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 ETOBICOKE ON M9C 5P1
 TELEPHONE: 1-800-355-9133 FAX: (416) 626-0997

STATEMENT OF HEALTH

Policyholder: _____

Policy No: _____

1. Employee Name: _____ Occupation: _____

Date of Birth: _____ Applicant's Name & Relationship to Employee _____
 DD MM YY

Correspondence to be Mailed to: _____

2. Name and address of usual personal physician or medical clinic: _____

3. a) Family History:

	Age if Living	State of Health	Age at Death	Cause of Death
Father				
Mother				

b) Have any of your parents, brothers or sisters, before attaining age 60, ever had heart or kidney disease, mental or nervous disorder, or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease)? Yes No If "Yes", give details: _____

c) What is your height? _____ weight? _____ d) Has your weight changed more than 4.5 kg or 10 lbs in the past year? Yes No If "Yes", state amount and the reason: _____

	Yes	No	Remarks
4. Have you ever consulted a physician, been treated for, or had any known indication of: [Please circle applicable impairment(s).] chest pain, heart or circulatory disorder, high blood pressure, blood disorder, thyroid disorder, cancer, tumors, neurological disorder, convulsions, epilepsy, lung disorder, bowel disorder, liver disorder, kidney disorder, genital or urinary disorder, limb disorder, sight or hearing disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Details of "Yes" answers. Please use reverse of form for details to question # 5. (Date, duration, results, names of doctors)
5. Have you ever consulted a physician, been treated for, or had any known indication of: diabetes, asthma or bronchitis, ulcer or colitis, arthritis, nervous or mental disorder, back or neck disorder? If "yes" to any disorder(s), please refer to the back of this form and complete the applicable questionnaire(s).	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you used tobacco in any form in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Are you currently taking any prescription medication? If yes, please indicate the reason, name, strength and quantity taken per month.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you ever used narcotics, hallucinogens or similar drugs, except as prescribed by a physician or been advised to reduce your consumption of alcohol or take treatment, including Alcoholics Anonymous, for alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you ever been tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), HIV (Human Immunodeficiency Virus) or any other Immunological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Do you currently have a referral, testing, treatment or investigation pending or contemplated, but not yet completed?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Are you now under observation, receiving medical advice or under medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Within the past 5 years, have you had any indication of, been treated for, or consulted a physician for:			
a. abnormal electrocardiogram, X-rays, blood tests or other medical tests?	<input type="checkbox"/>	<input type="checkbox"/>	
b. any medical conditions not mentioned on this application?	<input type="checkbox"/>	<input type="checkbox"/>	

I, the undersigned, declare that the answers to the above questions are full, complete and true, are correctly recorded and are in continuance of and form part of an application for benefits to Ontario Blue Cross. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of me or my health, to give Ontario Blue Cross, their reinsurer any such information. I further authorize the Medical Director of the Company to release all medically related information obtained during the underwriting process to my personal physician or other licensed medical practitioner as so directed.

Date _____ Signature of Applicant _____

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PLEASE DETACH AND RETAIN

Information regarding your insurability will be treated as confidential. Ontario Blue Cross or their reinsurer, may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit 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 coverage, or a claim for benefits is submitted to such company, the Bureau, on request, will supply such company with the information it may have in its files.

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 files, you may contact the Bureau and seek a correction. The address of the Bureau's information office is:

Medical Information Bureau
 330 University Avenue
 Toronto, Ontario, M5G 1R7

Telephone: (416) 597-0590

Ontario Blue Cross or their 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.

Applicant Name _____ Policy No. _____

1. DIABETES

- a) Date of onset of diabetes: _____
- b) Type of treatment: Insulin Oral Medication Diet
- c) Any history of diabetic comas or insulin reactions? Yes No
If "Yes" give details. _____

- d) Do you follow a diabetic diet? Yes No
- e) Have you ever had any of the following: Yes No
 Eye Trouble Albumin in the urine
 Numbness or a tingling sensation in the limbs. **Give full details**
including name and address of doctor(s) consulted for these conditions.

2. ASTHMA OR BRONCHITIS

- a) Type: asthma bronchitis
- b) Severity: mild moderate severe
- c) Duration of attacks or episodes: _____
- d) Frequency of attacks or episodes: _____
- e) Date of last attack: _____
- f) Any hospitalization required? Yes No
- g) Type of treatment: _____
- h) Any loss of time from work? Yes No
If "Yes", give details and duration

3. ULCER OR COLITIS

- 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)? _____
- e) Type of surgery (if required)? _____
- f) Type of treatment: _____
- g) Any loss of time from work? Yes No
If "Yes", give details and duration.

4. ARTHRITIS

- a) Type: Rheumatoid Osteoarthritis Gout Rheumatism
- b) Date of onset: _____
- c) Frequency of attacks or episodes: _____
- d) Type of treatment: _____
- e) Any loss of time from work? Yes No
If "Yes", give details and duration.

- f) What joints are affected and present condition regarding pain, deformity, limitations of movement:

5. NERVOUS OR MENTAL DISORDER

- a) Type of symptoms: Weight Loss Depression Insomnia
 Suicidal Thoughts Fatigue Nervousness Anxiety Phobia
- b) What was the cause? _____

- c) Date of onset: _____
- d) Date of last attack or episode: _____
- e) Type and duration of treatment: _____
- f) Any hospitalization required? Yes No
- g) Name and address of physician(s) consulted: _____

6. BACK OR NECK DISORDER

- a) What area of the back was involved: Neck Middle (Thoracic)
 Low (Lumbo Sacral)
- b) What was the cause? _____

- c) Date of first attack or episode: _____
- d) Date of last attack or episode: _____
- e) Frequency of attacks or episodes: _____
- f) Type of treatment: _____
- g) Any loss of time from work? Yes No
If "Yes", give details and duration.

- h) Have you had any X-rays or other investigation of your back? If "Yes", give date, results and name of physician.

- i) Any surgery performed or anticipated? If "Yes", give date and results.

- j) What is your present condition regarding pain, limitation of movement and activity?

I, the undersigned, declare that the answers to the above questions are full, complete and true, are correctly recorded and are in continuance of and form part of an application for benefits to Ontario Blue Cross.

Date _____ Signature of Applicant _____