

MEDICAL QUESTIONNAIRE



Instructions

1. You must complete this medical questionnaire at the time of insurance application and prior to the effective date of insurance.
2. Only you can complete and sign your medical questionnaire, not your spouse, broker or sales agent.
3. You must make sure that all medical questions on the medical questionnaire are answered YES or NO and provide dates and all pertinent results or information required.
4. If you have any doubt about your medical condition(s) as it relates to the questions asked, you must consult your medical physician for advice before completing the medical questionnaire.
5. You must make sure you have completed all sections, signed and dated your medical questionnaire prior to the effective date.
6. Your insurance coverage is issued on the basis of the answers you have provided on your medical questionnaire and receipt of required premium. Any inaccuracies on this application could affect your coverage if the inaccurate information directly affects the risk assessment made with respect to your policy.

SECTION I - PERSONAL INFORMATION

<small>(Mr, Mrs, Miss, Ms, Dr, Other)</small>			
Title	First Name(s)	Last Name	
<input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="Y"/>	<input type="text" value="M"/> <input type="text" value="F"/>	<input type="text"/>	<input type="text"/>
Date of Birth	Sex	Height	Weight
<input type="text"/>			<input type="text" value="M"/> <input type="text" value="Y"/>
Provincial Health Insurance Plan Number (optional)		(Version Code)	Expiry Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Nationality on Passport(s)	Foreign Country of Residence	Occupation	
Address		Mailing Address (if different from adjacent)	
<input type="text"/>		<input type="text"/>	
Telephone Number - Residence		Telephone Number - Work	
<input type="text"/>		<input type="text"/>	
Fax Number		E-mail Address	
<input type="text"/>		<input type="text"/>	
Name of family physician (If you do not have a family physician please provide the information for the physician you visited most recently)			
Physician's Address		<input type="text"/>	
<input type="text"/>		Physician's telephone number	
<input type="text"/>		<input type="text"/>	
		Physician's fax number	

SECTION II - MEDICAL HISTORY (Please attach any supporting documents. Use separate sheet if space is insufficient.)

1. In the last year (365 days), have you consulted a doctor? Yes No
If yes, please provide the dates, reasons and any medications prescribed.
2. Are you currently under observation, undergoing treatment or taking medication? Yes No
If yes, please provide the dates, reasons and the name(s) of any medication(s) you are currently taking.
3. Are you currently disabled? Yes No
If yes, please provide the date the disability was diagnosed and any treatment or medication required.
4. Have you had surgery on your breast(s), ovary(ies) or uterus? Yes No
If yes, please provide date and any treatment or medications required.
5. Are you pregnant? Yes No
If yes, please provide expected date of delivery.

SECTION III - MEDICAL CONDITIONS

Have you ever been told you had any disorder of: (Check the boxes which apply to your condition)

- | | |
|---|--|
| <p>1. The HEART or BLOOD VESSELS, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cardiac problems <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart attack <input type="checkbox"/> Murmur <input type="checkbox"/> Poor circulation <p>3. The ABDOMINAL ORGANS, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bowel obstruction <input type="checkbox"/> Gallstones <input type="checkbox"/> Liver disease <input type="checkbox"/> Internal bleeding <input type="checkbox"/> Diverticulitis <p>5. The GLANDULAR SYSTEM, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Hormone disorders <input type="checkbox"/> Skin disorders <p>7. The MUSCULO-SKELETAL SYSTEM, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Paralysis <input type="checkbox"/> Tumor of the bones, joints or muscles <p>9. MENTAL or EMOTIONAL disorders, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Psychological disorder | <p>2. The LUNGS, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Blood spitting <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Malignant tumor <p>4. The KIDNEY(S), GENITAL ORGANS, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nephritis (Kidney Infection) <input type="checkbox"/> Kidney stone <input type="checkbox"/> Infection (Bladder or Genital organs) <input type="checkbox"/> Sugar, albumin, blood or pus in urine <p>6. The NERVOUS SYSTEM, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Paralysis <p>8. The EYE(S), EAR(S), NOSE & THROAT, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infection <input type="checkbox"/> Inflammation <input type="checkbox"/> Tumor <p>10. The IMMUNE SYSTEM, such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> An immune deficiency syndrome <input type="checkbox"/> AIDS <input type="checkbox"/> Had test indicating exposure to HIV <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Epilepsy <input type="checkbox"/> Stroke <input type="checkbox"/> The AIDS-related complex (ARC) <input type="checkbox"/> The virus causing AIDS |
|---|--|

11. Have you been diagnosed with diabetes? Yes No

If yes, please provide date of diagnosis, type of diabetes and treatment required: _____

12. Indicate any disease, condition or abnormality not indicated above. Please include date of diagnosis, medication prescribed, date of medication prescribed, any treatment required, and the date of any changes related to treatment:

13. During the past 5 years, have you:

a) Had X-Rays, electrocardiograms, any laboratory or diagnostic tests? Yes No

If yes, please specify reason and provide date: _____ D M Y

Please attach test results to this questionnaire.

b) Been advised to have a surgical operation, or diagnostic test, or are you on a waiting list for admission to a hospital, or awaiting any kind of medical treatment, consultation or investigation? Yes No

If yes, please specify reason and provide date: _____ D M Y

c) Been under observation or treatment at a clinic, hospital or sanitarium? Yes No

If yes, please specify reason and provide date: _____ D M Y

SECTION IV - DECLARATION - A copy of this declaration shall be as valid as the original.

Part A - Pre-existing medical conditions

I/we understand that any condition and including condition(s) disclosed in this medical questionnaire (except for a minor ailment) for which the Insured Person(s) has sought or received medical treatment, advice, follow-up visits, counseling, or has taken prescription drugs within **one hundred and eighty (180) days** prior to becoming insured under this Policy, will not be covered until a continuous period of not less than **three hundred and sixty-five (365) consecutive days** has passed during which time the Insured Person(s) has not sought or received medical treatment, advice, follow-up visits, counseling, nor has taken prescription drugs related to such condition.

Part B - Release of Medical Information

By signing this medical questionnaire, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all health or medical records.

Part C - Disclosure

I personally completed this medical questionnaire and all information disclosed on it is true and accurate. I understand that the answers on my medical questionnaire are relevant to the risk and constitute the basis of my insurance application. Any inaccuracies on this application could affect your coverage if the inaccurate information directly affects the risk assessment made with respect to your policy. Where I was unsure of my medical history as it relates to my medical questionnaire, I have verified it with my medical doctor.

 Applicant's Signature _____ Date of Signature _____