) Date of first attack or episode:   d) Date of last attack or episode:   iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	, ,		f)	What joints are affected and present condition regarding pain,	
5. NERVOUS OR MENTAL DISORDER       e)       Type of symptoms: Weight Loss Depression Insomnia         a) Type of symptoms: Weight Loss Depression Anxiety Phobia       f)       Any hospitalization required? Yes No         b) What was the cause?       h)       Name and address of physician(s) consulted:         c) Date of onset:       h)       Name and address of physician(s) consulted:         d) Date of last attack or episode:       h)       Name and address of time from work: Yes No         a) What area of the back was involved: Neck Middle (Thoracic)       i)       Any loss of time from work: Yes No         b) What was the cause?       i)       Any loss of time from work: Yes No         c) Date of first attack or episode:       i)       Any loss of time from work: Yes No         li "Yes" give date and duration       ii "Yes" give date and duration         d) Date of last attack or episode:       ii Any loss of time from work: Yes No         lif "Yes" give date, results and name of physician       ii "Yes" give date, results and name of physician         c) Date of first attack or episode:       k       Any surgery performed or anticipated? If "Yes" give date and result         d) Date of last attack or episodes:       k       Any surgery performed or anticipated? If "Yes" give date and result	,			deformity, limitations of movement:	
a) Type of symptoms: Weight Loss   a) Type of symptoms: Weight Loss   b) What was the cause? i) Any hospitalization required?   c) Date of onset:	u)				
<ul> <li>Suicidal thoughts □ Fatigue □ Nervousness □ Anxiety □ Phobia</li> <li>What was the cause?</li> <li>C) Date of onset:</li></ul>	5.	NERVOUS OR MENTAL DISORDER	e)	Type and duration of treatment:	
b) What was the cause?   c) Date of onset:   d) Date of last attack or episode:   d) Date of last attack or episode:   a) What area of the back was involved: <a>Neck</a> Middle (Thoracic)   b) What was the cause?   j) Have you had any X-rays or other investigation of your back?   j) Have you had any X-rays or other investigation of your back?   ji) Have you had any X-rays or other investigation of your back?   ji) Have you had any X-rays or other investigation of your back?   jiii Yes" give date, results and name of physician   jiii Any surgery performed or anticipated? If "Yes" give date and result	a)		f)	Any hospitalization required?   Yes  No	
c)       Date of onset:	b)	• • •	0,	Date and duration of any time off work:	
d) Date of last attack or episode:	,		h)	Name and address of physician(s) consulted:	
<ul> <li>6. BACK OR NECK DISORDER</li> <li>a) What area of the back was involved: Deck Disorder</li> <li>b) What was the cause?</li> <li>c) Date of first attack or episode:</li> <li>d) Date of last attack or episode:</li> <li>e) Frequency of attacks or episodes:</li> <li>b) Ture of treatment:</li> </ul>	c)	Date of onset:			
<ul> <li>a) What area of the back was involved: Deck Divide (Thoracic)</li> <li>b) What was the cause?</li> <li>c) Date of first attack or episode:</li> <li>d) Date of last attack or episode:</li> <li>e) Frequency of attacks or episodes:</li> <li>b) Time of treatment:</li> </ul>	d)	Date of last attack or episode:			
<ul> <li>a) What area of the back was involved: Diversity Neck Diversity Middle (Thoracic)</li> <li>b) What was the cause?</li> <li>j) Have you had any X-rays or other investigation of your back? If "Yes" give date, results and name of physician</li> <li>c) Date of first attack or episode:</li> <li>d) Date of last attack or episode:</li> <li>e) Frequency of attacks or episodes:</li> <li>b) Time of treatment:</li> </ul>	6.	BACK OR NECK DISORDER	i)	Any loss of time from work:  Yes No	
<ul> <li>a) Take you had any X-rays of other investigation of your back?</li> <li>b) Date of first attack or episode:</li> <li>b) True of trootment:</li> </ul>	a)				
<ul> <li>c) Date of first attack or episode:</li></ul>	b)	What was the cause?	j)		
<ul> <li>d) Date of last attack or episode:</li> <li>e) Frequency of attacks or episodes:</li> <li>b) Type of tractment:</li> </ul>	c)	Date of first attack or episode:			
			k)	Any surgery performed or anticipated? If "Yes" give date and results	
f) Type of treatment: I) What is your present condition regarding pain limitation of movem	e)	Frequency of attacks or episodes:			
	f)		I)	What is your present condition regarding pain, limitation of movement	
g) Frequency of treatments: and activity?	g)				
h) Date of last treatment:	h)	Date of last treatment:			