

NOTICE: ANY INCOMPLETE REQUEST OR UNANSWERED QUESTION WILL DELAY THE STUDY OF YOUR FILE

SECTION A												
Contract No.: ID No.: ID No.:												
SECTION B - EMPLOYEE INFORMAT	TION											
First Name:			Last	Last Name:								
Place of Birth:			Оссі									
Address:												
City: Province:				Postal Code:								
Telephone: Home:			Offic	Office:								
Date of Birth (DD/MM/YYYY):						Gender:	□ M □	⊒ F				
What is your height? ft in cm												
Weight?lbskg												
SECTION C - PLEASE COMPLETE IF THE INSURANCE REQUESTED IS FOR DEPENDENTS												
First Name:												
Place of Birth:												
Date of Birth (DD/MM/YYYY):			Age:			Gender:	□ M □	⊒ F				
What is your height? ft in cm												
Weight?lbskg		If "Yes", sta	e amount	and reason: _								
CHILD / CHILDREN:	'											
Name (Sex		Date of Birth Age			Height		Weight			
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PERSONAL INFORMATION REPORT AND EXCHANGE NOTICE

DETACH AND GIVE TO THE EMPLOYEE

Within the past 5 years, have you: Employer Yes No Yes	nt(s) No			
1. Consulted or been examined or treated by a physician or other practitioner? 2. Been a patient in a hospital, clinic, sanatorium or other medical facility? 3. Undergone an electrocardiogram? 4. Undergone a chest x-ray? 5. Undergone laboratory tests or other tests for diagnostic purposes? 6. Requested or received a pension for disability or injury?				
SECTION G - DETAILS OF "YES" ANSWERS OF SECTION F				
Question Number Name of person Number Disease, operation, examinations, treatments, drugs, results Date illness Duration of illness Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in outpatient clinic or in a doctor's office.				
SECTION H - AT PRESENT	-			
 Are you under medical treatment? Employee: Yes No Dependent(s): Yes No Name and address of physician who has your medical records. Are you taking any medications? Employee: Yes No Dependent(s): Yes No If yes, name of medication, strength, daily dosage and how long you have been using them. 	_ _ 			
SECTION I				
1. Do you or did you ever use nicotine in any form, cigars, pipe, alcoholic beverages, narcotics or other drugs? Yes No Narcotics or other drugs? Alcoholic beverages Narcotics or other drugs?	10			
tity per week Now In the past				
Employee Employee	\Box			
Dependents				
2. If it is the case, give the date on which you stopped smoking:				
Have any of your parents, brothers or sisters, before attaining age 60, ever had colon or breast cancer, heart or kidney disease, mental or nervous disorder, or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease)? Ves No If yes, provide the following details:				
Family Member (Mother, Father, Brother, Sister) Age at onset of condition (type of cancer, heart or kidney disease etc.) If you have been investigated for this condition, indicate date and results (if no investigation done, state "none")				
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® ("Blue Cross Life") and/or Medavie Blue Cross. The information provided herein are 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 of health to give Blue Cross Life, Medavie Blue Cross or its reinsurers any such information. I further authorize Blue Cross Life and Medavie Blue Cross to disclose to 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 brie 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 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 ar I'm aware of the risks and benefits of consenting or refusing to consent. I have received and read the attached notice form	r my his f my			
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 Signature of Spouse (if spouse is applying) Date				

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.

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