Entire application must be completed in ink
Please print
Fax copies not acceptable

Group Policy # 6414

Health Care Providers Group Insurance Plan
Application for Optional Group Life Insurance for Spouse

Benefits applied for at this time:

Amount of Insurance ______ (Coverage is available in units of $10,000 to a maximum of $500,000.)

Applicant Information

1. Status of Applicant: ❑ Spouse

   Is Employee actively at work? ❑Yes ❑No If no, why ______

Name of Employee ______ Employer ______

2. Name of Spouse: ______ Sex: ❑ Male ❑ Female

Res. Address: ______

City ______ Province ______ Code ______

Annual Salary ______ Occupation ______

Date of Birth: ______ day ______ month ______ year Telephone number: Home ______ Business ______

3. Is Spouse currently insured for this coverage? ❑ No ❑ Yes - Grp./PID# ______

4. Beneficiary in the event of death of the Applicant (Designation by Employee only):

   Name (full given names): ______

   Relationship to Applicant: ______

   Note: For Spousal Applications the beneficiary of this insurance will be the employee.

Applicant's Declaration of Insurability

5. Has any family member been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ❑Yes ❑No

   If yes, specify: ______

6. Have any of your parents, brothers or sisters had any hereditary disorders? ❑Yes ❑No

   If yes, specify: (ie: Huntington's chorea, polycystic kidney disease, etc.)

7. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last 2 years? ❑Yes ❑No If YES, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

8. Your height ______ Your weight ______

Has your weight changed in the past year? ❑Yes ❑No

If YES, how much? ______ Why? ______

9. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? ❑Yes ❑No

   If NO, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

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 care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.)

    ❑Yes ❑No

    If YES, What? ______ Why? ______

11. Who is your regular physician or family doctor?

Address:

Date Last Seen: Reason and Result:

12. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ❑ Yes ❑ No If yes, give details:

13. Have you ever had or been told you had any of the following:

		Yes	No
a)	Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)?	❑ Yes	❑ No
b)	Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)?	❑ Yes	❑ No
c)	Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)?	❑ Yes	❑ No
d)	Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine?	❑ Yes	❑ No
e)	Cancer, cyst, tumour, growth or blood disorder?	❑ Yes	❑ No
f)	Epilepsy, paralysis, dizziness, nervous or mental disorder?	❑ Yes	❑ No
g)	Neuritis, arthritis, rheumatism, back, spine, bone joint, or muscle disorder?	❑ Yes	❑ No
h)	Nervous disorders, including depression, severe anxiety or suicidal thoughts?	❑ Yes	❑ No
i)	AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder?	❑ Yes	❑ No
j)	Hepatitis A,B, C or type unknown, or any other disorder of the liver?	❑ Yes	❑ No
k)	Any disease, impairment or deformity not named above?	❑ Yes	❑ No

If yes to any questions in #13, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

14. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ❑ Yes ❑ No If YES, give details:

15. Have you ever been refused life insurance or offered insurance modified in any way? ❑ Yes ❑ No If YES, give details including date and reason:

16. Tobacco Use: Have you smoked any Tobacco Products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.) ❑ Yes ❑ No

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

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 their 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 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(s) 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 this authorization shall be as valid as the original.

Date Signed ____________________________ Spouse's Signature:____

Date Signed ____________________________ Employee Signature: ____

I wish to apply for the optional coverage under group policy # ____________________ Account# ____________ PID# ____________ issued by Co-operators Life Insurance Company, and authorize my employer to deduct regularly from my salary any contribution required by me.

This form must be received in our office within 60 days of the above date otherwise a new application must be completed.