UL MUTUAL

HEALTH STATEMENT

GROUP INSURANCE

REASON FOR THIS STATEMENT : ☐ LATE APPLICANT ☐ OPTIONAL LIFE

☐ AMOUNT EXCEEDING THE MAXIMUM WITHOUT PROOF OF INSURABILITY ☐ OTHER

EMPLOYER	GROUP	DIVISION	CERTIFICATE

NAME	MAIDEN NAME	GIVEN NAME	SEX
			M ☐ F ☐

OCCUPATION	HEIGHT	WEIGHT	SOCIAL INSURANCE N°	DATE OF BIRTH
	____ FT.IN OR ____ CM	____ LBS OR ____ KG		D M Y

QUESTIONNAIRE

FOR EACH AFFIRMATIVE RESPONSE, GIVE DETAILS IN THE "EXPLANATIONS" SECTION BELOW.

	yes	no
1. A) IN THE LAST 12 MONTHS HAVE YOU USED CIGARETTES, PIPES, CIGARS, CIGARILLOS OR ANY OTHER PRODUCT CONTAINING NICOTINE ?	☐	☐
B) IN THE LAST 3 YEARS HAVE YOU FLOWN OTHER THAN AS A FARE PAYING PASSENGER OR ON A REGULARY SCHEDULED AIRLINE OR DO YOU INTEND TO FLY OTHER THAN AS A FARE PAYING PASSENGER ON A REGULARLY SCHEDULED AIRLINE ?	☐	☐
C) IN THE LAST THREE (3) YEARS HAVE YOU PRACTICED SCUBA DIVING, RACE CAR DRIVING OR OTHER DANGEROUS ACTIVITIES OR SPORTS OR DO YOU INTEND TO?	☐	☐
D) IN THE LAST THREE (3) YEARS HAVE YOU HAD YOUR DRIVER'S LICENSE SUSPENDED OR REVOKED?	☐	☐
E) HAVE YOU EVER MADE AN APPLICATION FOR LIFE, HEALTH OR DISABILITY INSURANCE THAT WAS DECLINED, MODIFIED OR ACCEPTED WITH AN EXTRA PREMIUM OR AN EXCLUSION?	☐	☐

2. HAVE YOU EVER BEEN TREATED FOR ANY OF THE ILLNESSES OR DISEASES MENTIONED BELOW, OR EXPERIENCED ANY SYMPTOMS ?

	yes	no		yes	no		yes	no
ALCOHOLISM OR DRUG ABUSE	☐	☐	HEART DISEASE	☐	☐	SPINAL CORD DISORDERS	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐	BLOOD OR GLAND ILLNESS	☐	☐	GENITAL ORGAN DISORDERS	☐	☐
CANCER OR TUMOR	☐	☐	MENTAL ILLNESS	☐	☐	KIDNEY OR URINARY TRACK DISORDERS	☐	☐
DIABETES	☐	☐	CEREBRAL OR NEUROLOGICAL DISORDERS	☐	☐	BLOOD VESSEL DISORDERS	☐	☐
HIGH BLOOD PRESSURE	☐	☐	STOMACH, INTESTINAL OR LIVER DISORDERS	☐	☐	LUNG DISORDERS	☐	☐

3. HAVE YOU EVER HAD ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC), AN AIDS RELATED CONDITION OR TEST RESULTS INDICATING EXPOSURE TO THE AIDS VIRUS ?	☐	☐
4. DO YOU HAVE ANY PHYSICAL ABNORMALITIES, DEFORMITIES, ILLNESSES OR ANY HEALTH PROBLEMS NOT MENTIONNED IN QUESTION NUMBER TWO (2)?	☐	☐
5. A) IN THE LAST FIVE (5) YEARS HAVE YOU HAD AN ACCIDENT OR ANY INJURIES?	☐	☐
B) IN THE LAST TWO (2) YEARS HAVE YOU CONSULTED A DOCTOR, UNDERGONE ANY TESTS OR RECEIVED ANY TREATMENTS OR TAKEN ANY MEDICATION?	☐	☐
C) IN THE LAST TWELVE (12) MONTHS, HAVE YOU BEEN ABSENT FROM WORK DUE TO AN ILLNESS OR INJURY?	☐	☐
D) ARE YOU PRESENTLY TAKING ANY MEDICATION, FOLLOWING A DIET, RECEIVING ANY MEDICAL CARE OR MEDICAL TREATMENTS?	☐	☐
E) DO YOU ANTICIPATE CONSULTING A DOCTOR OR ANY OTHER MEDICAL PROFESSIONAL OR UNDERGOING ANY TESTS OR SURGERY?	☐	☐
6. HAVE YOU OR DO YOU USE AMPHETAMINES, BARBITURATES, COCAINE, HEROIN, SEDATIVES OR ANY CONTROLLED SUBSTANCE NOT PRESCRIBED BY A PHYSICIAN ?	☐	☐

