the co-operators®
A Better Place For You®

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN PLAN MEMBER GROUP HEALTH FORM

Group Health form to be used when Plan Member is applying for:
- Basic Life, AD&D, & Disability
- Optional Group Life Insurance
- Optional Long Term Disability

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To avoid delays, please complete the required information by printing clearly in ink. All questions must be answered or form will be returned.

PLAN MEMBER INFORMATION (To be completed by the Plan Member)

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

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

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

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female Height _____ Weight _____

Occupation _____ Are you actively at work? ☐ Yes ☐ No If no, why? _____

IF APPLYING FOR ADDITIONAL EMPLOYEE GROUP LIFE COVERAGE, PLEASE COMPLETE THE FOLLOWING SECTION:

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

Beneficiary _____ (First Name) _____ (Initial) _____ (Last Name) Relationship _____

HEALTH EVIDENCE

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 disorder (i.e.: Huntington's chorea, polycystic kidney disease, etc.)?	☐ Yes ☐ No	If yes, specify: _____
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):		**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) Disorder of eyes, ears, nose or throat?	☐ Yes ☐ No	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?	☐ Yes ☐ No	
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
g) Hepatitis A, B, C, or "type unknown"?	☐ Yes ☐ No	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	☐ Yes ☐ No	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, pituitary, adrenals or other glands or unexplained infections?	☐ Yes ☐ No	
l) Thyroid or other endocrine disorders?	☐ Yes ☐ No	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	☐ Yes ☐ No	
n) Other than previously listed, have you had any other conditions, illnesses, ailments, diseases, injuries, operations, visited any other doctor or had any diagnostic tests?	☐ Yes ☐ No	
4. In the past 10 years have you:		
a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions?	☐ Yes ☐ No	
b) Received advice or treatment in connection with any of the categories mentioned in (4a)?	☐ Yes ☐ No	
c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	☐ Yes ☐ No	
5. Has an application for insurance on your life/health ever been declined, rated or modified in any way?	☐ Yes ☐ No	When? _____ Why? _____ Company? _____

HEALTH EVIDENCE (CONTINUED) To be completed by the Plan Member

6. Do you currently have an individual life policy with The Co-operators that has been issued within the last five years?	☐ Yes ☐ No	If yes, Policy # _____
7. Have you applied for or received a pension or Workers' Compensation or disability benefits because of illness or injury?	☐ Yes ☐ No	When? _____ Why? _____
8. Have you lost any time from work during the last 12 months because of illness or injury?	☐ Yes ☐ No	When? _____ Amount of time? _____ Why? _____
9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? If yes, give details and dates.	☐ Yes ☐ No	
10. Are you receiving any treatment/medication from any physician or alternative healthcare provider as previously not defined? If yes, state type and frequency.	☐ Yes ☐ No	
11. Female Applicant		If yes, 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) Have you ever had any disease of the breasts, ovaries, cervix or uterus?	☐ Yes ☐ No	
b) Have any pregnancies or labours been abnormal?	☐ Yes ☐ No	
c) Are you pregnant?	☐ Yes ☐ No	If yes, give expected delivery date: _____
12. Do you now or have you ever used alcohol?	☐ Yes ☐ No	If Yes, complete the following: Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Amount consumed on each occasion: _____ Date last used: _____
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	☐ Yes ☐ No	If yes, give details and dates: _____
14. Do you now or have ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)?	☐ Yes ☐ No	If Yes, complete the following: Type of drug: _____ Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Date last used: _____
15. Have you ever used any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)?	☐ Yes ☐ No	If yes, for how long and how many per day? _____

16. Who is your regular family physician?(If none, Walk In Clinic visited) _____

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason/**Outcome** _____

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.

PLAN MEMBER DECLARATION AND AUTHORIZATION

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.

Plan Member Signature _____ Date _____ (MMM/DD/YYYY)

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