Equitable Life of Canada®

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HEALTH INFORMATION

APPLICATION/POLICY NUMBER

1. **Name in full:** **Date of Birth:** dd/mm/yyyy ☐ **Male** ☐ **Female**

2. a) Name and address of regular medical/health care advisor or medical clinic: _____

b) Date of Last consult with any medical/health care professional or clinic (even if outside of Canada) _____ (dd/mm/yyyy)

If a different doctor/clinic than listed in 2a, provide name /address: _____

Reason for last medical consultation: _____

At the last medical consultation was there: (i) a diagnosis made; (ii) treatment or medication prescribed; (iii) test results obtained or provided; or (iv) follow-up advised? ☐ Yes ☐ No If "Yes" provide details:

3. HEIGHT ft. ins. ☐ cms. ☐

WEIGHT lbs. ☐ kilos ☐

Weight change in past 12 months: ☐ Yes ☐ No

Gain_____Loss_____

Reason:_____

PERSONAL HISTORY	Yes No	Give full particulars, conditions, dates, duration, testing and results, full names and addresses of doctors, hospitals and clinics.
4. Family History: Has any family (father, mother, brother or sister) member ever been diagnosed with: • Alzheimer's disease • amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) • cancer (include type) • diabetes (include type) • heart disease • hepatitis • Huntington's chorea • multiple sclerosis • Parkinson's disease • stroke • polycystic kidney disease • retinitis pigmentosa • any other hereditary disease or disorder • any other motor neuron disease	☐Yes ☐No	

Life #	Family member: Father, Mother, Sisters and Brothers	Condition	Age at onset	Age if living	Age at death

5. Heart and circulatory system: Have you ever been treated for or had any symptoms, complaints or indication of: • aneurysm • angina • blood clot • chest pain or shortness of breath • pacemaker • heart attack (myocardial infarction) • coronary artery disease (CAD) including Bypass/angioplasty • heart murmur • high cholesterol (hyperlipidemia) • high blood pressure (hypertension) • peripheral vascular disease (poor circulation) • irregular heart beat, pulse • transient ischemic attack (TIA) • stroke or cerebrovascular accident (CVA) • any other disease or disorder of the heart or blood vessels	☐Yes ☐No	
6. Abnormal growths or malignancy: Have you ever been treated for or had any symptoms, complaints or indication of: • abnormal mammogram • cancer • leukemia • lump/cyst • lymphoma • polyp • tumour • basal cell carcinoma • melanoma • any other growths or malignancies	☐Yes ☐No	

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PERSONAL HISTORY	Yes No	Give full particulars, conditions, dates, duration, testing and results, full names and addresses of doctors, hospitals and clinics.
7. **Blood, glandular and endocrine system: Have you ever been treated for or had any symptoms, complaints or indication of:** • abnormal blood sugar • diabetes • gestational diabetes • goiter • hyperthyroidism/hypothyroidism • lymph, adrenal or pituitary gland disease or disorder • a bleeding disorder • anemia • hemophilia • any other thyroid or endocrine disease or disorder • any other blood disease or disorder	☐Yes ☐No	
8. **Gastrointestinal system: Have you ever been treated for or had any symptoms, complaints or indication of**: • cirrhosis • Crohn's disease • diverticulitis • hepatitis (including carrier state) • irritable bowel syndrome • jaundice • pancreatitis • persistent diarrhea • rectal or intestinal bleeding • ulcer (peptic or gastric) • ulcerative colitis • any other disease or disorder of the esophagus, intestine, rectum, pancreas, stomach or liver	☐Yes ☐No	
9. **Ears, eyes, nose, throat and mouth: Have you ever been treated for or had any symptoms, complaints or indication of: (excluding routine check-ups, tonsillectomy, adenoidectomy, sinusitis, or other disorder requiring eye glasses, contact lenses or ear tubes):** • blindness • blurred or double vision • deafness • glaucoma • impaired hearing • impaired sight • labyrinthitis • optic neuritis • tinnitus • any other disease or disorder of ears, eyes, nose, throat or mouth	☐Yes ☐No	
10. **Respiratory system: Have you ever been treated for or had any symptoms, complaints or indication of :** • asthma • chronic obstructive pulmonary disease (COPD) • chronic bronchitis • cystic fibrosis • emphysema • persistent cough • sarcoidosis • sleep apnea • tuberculosis • any other respiratory disease or disorder	☐Yes ☐No	
11. **Mental Health: Have you ever been treated for or had any symptoms, complaints or indication of:** • attention deficit disorder • burnout • anxiety • chronic fatigue • depression • eating disorder • bipolar disorder • schizophrenia • suicide attempt or ideation • any other psychological, developmental, emotional or behavioural disorder	☐Yes ☐No	
12. **Skin and connective tissue: Have you ever been treated for or had any symptoms, complaints or indication of (excluding poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema):** • dysplastic nevi or nevus • lupus • psoriasis • scleroderma • any other lesions, freckles or moles that have changed in size, colour or bleed • any other skin disease or disorder	☐Yes ☐No	
13. **Kidney, bladder and reproductive system: Have you ever been treated for or had any symptoms, complaints or indication of:** • abnormal pap smear • abnormal prostate specific antigen (PSA) • hysterectomy • kidney stone(s) • nephritis • uterine fibroid • sexually transmitted infection • sugar, blood or protein in the urine • any other kidney or bladder disease or disorder • any other reproductive, prostate or breast related disease or disorder	☐Yes ☐No	

