

**Health Care Providers Group Insurance Plan™
Employee Group Health Form**

**Group Health Form to be used
when Employee applying for:**
- Basic Life, ADD&D, & Disability
- Optional Group Life Insurance
- Optional Long Term Disability

TO BE COMPLETED BY EMPLOYEE (Fax copies not accepted)

Entire application to be completed in ink. PLEASE PRINT.

Group# 6414	Account # 1	PID#	Name of Employee	Street Address: City: Province: Postal Code:	Phone Bus: () Home: ()
Name of Employer:			Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Salary per month \$ _____	Occupation
Date of Birth: Day Month Year			Height:	Weight: _____ Has weight changed over past year Gain/Loss? Reason? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex:

IF APPLYING FOR OPTIONAL EMPLOYEE GROUP LIFE COVERAGE, PLEASE COMPLETE THIS SECTION:

Amount of Optional Employee Group Life Insurance being applied for: \$ _____ (coverage is available in Units of \$10,000 to a max of \$500,000)

Beneficiary: _____ Relationship: _____

1. Have any family members been diagnosed with diabetes, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?
 Yes No If "Yes", specify:

2. Have any of your parents, brothers or sisters had any hereditary disorder? (ie: Huntington's chorea, polycystic kidney disease, etc.)
 Yes No If "Yes", specify:

			Details of yes answers: Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
3. Have you ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc) for, or ever had any indication of (please specify which):	Yes	No	
a. Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Nervous disorders, including depression, severe anxiety or suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	
d. High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding, or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum or digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Hepatitis A,B, C, or "type unknown"?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Arthritis, gout, rheumatism, sciatica, deformity, or disorder of joints or limbs, any disorder of the spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
k. Cancer, tumors, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of the thyroid, pituitary, adrenals or other glands or unexplained infections?	<input type="checkbox"/>	<input type="checkbox"/>	
l. Thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
m. Venereal disease or any sexually transmitted disease or disorder of reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	
n. Any other conditions, illnesses, diseases, injuries or operations not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	

4. In the past 10 years have you:	Yes	No	Details of yes answers: Identify question number, circle applicable items, include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Received advice or treatment in connection with any of the categories mentioned in #4(a) above?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Tested positive for antibodies to the AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has an application for insurance on your life/health ever been declined, rated or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	When? Why? Company?
6. Do you currently have an individual life policy with The Co-operators that has been issued within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	When? Why?
8. Have you lost any time from work during the last 12 months because of sickness or illness?	<input type="checkbox"/>	<input type="checkbox"/>	When? Amount of time? Why?
9. Are you in need of surgical operation or do you expect to receive any health care (including attention due to pregnancy) in the future? If "Yes", give details and dates.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment, or condition? (Alternative Health Provider includes herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, state type and frequency, why?
11. Are you now to the best of your knowledge and belief in good health and free from all symptoms of illness and disease?	<input type="checkbox"/>	<input type="checkbox"/>	If no, give details,
12. Female applicant			
a) Have you ever had any disease of the breasts, ovaries, cervix or uterus?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have any pregnancies or labours been abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Are you pregnant? If "Yes", give expected date of delivery	<input type="checkbox"/>	<input type="checkbox"/>	
13. Do you now or have you ever used alcohol? If "Yes" complete the following:	<input type="checkbox"/>	<input type="checkbox"/>	
a) Frequency of use (daily, weekly, monthly) _____			
b) Amount consumed on each occasion _____			
c) Date last used _____			
14. Have you ever received or been advised to obtain any treatment for alcohol/drug use? (including AA membership)	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If "Yes" complete the following:	<input type="checkbox"/>	<input type="checkbox"/>	
a) Type of drug _____			
b) Frquency of use (daily, weekly, monthly) _____			
c). Date last used _____			
16. Tobacco Products: Proposed insured currently uses <input type="checkbox"/> Formerly used <input type="checkbox"/> Never used <input type="checkbox"/> If current or former user, number of years _____ type and amount of tobacco used per day _____ If former user, date last used _____			Note : Tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.
17. Who is your regular physician or family doctor? Please provide full name/address	Date Last Seen		Reason, diagnosis, treatment, result/outcome
	Month	Yr.	

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Applicant Declaration and Authorization Note:

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with Co-operators, the group plan administrator or the representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite my Application for insurance coverage, evaluate my eligibility for coverage and adjudicate all claims.

I authorize the release by Co-operators of information obtained during the underwriting process to my personal physician and to Co-operator's re-insurers, and when required to Public Health Authorities. I further authorize Co-operators, the group plan administrator or their representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation as may be required for such purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of my Application. I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

This authorization shall remain valid until revoked in writing by me. Any copy of the authorization shall be as valid as the original.

Employee Signature: _____

Date: _____