

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

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:  Spouse \_\_\_\_\_  
First Name Initial Last Name

Mailing Address \_\_\_\_\_  
Street City Province Postal Code

Phone Number: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_  
MMM/DD/YYYY

Annual Salary \$ \_\_\_\_\_ Occupation \_\_\_\_\_

## COVERAGE AMOUNT (coverage is available in units of \$10,000 to a maximum of \$500,000)

Existing Optional Group Life Amount: \$ \_\_\_\_\_ New Total Amount Requested: \$ \_\_\_\_\_  
(under this group)

## BENEFICIARY INFORMATION (designation by plan member only)

Beneficiary in the event of death of the Applicant \_\_\_\_\_  
First Name Initial Last Name Relationship \_\_\_\_\_

For Spousal Applications the beneficiary of this insurance will be the employee.  
 In Quebec, the designation of your spouse as a beneficiary is irrevocable unless you declare otherwise. I designate my spouse as a revocable beneficiary:  Yes

## 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 (ie: 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. 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	_____	_____
5. 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? \_\_\_\_\_
6. 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
7. 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)**

8. 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 8, 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	_____	_____

9. 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

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

If yes, date \_\_\_\_\_ Reason \_\_\_\_\_  
MMM/DD/YYYY

11. 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/day? \_\_\_\_\_

**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](http://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](mailto: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**

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 \_\_\_\_\_ Date \_\_\_\_\_  
(Spouse Signature) MMM/DD/YYYY

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Plan Member Signature) MMM/DD/YYYY