



E M P L O Y E E S T A T E M E N T O F H E A L T H



EMPLOYEE INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

Employee's Name _____ Date of Birth (D/M/Y) _____
 Company Name _____ Daytime Phone Number _____
 Height _____ ft/in cm Weight _____ lbs kg Monthly Income _____
 Weight changes in the past 12 months gain loss _____ lbs kg
 Reason for weight change _____



HEALTH QUESTIONNAIRE

Date you last consulted a physician (D/M/Y) _____ Reason _____
 If "Reason" is "checkup", what problems/symptoms did you have? None OR _____
 Findings, treatment and any medication(s) prescribed _____
 Name and address of personal physician (if none, please state "none") _____

| | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1) Have you ever consulted a doctor because of, suffered from, been treated for, or had any indication of the following medical conditions? | | | 2) Have you used cigarettes or any other tobacco product in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Lung disorder (asthma, bronchitis, tuberculosis)? | <input type="checkbox"/> | <input type="checkbox"/> | 3) Are you currently taking any prescription medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmur)? | <input type="checkbox"/> | <input type="checkbox"/> | 4) Have you ever been unable to work for your employer on a full time basis for more than three days? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? | <input type="checkbox"/> | <input type="checkbox"/> | 5) In the past 5 years, have you been attended to by a physician or other health professional (such as a chiropractor, massage therapist, psychologist) and/or had medical or surgical treatments other than stated above? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Diabetes, kidney disease or urine abnormality? | <input type="checkbox"/> | <input type="checkbox"/> | 6) Have you ever used narcotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce your consumption of alcohol or taken treatment for alcoholism or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Cancer, tumor or growth, or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| f) Positive test results or pretest counselling for, or diagnosis of AIDS, antibodies to HIV or any other immunological disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| g) Epilepsy, paralysis, nervous, mental or emotional disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| h) Back, spine, neck or muscle pain/disorders, neuritis, arthritis, rheumatism, or fibromyalgia/chronic fatigue syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| i) Any disease, impairment or deformity not named? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you answer "Yes" to any of the above questions, please give details below.

| Question Number | Nature of Disorder | Date of | | Medication and/or Treatment | Approximate Monthly Cost | Attending Physician or Hospital |
|-----------------|--------------------|---------|----------|-----------------------------|--------------------------|---------------------------------|
| | | Onset | Recovery | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

I hereby declare that the above answers and statements are complete and true and I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively engaged in my occupation on a full-time basis. I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital or clinic or other medically related facility, insurance company or other organization, institution or person, with any records or knowledge of me or my health, to give any such information to the Insurer or its Reinsurer(s). A photocopy of this authorization shall be valid as the original.

Dated at _____ this _____ day of _____ 20 _____

Employee's signature _____

Information about your insurability and your dependents will be treated as confidential.



EMPLOYEE STATEMENT OF DEPENDENTS' HEALTH



DEPENDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

List all your dependents, including your spouse:

Table with 7 columns: Relation, First Name, Last Name (if different), Birthdate (D/M/Y), Sex (M/F), Height, Weight. Rows for Spouse and four Child entries.



DEPENDENT HEALTH QUESTIONNAIRE

- 1) Have any of your dependents ever consulted a doctor... 2) Have any of your dependents used cigarettes... 3) Are any of your dependents currently taking any prescription medication? 4) In the past 5 years, have any of your dependents been attended to by a physician... 5) Have any of your dependents ever used narcotics, hallucinogens or similar drugs...

If you answer "Yes" to any of the above questions, please give details below.

Table with 6 columns: Question Number, Name, Nature of Disorder, Date of Onset/Recovery, Medication and/or Treatment, Approximate Monthly Cost.

I hereby declare that the above answers and statements are complete and true to the best of my knowledge and shall form part of the application for insurance.

Dated at _____ this _____ day of _____ 20 _____

Employee's signature _____

Information about your insurability and your dependents will be treated as confidential.