

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:

1. 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: _____

2. 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
3. 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
4. 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:

5. 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

