



**GROUP INSURANCE PLAN
CRITICAL ILLNESS STATEMENT OF HEALTH**

EMPLOYEE (PLAN MEMBER) INFORMATION (Please PRINT all answers in ink)

Last Name:		Policy #:	
First Name:		Telephone #: ()	
Company:		Firm #:	
Home Address:			
City:		Province:	Postal Code:
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> French		Birthdate (D/M/Y)	
Spouse's Name (if applicable):		Spouse's Birthdate (D/M/Y):	

DEPENDENT INFORMATION (Please list minor dependents named in the application – if applicable)

Relation	Last Name	First Name	Birthdate (D/M/Y)	Gender (M/F)	Dependent Children (< age 21)	Full-Time Student (< age 25)	Disabled Dependent (> age 21)
Spouse					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH QUESTIONNAIRE

		Employee		Spouse		Dependent1		Dependent2*	
		Yes	No	Yes	No	Yes	No	Yes	No
1.	Have you ever sought advice or received treatment for, or had any known indication of:								
	a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Cancer, tumour or malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Advanced ophthalmic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Multiple sclerosis or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) AIDS, HIV, chronic or unexplained infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Within the last five years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following:								
	a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Hospitalized due to a medical problem with respect to severe respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If more than two dependents are named in the application, please complete additional Health Questionnaire section and attach to this application.

				Employee		Spouse		Dependent1		Dependent2*					
				Yes	No	Yes	No	Yes	No	Yes	No				
	d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3.	Have you ever been declined for life insurance or offered coverage only at higher than standard rates?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4.	Does your height and weight fall outside the chart noted below?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Males						Females					
	Height	Min. Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight			
	4' 8"	95	145	5' 8"	132	207	4' 8"	86	145	5' 8"	119	207			
	4' 9"	98	150	5' 9"	137	213	4' 9"	88	150	5' 9"	123	213			
	4' 10"	100	155	5' 10"	141	219	4' 10"	90	155	5' 10"	127	219			
	4' 11"	103	160	5' 11"	145	225	4' 11"	93	160	5' 11"	131	225			
	5' 0"	105	165	6' 0"	150	233	5' 0"	95	165	6' 0"	135	233			
	5' 1"	108	170	6' 1"	155	241	5' 1"	97	170	6' 1"	140	241			
	5' 2"	111	175	6' 2"	160	249	5' 2"	100	175	6' 2"	144	249			
	5' 3"	114	180	6' 3"	165	257	5' 3"	103	180	6' 3"	149	257			
	5' 4"	118	185	6' 4"	170	265	5' 4"	106	185	6' 4"	153	265			
	5' 5"	121	190	6' 5"	175	272	5' 5"	109	190	6' 5"	158	272			
	5' 6"	124	195	6' 6"	180	279	5' 6"	112	195	6' 6"	162	279			
	5' 7"	128	201	6' 7"	185	285	5' 7"	115	201	6' 7"	167	285			
				Employee		Spouse		Dependent1		Dependent2*					
				Yes	No	Yes	No	Yes	No	Yes	No				
5.	Have you ever sought advice or received treatment for, or had any known indication of:														
	a) Advanced loss of hearing?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	c) any psychiatric disorder, mental deterioration or loss of intellectual ability?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	d) Gout, Arthritis, Scleroderma, Muscular Dystrophy, Ataxia, Systemic Lupus Erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	e) Amputation due to disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
6.	Do you currently:														
	a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

PRIVACY STATEMENT

At Chubb Life, we are committed to protecting our customers' privacy. Chubb Life's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, we, our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb and/or Chubb Life may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

AUTHORIZATION

I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb and/or Chubb Life, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Signed at _____ **this** _____ **day of** _____ **20** _____

Employee's Signature

Spouse's Signature (if applicable)

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