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**DECLARATION OF INSURABILITY
GROUP INSURANCE**

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

A- PARTICIPANT'S LAST NAME (MAIDEN NAME IF APPLICABLE) FIRST NAME

NO. STREET APT. CITY PROVINCE POSTAL CODE
ADDRESS

TELEPHONE CURRENT DUTIES (employment) ARE YOU CURRENTLY WORKING? IF NO, WHY NOT?
HOME: () - WORK: () - YES NO

B- PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH OF THE PROPOSED INSURED:

	LAST NAME (MAIDEN NAME IF APPLICABLE)	FIRST NAME	DATE OF BIRTH YEAR / MONTH / DAY	HEIGHT FT. IN/CM	CURRENT WEIGHT LB/KG	WEIGHT A YEAR AGO LB/KG
PARTICIPANT						
DEPENDENTS (FAMILY OR SINGLE-PARENT COVERAGE)						
SPOUSE						
CHILD						
CHILD						
CHILD						

C- MEDICAL QUESTIONNAIRE

IMPORTANT: ANSWER ALL QUESTIONS AND EXPLAIN ANY ANSWERS UNDER SECTION D ON THE REVERSE, IF NECESSARY

PLEASE SPECIFY WHETHER ANY OF THE PROPOSED INSURED:

	PARTICIPANT		SPOUSE		CHILDREN		FIRST NAME
	YES	NO	YES	NO	YES	NO	
1) IS CURRENTLY, OR HAS BEEN WITHIN THE LAST 3 YEARS , ABSENT FROM HIS OR HER REGULAR DUTIES DUE TO CONVALESCENCE, ILLNESS OR INJURY? DATE: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) HAS EVER SUBMITTED AN APPLICATION FOR INSURANCE THAT WAS DECLINED, DEFERRED OR APPROVED WITH A HIGHER PREMIUM? DATE: _____ CO.: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) PRACTISES OR PLANS TO PRACTISE A PROFESSIONAL SPORT OR A HAZARDOUS LEISURE ACTIVITY? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) IS TAKING ANY PRESCRIPTION DRUGS OR HOMEOPATHIC MEDICINES? NAME: _____ QTY/DAY: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) TAKES, OR HAS EVER TAKEN DRUGS OR NARCOTICS? TYPE: _____ DATE LAST USED: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) SUFFERS FROM ANY PHYSICAL OR MENTAL ABNORMALITY, DISABILITY OR ANY AFTER-EFFECTS OF AN ACCIDENT? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) SUFFERS OR HAS EVER SUFFERED FROM AN ILLNESS, OR HAS EVER HAD A HEALTH PROBLEM? DATE: _____ PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8) IS CONSULTING, PLANS TO CONSULT OR HAS BEEN ADVISED TO CONSULT A PHYSICIAN OR HAS BEEN TOLD HE OR SHE NEEDS TO HAVE AN OPERATION? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9) IS CONSULTING OR PLANS TO CONSULT ANOTHER HEALTH CARE PROFESSIONAL , INCLUDING ALTERNATIVE MEDICINE? PLEASE SPECIFY: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) WITHIN THE LAST 5 YEARS , HAS CONSULTED A PHYSICIAN, THERAPIST OR OTHER HEALTH CARE PROFESSIONAL, INCLUDING ALTERNATIVE MEDICINE, OR BEEN ADMITTED TO A HOSPITAL OR OTHER MEDICAL ESTABLISHMENT? IF YES, EXPLAIN UNDER SECTION D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11) HAS UNDERGONE, IS DUE TO UNDERGO, OR HAS EVER BEEN ADVISED TO UNDERGO A HIV (AIDS) TEST? DATE: _____ REASON: _____ RESULT: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

