

1920 College Avenue  
Regina, Saskatchewan  
S4P 1C4

Group # _____
Account # _____
PID # _____

**TO BE COMPLETED BY EMPLOYEE**

**Entire application to be completed in ink. PLEASE PRINT.  
Fax copies not acceptable**

Name of employee		City		Prov.	Postal Code	Phone
Address of employee						Work (    ) Home (    )
Name of policyholder/employer			Salary per month \$ _____		Occupation	
Date of Birth		Height		Weight		Sex
Day	Month	Year				
1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify:						
2. Have any of your parents, brothers or sisters had any hereditary disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify: (ie: Huntington's chorea, polycystic kidney disease, etc.)						
			<b>Yes</b>	<b>No</b>	<b>Details of "Yes" answers:</b>	
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 condition of (please specify which):					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) 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) 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"/>		
i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome?			<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, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of 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 prostate or 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"/>		

	Yes	No	Details of "Yes" answers:
4. In the past 10 years have you: 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"/>	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.
b) Received advice or treatment in connection with any of the categories mentioned in (4a)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Tested positive for antibodies to 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 receiving any treatment/medication from any physician or alternative healthcare provider as previously defined?	<input type="checkbox"/>	<input type="checkbox"/>	State type and frequency.
11. 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 delivery date.	<input type="checkbox"/>	<input type="checkbox"/>	
12. Do you now or have you ever used alcohol? If "Yes", complete the following: a) Frequency of use (daily, weekly, monthly) _____ b) Amount consumed on each occasion _____ c) Date last used _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)	<input type="checkbox"/>	<input type="checkbox"/>	
14. Do you now or have ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If "Yes", complete the following: a) Type of drug _____ b) Frequency of use (daily, weekly, monthly) _____ c) Date last used _____	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you ever used any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)? If "Yes", for how long and how often? How long have you been smoking?	<input type="checkbox"/>	<input type="checkbox"/>	
16. In the past 5 years, has a family physician or any other practitioner examined, advised or treated you? If "Yes", give names below or each instance and add details to the right.	<input type="checkbox"/>	<input type="checkbox"/>	Reason, diagnosis and treatment
Full Names and Addresses of Physician and Practitioners		Date Mo. Yr.	

### Applicant Declaration and Authorization

The answers recorded are given by me and are complete and true. I acknowledge receipt of the notice regarding the Medical Information Bureau. I have been notified that a consumer report may be requested or a personal investigation conducted in connection with this application and hereby authorize Co-operators Life Insurance Company to procure such consumer report or to conduct or cause to be conducted a personal investigation. 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, institution or person, that has any records or knowledge of me or my health, to give the Co-operators Life Insurance Company or its reinsurer(s) any such information. A copy of this authorization shall be as valid as the original.

DATE \_\_\_\_\_ SIGNATURE OF EMPLOYEE (in ink) \_\_\_\_\_

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

APPLICANTS (Detach and Retain for your records)

### NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Co-operators Life Insurance Company uses underwriting procedures designed to provide the best possible products on the most favourable basis and in considering your application, requires information about you and your health. This information includes the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Co-operators Life Insurance or its reinsurer(s) may, however, make a brief report to the 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 Bureau member company for life or health insurance coverage or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is:

Medical Information Bureau, 330 University Ave., Suite 403, Toronto, Ontario, M5G 1R7  
Telephone: (416) 597-0590

## DEPENDENT GROUP HEALTH EVIDENCE FORM

**COMPLETE IF LATE APPLICANT for EHC & Dependent Group Life**

Proposed lives to be insured	Date of Birth			Height	Weight
	Day	Month	Year		
Spouse:					
Child:					
Child:					
Child:					

	Yes	No	
			<p><b>Details of "Yes" answers:</b> Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment, outcome/result, as well as name and address of doctor consulted.</p>
1. Do all the dependents named above reside with the employee? If "No", give details. Identify child.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was any child born prematurely? If "Yes", identify child and state how many months.	<input type="checkbox"/>	<input type="checkbox"/>	
3. If any child is less than one year old, give name and birth weight:			
4. Has any dependent ever had			
a) Rheumatic fever, arthritis or any disorder of the bones, muscles, joints or spine?	<input type="checkbox"/>	<input type="checkbox"/>	
b) High blood pressure, chest pain or any heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Tuberculosis, pleurisy, asthma, bronchitis, or any other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Ulcers, recurrent indigestion, chronic diarrhea, stomach or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Sugar, albumin, or blood in urine, diabetes, nephritis, kidney stone; or any disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
f) Cancer, tumour, enlarged glands (nodes) or skin lesions?	<input type="checkbox"/>	<input type="checkbox"/>	
g) Convulsions, epilepsy, nervous breakdown; or any disorder of the brain or nervous system	<input type="checkbox"/>	<input type="checkbox"/>	
h) Any other disease, conditions, or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	
i) An application for insurance declined, postponed or modified in any way? When, why and what company?	<input type="checkbox"/>	<input type="checkbox"/>	
j) Within the past 5 years an electrocardiogram, x-ray, blood test or any surgical operation? State results.	<input type="checkbox"/>	<input type="checkbox"/>	
k) Advice that surgery is required?	<input type="checkbox"/>	<input type="checkbox"/>	
l) Venereal disease or any sexually transmitted disease or disorder of reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Female Dependents:			
a) Has any dependent ever had any disease of the breasts, ovaries or uterus?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have any pregnancies or labours been abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Is any dependent pregnant? If "Yes", give expected delivery date.	<input type="checkbox"/>	<input type="checkbox"/>	

*continued . . .*



the co-operators

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<p style="text-align: right; margin: 0;"><b>Yes   No</b></p> <p>6. In the past 10 years has any dependent:</p> <p>a) Had or been told they had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions?      <input type="checkbox"/>   <input type="checkbox"/></p> <p>b) Received advice or treatment in connection with any of the categories mentioned above in (6a)?      <input type="checkbox"/>   <input type="checkbox"/></p> <p>c) Tested positive for antibodies to the AIDS (Human T-cell Lymphotropic, TYPE III); HIV virus? If "Yes", give details.      <input type="checkbox"/>   <input type="checkbox"/></p>																					
<p>7. In the past 5 years, has a family physician or any other practitioner or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) examined, advised or treated any dependent? If "Yes", give name and dates below for each instance and details to the right.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Name of Dependent</th> <th style="width: 60%;">Full Names and Addresses of Physician and Practitioners</th> <th colspan="2" style="width: 25%;">Date</th> </tr> <tr> <td></td> <td></td> <th style="width: 10%;">Mo.</th> <th style="width: 15%;">Yr.</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Name of Dependent	Full Names and Addresses of Physician and Practitioners	Date				Mo.	Yr.													Reason, diagnosis and treatment.
Name of Dependent	Full Names and Addresses of Physician and Practitioners	Date																			
		Mo.	Yr.																		

**I declare, understand and authorize as follows:**

- That any dependent children listed who are not my natural or adopted children have been residing with me for at least 12 consecutive months;
- The statements and answers provided on this form are complete and true;
- In the event any statement is incomplete or false, that any coverage granted may be voided;
- Any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my dependents health, to give the Co-operators Life Insurance Company any such information. A photographed copy of this authorization shall be as valid as the original.

DATE \_\_\_\_\_ SIGNATURE OF EMPLOYEE (in ink) \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF SPOUSE \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF CHILD \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF CHILD \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF CHILD \_\_\_\_\_

**Any expense incurred in providing this or additional information is the responsibility of the employee.  
This form must be received in our office within 60 days of the above date. Otherwise, a new form must be completed.**