ACE INA Life Insurance

GROUP INSURANCE PLAN

CRITICAL ILLNESS STATEMENT OF HEALTH

EMPLOYEE INFORMATION (Please answer all questions in ink)

Last Name ______________________ Policy # ______________

First Name ______________________ Telephone ______________

Company ______________________ Firm # ______________

Home Address ______________________ Language Preference ❑ English ❑ French

City ____________ Province ____________ Postal Code ____________ Birthdate (D/M/Y) ______________

Spouse's Name ______________________ *(if applicable)* Spouse Birthdate (D/M/Y) ______________

HEALTH QUESTIONNAIRE

		EMPLOYEE Yes	EMPLOYEE No	SPOUSE Yes	SPOUSE 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?	❑	❑	❑	❑
	(b) Cancer/malignancy?	❑	❑	❑	❑
	(c) Advanced ophthalmic disease?	❑	❑	❑	❑
	(d) Multiple sclerosis or paralysis?	❑	❑	❑	❑
	(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?	❑	❑	❑	❑
	(f) AIDS, HIV, chronic or unexplained infections?	❑	❑	❑	❑
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, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	❑	❑	❑	❑
	(b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	❑	❑	❑	❑
	(c) Hospitalized due to a medical problem with respect to severe respiratory disorder?	❑	❑	❑	❑
	(d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?	❑	❑	❑	❑
3)	Have you ever been declined for life insurance or offered coverage only at higher than standard rates?	❑	❑	❑	❑
4)	Does your height and weight fall outside the chart noted below?	❑	❑	❑	❑

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

FOR ENHANCED COVERAGE ONLY:

		EMPLOYEE		SPOUSE	
		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?	❑	❑	❑	❑
	(b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?	❑	❑	❑	❑

Privacy Statement: When you apply to enroll in the ACE INA Group Insurance Plan, underwritten by ACE INA Life Insurance ("ACE"), the information in ACE'S existing insurance files and the information requested on your application is required by ACE, its reinsurers and authorized agents to process your application (*and if approved*), administer your insurance policy, assess claims and investigate misrepresentation. ACE will create a file with your insurance information, and in the event of a claim, with such information as ACE obtains from you and other sources, for the purpose of considering you claim and administering benefits under the Plan. Access to this file will be restricted to those ACE employees, authorized agents and reinsurers who require access to administer the Plan and process claims and persons authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer; ACE INA Life Insurance, The Exchange Tower, 130 King Street West, 12th Floor, Toronto, ON, M51A6.

AUTHORIZATION

I hereby declare that the above answers and statements are complete and true and I agree that any coverage issued in consequence of this application shall not take effect, unless, on the date the insurance is to 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 hereby authorize any licensed physician, medical practitioner, hospital or clinic or medically related facility, insurance company or other organization, institution or person, with any records or knowledge of me or my health, to give any such information to the Insurer or its Reinsurer(s). A photocopy of this authorization shall be valid as the original.

Signed at ______________________ this ________ Day of ______________ 20 ________

Employee's signature ____

Signed at ______________________ this ________ Day of ______________ 20 ________

Employee's signature ____

Spouse's Signature *(if applicable)* ____

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