



HEALTH STATEMENT FOR DEPENDENTS

GROUP INSURANCE

EMPLOYER	GROUP	DIVISION	CERTIFICATE N ^o
NAME	MAIDEN NAME	GIVEN NAME	

SPOUSE

SPOUSE'S NAME (MAIDEN NAME)	DATE OF BIRTH D M Y	PLACE OF BIRTH	SOCIAL INSURANCE N ^o
HEIGHT FT.IN. OR CM	ACTUAL WEIGHT LBS. OR KG	WEIGHT ONE YEAR AGO LBS. OR KG	REASON FOR WEIGHT VARIATION

CHILDREN

GIVEN NAME	DATE OF BIRTH D M Y	HEIGHT FT.IN. OR CM	ACTUAL WEIGHT LBS. OR KG
GIVEN NAME	DATE OF BIRTH D M Y	HEIGHT FT.IN. OR CM	ACTUAL WEIGHT LBS. OR KG
GIVEN NAME	DATE OF BIRTH D M Y	HEIGHT FT.IN. OR CM	ACTUAL WEIGHT LBS. OR KG
GIVEN NAME	DATE OF BIRTH D M Y	HEIGHT FT.IN. OR CM	ACTUAL WEIGHT LBS. OR KG

REASON FOR DEPENDENT COVERAGE

MARRIAGE
 COHABITATION
 LOSS OF EMPLOYMENT
 SPECIFY DATE : DAY _____ MONTH _____ YEAR _____

OTHER, SPECIFY : _____

INFORMATION CONCERNING YOUR SPOUSE AND CHILDREN

	SPOUSE		CHILDREN		GIVEN NAME
	YES	NO	YES	NO	
1. DOES YOUR SPOUSE HAVE ANY FAMILY MEMBERS (PARENTS, GRANDPARENTS, UNCLES, AUNTS) WITH DIABETES, CANCER, TUBERCULOSIS, HIGH BLOOD PRESSURE, HEART DISEASE OR MENTAL DISORDERS ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. DOES YOUR SPOUSE OR ANY OF YOUR CHILDREN SUFFER FROM OR HAVE SUFFERED FROM ANY ILLNESS, INJURY OR PHYSICAL OR MENTAL DISABILITY ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. IN THE LAST FIVE YEARS, HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN BEEN EXAMINED, CONSULTED OR TREATED BY A PHYSICIAN OR ANY OTHER PRACTITIONER ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER RECEIVE ANY TREATMENT IN THE HOSPITAL, CLINIC, IN A SANITARIUM, ETC ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. DOES YOUR SPOUSE OR ANY OF YOUR CHILDREN PRESENTLY RECEIVE ANY TREATMENT FROM A PHYSICIAN OR TAKE ANY MEDICATION ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER BEEN TREATED FOR ALCOHOL OR DRUG ADDICTION ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER RECEIVE OR REQUEST A PENSION OR INDEMNITY FOR BODILY INJURY OR DISABILITY ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. IS YOUR SPOUSE PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, SPECIFY DELIVERY DATE DAY _____ MONTH _____ YEAR _____					

IF YOU HAVE ANSWERED YES FOR ANY OF THE PRECEEDING QUESTIONS, GIVE DETAILS IN THE EXPLANATIONS SECTION BELOW

EXPLANATIONS

QUESTION NUMBER	GIVEN NAME OF THE CONCERNED PERSON	DATE	TERM		ILLNESS, SURGERY, EXAMS, TESTS, CONSULTATIONS, TREATMENTS, MEDICATION, RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL
			HOSPITAL	ILLNESS		

I CERTIFY THAT ALL THE INFORMATION GIVEN IN THIS HEALTH DECLARATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND ARE PART OF MY REQUEST FOR INSURANCE.

	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
DATE	EMPLOYEE'S SIGNATURE	SPOUSE'S SIGNATURE
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	SIGNATURE OF CHILDREN AGES 14 YEARS AND MORE	WITNESS

NOTICE TO INSURED

ALL INSURANCE COMPANIES INCLUDING **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS MAY AT TIMES REQUEST AN INVESTIGATION REPORT WITH RESPECT TO THEIR STANDARDS IN PROCESSING AN APPLICATION. THE INFORMATION CONCERNING YOUR INSURABILITY WILL BE TREATED CONFIDENTIALLY. HOWEVER **UL MUTUAL** AND ITS REINSURERS MAY COMMUNICATE A SUMMARY TO THE MEDICAL INFORMATION BUREAU, THE BUREAU IS A NON-PROFIT ORGANISATION FOR THE EXCLUSIVE USE OF ITS MEMBER LIFE INSURANCE COMPANIES WHOSE PURPOSE IS TO ALLOW ITS MEMBERS THE EXCHANGE OF INFORMATION. IF YOU HAVE MADE AN APPLICATION FOR LIFE OR HEALTH INSURANCE, OR SUBMITTED A DISABILITY CLAIM TO ONE OF THE MEMBER COMPANIES, THE BUREAU WILL PROVIDE, UPON REQUEST, THE INFORMATION CONTAINED IN THEIR FILES. UPON REQUEST THE BUREAU WILL TRANSMIT ALL INFORMATION IT HAS ON YOU. SHOULD YOU CHALLENGE THE ACCURACY OF THE INFORMATION, YOU MAY REQUEST TO RECTIFY IT BY SENDING A REQUEST TO THE MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, TORONTO, ONTARIO M5G 1R7. TELEPHONE (416) 597-0590. **UL MUTUAL** AND ITS REINSURERS MAY COMMUNICATE ALL INFORMATION THEY HAVE TO ANOTHER INSURANCE COMPANY THAT HAS RECEIVED AN APPLICATION FOR LIFE OR MEDICAL INSURANCE OR A DISABILITY CLAIM FROM YOU.

AUTHORIZATION

I HEREBY AUTHORIZE ANY HEALTH CARE PROFESSIONAL, HOSPITAL, CLINIC, PUBLIC OR PRIVATE HEALTH OR SOCIAL SERVICE ORGANISATION, OR ANY OTHER MEDICAL OR MEDICALLY RELATED FACILITY, THE MEDICAL INFORMATION BUREAU, FINANCIAL INSTITUTION, OTHER ORGANIZATION, INSTITUTE OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF ME, TO GIVE **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS ANY SUCH INFORMATION.

I FURTHER AUTHORIZE **UL MUTUAL**, OR THIRD PARTY INVESTIGATION AGENCIES OR ORGANIZATIONS HIRED **UL MUTUAL** TO ACQUIRE INFORMATION ABOUT ME.

I CONSENT TO **UL MUTUAL** RELEASING THE RESULTS OF ANY TESTS, REPORTS AND PERSONAL INFORMATION GATHERED ABOUT ME TO ITS REINSURERS, IF INVOLVED IN THE UNDERWRITING, TO MY ATTENDING PHYSICIAN, TO THE MEDICAL INFORMATION BUREAU AND OTHER AUTHORIZED INSURERS, AND TO INQUIRE TO THEM FOR THE APPRAISAL OF THE RISK OR THE EVALUATION OF A CLAIM.

A REPRODUCTION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
DATE	EMPLOYEE'S SIGNATURE	SPOUSE'S SIGNATURE
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	SIGNATURE OF CHILDREN AGES 14 YEARS AND MORE	SIGNATURE OF WITNESS