IF SO NAME:_____

AMOUNT AND FREQUENCY:_____DATE LAST USED_____

7. DO YOU OR HAVE YOU EVER CONSUMED ALCOHOLIC BEVERAGES?	☐	☐

TYPE OF ALCOHOLIC BEVERAGES YOU NOW CONSUME : _____ THREE (3) YEARS AGO :

_____

WEEKLY CONSUMPTIONS : _____ THREE YEARS (3) AGO :

_____

EXPLANATIONS

QUESTION NUMBER	ILLNESS, SURGERY, EXAMS, TESTS, CONSULTATIONS, TREATMENTS, MEDICATION, RESULTS	DATE	HOSPITAL STAY	ILLNESS	NAME AND ADDRESS OF PHYSICIANS AND HOSPITALS. SPECIFY IF HOSPITALIZED, TREATED IN A CLINIC OR DOCTOR'S OFFICE.

I CERTIFY THAT ALL THE INFORMATION GIVEN IN THIS HEALTH STATEMENT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND ARE PART OF MY INSURANCE APPLICATION.

X

DATE EMPLOYEE'S SIGNATURE

NOTICE TO INSURED

ALL INSURANCE COMPANIES INCLUDING **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS MAY AT TIMES REQUEST AN INVESTIGATION REPORT WITH RESPECT TO THEIR STANDARDS IN PROCESSING AN APPLICATION.

THE INFORMATION CONCERNING YOUR INSURABILITY WILL BE TREATED CONFIDENTIALLY. HOWEVER, **UL MUTUAL** AND ITS REINSURERS MAY COMMUNICATE A SUMMARY TO THE MEDICAL INFORMATION BUREAU, THE BUREAU IS A NON-PROFIT ORGANISATION FOR THE EXCLUSIVE USE OF ITS MEMBER LIFE INSURANCE COMPANIES WHOSE PURPOSE IS TO ALLOW ITS MEMBERS THE EXCHANGE OF INFORMATION. IF YOU HAVE MADE AN APPLICATION FOR LIFE OR HEALTH INSURANCE, OR SUBMITTED A DISABILITY CLAIM TO ONE OF THE MEMBER COMPANIES, THE BUREAU WILL PROVIDE, UPON REQUEST, THE INFORMATION CONTAINED IN THEIR FILES.

UPON REQUEST THE BUREAU WILL TRANSMIT ALL INFORMATION IT HAS ON YOU. SHOULD YOU CHALLENGE THE ACCURACY OF THE INFORMATION, YOU MAY REQUEST TO RECTIFY IT BY SENDING A REQUEST TO THE MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, TORONTO, ONTARIO M5G 1R7. TELEPHONE (416) 597-0590.
UL MUTUAL AND ITS REINSURERS MAY COMMUNICATE ALL INFORMATION THEY HAVE TO ANOTHER INSURANCE COMPANY THAT HAS RECEIVED AN APPLICATION FOR LIFE OR MEDICAL INSURANCE OR A DISABILITY CLAIM FROM YOU.

AUTHORIZATION

I HEREBY AUTHORIZE ANY HEALTH CARE PROFESSIONAL, HOSPITAL, CLINIC, PUBLIC OR PRIVATE HEALTH OR SOCIAL SERVICE ORGANISATION, OR ANY OTHER MEDICAL OR MEDICALLY RELATED FACILITY, THE MEDICAL INFORMATION BUREAU, FINANCIAL INSTITUTION, OTHER ORGANIZATION, INSTITUTE OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF ME, TO **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS ANY SUCH INFORMATION.

I FURTHER AUTHORIZE **UL MUTUAL** OR THIRD PARTY INVESTIGATION AGENCIES OR ORGANIZATIONS HIRED BY **UL MUTUAL** TO ACQUIRE INFORMATION ABOUT ME.

I CONSENT TO **UL MUTUAL** RELEASING THE RESULTS OF ANY TESTS, REPORTS AND PERSONAL INFORMATION GATHERED ABOUT ME TO ITS REINSURERS, IF INVOLVED IN THE UNDERWRITING, TO MY ATTENDING PHYSICIAN, TO THE MEDICAL INFORMATION BUREAU AND OTHER AUTHORIZED INSURERS, AND TO INQUIRE TO THEM FOR THE APPRAISAL OF THE RISK OR THE EVALUATION OF A CLAIM. A REPRODUCTION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

X X

EMPLOYEE'S SIGNATURE WITNESS

RETURN THE ORIGINAL AND KEEP THE COPY