

# CAUS Canadian Benefits

## SHORT FORM MEDICAL

BROKER ID **W** \_\_\_\_\_

This form must be completed if applying for the **Value Plus** or **Business Value Plan**  
(This form is not required if applying for the Guaranteed Issue Value Plan)

### PLEASE PRINT

ORGANIZATION/COMPANY/UNION NAME: \_\_\_\_\_

APPLICANT: \_\_\_\_\_  
(Last Name) (First Name)

Coverage Applying For:

- Value Plus**
- Business Value Plan**

BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ S.I.N. # \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX: F  M  HEIGHT: \_\_\_\_ WEIGHT: \_\_\_\_  
MM DD YY

I wish to be insured and understand that, to be considered, I must answer the following questions:

- Have you, within the past 12 months, consulted a physician / been treated for or had any known identification of the following:  
Yes  No

If "YES" please clearly indicate the nature of the problem:

|   |       |                       |       |
|---|-------|-----------------------|-------|
| Heart, Circulatory Problems, High Cholesterol | _____ | Stroke                | _____ |
| Nervous System Disorder, Epilepsy             | _____ | Cancer                | _____ |
| Diabetes                                      | _____ | Respiratory Ailment   | _____ |
| Liver, Intestinal, or Kidney Dysfunction      | _____ | Asthma, Allergies     | _____ |
| Mental, or Emotional Disorder                 | _____ | Aids, HIV             | _____ |
| Muscle, Bone or Joint disorder                | _____ | Fibromyalgia          | _____ |
| Chronic Fatigue Syndrome                      | _____ | Arthritis, rheumatism | _____ |

I have read and considered all of the ailments listed above. Initial: \_\_\_\_\_

- Have you been confined in a hospital or other institution due to an accident or illness for more than 5 days in the past 3 years or are you currently receiving medical treatment? Yes  No
- Have you, within the last five years, had an application for life or health insurance declined or had a policy rated up, waived or issued for a smaller amount than applied for? Yes  No
- Within the past three (3) years have you used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol use? Yes  No

I understand that, to be considered, I must also answer the following questions:

- Are you or your dependents presently taking any medications, which require a prescription to be dispensed (excluding birth control pills)? Yes  No   
If yes, what medications? \_\_\_\_\_ Approximate Monthly Cost \$ \_\_\_\_\_  
Any Other Medications? \_\_\_\_\_ Approximate Monthly Cost \$ \_\_\_\_\_  
Dependent's Name? \_\_\_\_\_ Medications? \_\_\_\_\_ Approx. Cost \$ \_\_\_\_\_  
Dependent's Name? \_\_\_\_\_ Medications? \_\_\_\_\_ Approx. Cost \$ \_\_\_\_\_

If you have answered "Yes" to any of the above questions, complete the Long Form Medical Application on reverse.

The answers given on this application are full, true, complete to the best of my knowledge and correctly recorded. I understand any material misrepresentation shall render the coverage voidable at the option of the Insurer.

I understand the information provided on this document will be treated as confidential and is gathered for the purpose of underwriting the insurance applied for. It is further understood that coverage applied for will not become effective until approved by the Insurers.

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Signature of Applicant)

This enrollment form and medical form should be mailed or given to your broker

1. (a) Name \_\_\_\_\_  
 \_\_\_\_\_  
 (b) Residence Address \_\_\_\_\_  
 \_\_\_\_\_  
 (c) Place of Birth (Town/City/Prov./ State/Country) \_\_\_\_\_  
 Date of Birth: Day \_\_\_\_ Mth. \_\_\_\_\_ Year \_\_\_\_\_

2. (a) Occupation \_\_\_\_\_  
 (b) Average Gross Monthly Earnings \_\_\_\_\_  
 (c) Employer's Name \_\_\_\_\_  
 (d) Daytime Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

3. (a) Height \_\_\_\_\_ Weight \_\_\_\_\_  
 If "Yes" how much? \_\_\_\_\_  
 (b) Has your weight changed in the last year? Yes  No   
 Why? \_\_\_\_\_

4. Do you have a physical or mental health problem or any physical defect or any symptoms of illness or disease? Yes  No   
 If "Yes", give details in #9 below.

5. (a) Name and address of your personal physician \_\_\_\_\_  
 (b) Date and reason for last consultation \_\_\_\_\_  
 (c) Describe any treatment or medication \_\_\_\_\_

If the answer to any of the following questions is "Yes", please give additional details in #9 below.

6. Have you ever been told you have any of the following:
- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
|   | Yes                      | No                       |   | Yes                      | No                       |
| (i) Lung Disorder (e.g. asthma, bronchitis, tuberculosis)   | <input type="checkbox"/> | <input type="checkbox"/> | (viii) Neuritis, arthritis, rheumatism, back  | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Heart trouble (e.g. chest pain, shortness of breath, high blood pressure or heart murmur)?                               | <input type="checkbox"/> | <input type="checkbox"/> | (ix) Any disease, impairment or deformity not named above?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Stomach trouble (e.g. ulcer, indigestion or gall bladder disorders)?  | <input type="checkbox"/> | <input type="checkbox"/> | 7. In the past 5 years, have you ever been hospitalized or under medical observation, or had medical or surgical advice or treatment other than stated above? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Diabetes, kidney disease or urine abnormality?   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever taken drugs, other than for medical purposes, or been advised to drink less alcohol or received treatment for drug addiction or alcoholism?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) Cancer, tumor or growth, or blood disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| (vi) Positive test results or counseling or diagnosis of AIDS, ARC or antibodies to AIDS or any other immunological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| (vii) Epilepsy, paralysis, nervous or mental disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

9. Details of above

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

I hereby declare that the above answers and statements are complete and true, and agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance would have 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 understand the information provided on this document will be treated as confidential and is gathered for the purpose of underwriting the insurance applied for.

I hereby authorize any licensed physician, medical practitioner, hospital, 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 such information to Canadian Group Benefit Insurance Programs or its reinsurer(s). A photocopy of this authorization shall be as valid as the original.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
 (Applicant's Signature)

\_\_\_\_\_  
 (Signature of Witness)

**INFORMATION ABOUT YOU OR YOUR DEPENDENTS' INSURABILITY WILL BE TREATED AS CONFIDENTIAL**

This enrollment form and medical form should be mailed or given to your broker