Request for Evidence of Insurability for RTOERO Members

securian CANADA

Policy numbers 141000 and 141001

Please PRINT clearly.

1. General information

Information about you

First name	Initial	Last name	Former/maiden name (if applicable)	
Date of birth (dd-mm-yyyy)	Province of birth	Country of birth		☐ Male ☐ Female
Address (street number and name)			Apartment or suite	
City		Province	Postal code	
Telephone number	Email address			

Information about your spouse (complete if applying for benefits)

First name	Initial	Last name	Former/maiden name (if applicable)	
Date of birth (dd-mm-yyyy)	Province of birth	Country of birth		☐ Male ☐ Female
Telephone number	Email address			

Information about your dependent child(ren) (complete if applying for benefits)

First name	Initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female
First name	Initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female
First name	Initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female

If you need more space, please complete on separate sheet of paper, and sign and date it.

For office use only

Certificate number: _____

☐ Extended Health Care Plan: ☐ Single ☐ Couple ☐ Family
☐ Semi-Private Hospital & Convalescent Care Plan: ☐ Single ☐ Couple ☐ Family

Notes:

_____

_____

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2. Statement of insurability

Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled.

Do not tell us about genetic testing or genetic test results.

2.1 Background information

Information about you

Height ft in / m cm	Weight ☐ kg ☐ lbs
Have you lost or gained more than 10lbs in the last 12 months? ☐ Yes ☐ No	If yes, please check gain or loss and the amount of weight change ☐ Gain: ☐ Loss: ☐ kg ☐ lbs
Name of attending physician	
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)	
Name of physician, diagnosis, treatment given, results, medication prescribed	
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them	

Information about your spouse (complete if applying for benefits)

Height ft in / m cm	Weight ☐ kg ☐ lbs
Have you lost or gained more than 10lbs in the last 12 months? ☐ Yes ☐ No	If yes, please check gain or loss and the amount of weight change ☐ Gain: ☐ Loss: ☐ kg ☐ lbs
Name of attending physician	
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)	
Name of physician, diagnosis, treatment given, results, medication prescribed	
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them	

If you need more space, please complete on separate sheet of paper, and sign and date it.

2. Statement of insurability (continued)

2.2 Medication and/or treatment information

(Complete if you are under age 65. Otherwise, proceed to section 2.3)

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

You	Your spouse	Your dependent child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If **yes,** please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Price you pay per month	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

2. Statement of insurability (continued)

2.3 Health questionnaire

Do not tell us about genetic testing or genetic test results.

In the last 10 years has there been any treatment for, known indication of, or consultation with any health care professional about:	You	Your spouse	Your dependent child(ren)
a) heart disease, stroke, TIA, circulatory disorder, chest pains or angina?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) blood disorders including cholesterol, high or low blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) tumours, cancer, moles, other growths or disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or other immune disorder including Hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) respiratory problems or any lung diseases?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) stomach, digestive problems, intestinal or colon problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) kidney problems or disease, liver problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) urinary tract problems, breast, prostate or genital problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) multiple sclerosis, seizures, paralysis or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) diabetes or high blood sugar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) depression, anxiety, or any other psychiatric problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) bone or joint problems, or any muscular pain including any neck or back pain?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) any other condition not listed above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) substance abuse (including drugs or alcohol)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) had his or her driver's license suspended or revoked, or had three or more moving violations in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) engaged or intend to engage in, any hazardous sport or activity (eg., auto or motorcycle racing, scuba or sky diving, or hang gliding)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) had an application for insurance declined, postponed, rescinded, cancelled or modified in any way, or been denied a renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details below for any yes answers in section 2.3 (a-q). Include the results of all physical examinations and check-ups. If you need more space, please complete on separate sheet of paper and sign and date it.

Question	Name of person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results

3. Declaration and authorization

I declare that my answers in this Application form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Application form will cause the insurance to be void.

I hereby certify that I have read the Medical Information Bureau (MIB) notice in section 4, and having read the contents, I have, by my signature below, authorized the MIB to give to Canadian Premier Life Insurance Company, or its reinsurers, any information it may have.

With respect to this application, I authorize Canadian Premier Life Insurance Company, its agents and service providers to collect, use and disclose relevant information needed for the purposes of underwriting, administration and adjudicating claims with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers, and to collect, use and disclose information with Johnson Insurance for the purpose of administration.

A photocopy or electronic version of this authorization is as valid as the original.

Your signature **X**		Your spouse's signature (if applying for benefits) **X**
City signed	Province signed	Date (dd-mm-yyyy)

Please return completed application to:

Johnson Inc.
PO Box 4408 STN A
Toronto, ON M5W 3V7

4. Medical Information Bureau notice

In the course of underwriting your application, Canadian Premier Life Insurance Company may disclose information about you to its reinsurers. Canadian Premier Life Insurance Company and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Canadian Premier Life Insurance Company or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

Write to the MIB at: **Medical Information Bureau**
330 University Avenue
Toronto, Ontario M5G 1R7
or call: 416-597-0590

5. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, government agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.securiancanada.ca/privacy-statement.