the co-operators®
A Better Place For You®

# OPTIONAL GROUP LIFE INSURANCE APPLICATION FOR CHILDREN HEALTH CARE PROVIDERS GROUP INSURANCE PLAN

6

To avoid delays, please complete the required information by printing clearly in ink.

**This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.**

## PLAN MEMBER INFORMATION

Group ____ **6414** ____ Account ___ **1** ___ Certificate _____ Group Name _____

Plan Member _____ _____ _____
First Name Initial Last Name

Is plan member actively at work? ☐ Yes ☐ No If no, why? _____

## APPLICANT INFORMATION

Applicant: ☐ Child _____ _____ _____
First Name Initial Last Name

Mailing Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ ☐ Male ☐ Female
MMM/DD/YYYY

## COVERAGE AMOUNT (coverage is available in units of $5,000 to a maximum of $50,000)

**Existing Optional Group Life Amount**: (under this group) $ _____

**New Total Amount Requested**: $ _____

## BENEFICIARY INFORMATION (designation by plan member only)

Beneficiary in the event of death of the Applicant

_____ _____ _____ Relationship _____
First Name Initial Last Name

For Child Applications the beneficiary of this insurance will be the employee.

## APPLICANT DECLARATION OF INSURABILITY

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? ☐ Yes ☐ No

   If yes, specify _____

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

   If yes, specify (e.g. Huntington's chorea, polycystic kidney disease, etc.) _____

3. 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 Onset | Date of Recovery | Attending Physician or Hospital | Result |
|---|---|---|---|---|
| | MMM/DD/YYYY | MMM/DD/YYYY | | |
| | MMM/DD/YYYY | MMM/DD/YYYY | | |

4. Height _____ Weight _____ Has your weight changed in the past year? ☐ Yes ☐ No

   If yes, how much? _____ Why? _____

5. 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 Onset | Attending Physician or Hospital | Result |
|---|---|---|---|
| | MMM/DD/YYYY | | |
| | MMM/DD/YYYY | | |

6. 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? _____

7. Who is your regular physician or family doctor? _____ If none, walk-in clinic visited:

   _____ _____ _____ _____
   Street City Province Postal Code

   Approximate Date Last Seen _____ Reason and Result _____
   MMM/DD/YYYY

8. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ☐ Yes ☐ No

   If yes, give details _____

## APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

9. Have you ever had or been told you had any of the following:
   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 or brain disorder? ☐ Yes ☐ No
   g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   h) Nervous or mental 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 question in number 9, give details below:

| Name of Disorder | Date of Onset | Date of Recovery | Attending Physician or Hospital | Result |
|---|---|---|---|---|
| | MMM/DD/YYYY | MMM/DD/YYYY | | |
| | MMM/DD/YYYY | MMM/DD/YYYY | | |

10. 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 including: frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

    Amount consumed on each occasion _____ Date last used _____ MMM/DD/YYYY

11. Have you ever been refused life insurance or offered insurance modified in any way? ☐ Yes ☐ No

    If yes, date _____ MMM/DD/YYYY Reason _____

12. 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

    If yes, for how long? _____ how many per day? _____

## PRIVACY AND DECLARATION

### PRIVACY STATEMENT CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

The 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.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about The Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co-operators at Priory Square, Guelph, ON, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

### APPLICANT DECLARATION AND AUTHORIZATION

The applicant includes the Parent or Guardian of a child under 16 years of age to be insured.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependents for the purpose stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide The Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize The Co-operators to release my personal and health information to my physician, the Public Health authorities, and The Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

I declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months. I confirm that I am authorized to act on behalf of my spouse and dependents. I understand that The Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in The Co-operators voiding my insurance coverage.

Signature _____ (Child Signature, if age 16 or over) Date _____ MMM/DD/YYYY

Signature _____ (Plan Member Signature, application for child under age 16 years) Date _____ MMM/DD/YYYY