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PERSONAL HISTORY	Yes No	Give full particulars, conditions, dates, duration, testing and results, full names and addresses of doctors, hospitals and clinics.
14. **Musculoskeletal system: Have you ever been treated for or had any symptoms, complaints or indication of:** • arthritis • chronic fatigue • chronic pain syndrome • fibromyalgia • muscular dystrophy • numbness or weakness of any arm or leg • paralysis • any other disease or disorder of the muscles, joints, limbs, back or bones	☐Yes ☐No	
15. **Nervous system: Have you ever been treated for or had any symptoms, complaints or indication of:** • Alzheimer's disease • amyotrophic lateral sclerosis (ALS) • cerebral palsy • cognitive impairment • coma • dementia • developmental delay or Down's syndrome • dizziness or vertigo • epilepsy or seizures • fainting or syncope • loss of sensation, speech or balance • multiple sclerosis (MS) • Parkinson's disease • any other motor neuron disease or disorder • tremor • severe headache • post concussion syndrome • Autism • any other congenital neurological disease or disorder • any other disease or disorder of the brain or nervous system	☐Yes ☐No	
16. **Immune system: Have you ever been treated for or had any symptoms, complaints or indication of:** • AIDS • HIV • any other immune system disease or disorder	☐Yes ☐No	
17. **In the last 5 years have you had any of the following medical or diagnostic tests:** • ECG • X-ray • CT scan • MRI • Colonoscopy • ultrasound • biopsy • blood test • any other medical or diagnostic tests	☐Yes ☐No	
18. **In the last 5 years have you had an illness or injury which prevented you from performing your usual activities or the regular duties of your occupation for a period exceeding 2 weeks?**	☐Yes ☐No	
19. **Do you have any symptoms, complaints or indication, including persistent or undiagnosed pain, regarding your health for which you have not yet consulted a physician or received medical treatment?**	☐Yes ☐No	
20. **Do you have any medical conditions, not addressed in the previous questions, for which you have been or are being investigated, under observation, tested or treated for, or for which you are currently awaiting investigation, observation, testing, test results or treatment?**	☐Yes ☐No	
21. **Are you taking any prescribed or non-prescribed medication including herbal or holistic treatment (excluding vitamins), for any symptoms, complaints, indication or medical conditions not addressed in the previous questions**	☐Yes ☐No	

HEALTH INFORMATION

I certify that I have read the answers to the foregoing questions and that they are correctly recorded as I have made them and that I know nothing not disclosed herein affecting my insurability. I agree that they shall be part of my application for insurance. Failure to disclose every fact within your knowledge that is material to the insurance or any misrepresentation of such facts in this Statement of Health shall make the policy voidable by the Company.

AUTHORIZATION TO CONSULT PHYSICIAN, HOSPITAL OR OTHER INSTITUTION

I hereby authorize any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment; or any hospital or clinic where I have been a patient for such diagnosis, treatment, disease or ailment; or any medical or medically related facility; Insurance Company, the MIB Inc or other organization, institution or person that has any records or knowledge of me or my health, to give full particulars thereof, including any prior medical history, to The Equitable Life Insurance Company of Canada or its reinsurer(s). A photostatic copy of this authorization shall be as valid as the original.

SIGNATURE OF PERSON TO BE INSURED _____

WITNESS _____

Date _____

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