

# Declaration of Health



## Administrative Information

Name of Employee	Name of Municipality
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## Participant Statement – Information on Persons Applying for Coverage

Complete for all persons applying for coverage.

<input type="checkbox"/> <b>EMPLOYEE</b> Height    Weight <input type="checkbox"/> lbs.    Gender <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Occupation Home Address    No.    Street    City    Postal Code Phone Number    Date of Birth Name of Attending Physician (first, initial, last) Address of Attending Physician    No.    Street    City    Postal Code	<input type="checkbox"/> <b>CHILDREN</b> Surname (2)    Given Name    Date of Birth Height    Weight    Relationship to Employee    Gender <input type="checkbox"/> lbs. <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Surname (3)    Given Name    Date of Birth Height    Weight    Relationship to Employee    Gender <input type="checkbox"/> lbs. <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Surname (4)    Given Name    Date of Birth Height    Weight    Relationship to Employee    Gender <input type="checkbox"/> lbs. <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Surname (5)    Given Name    Date of Birth Height    Weight    Relationship to Employee    Gender <input type="checkbox"/> lbs. <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Name of Attending Physician (first, initial, last)    Phone Number Address of Attending Physician    No.    Street    City    Postal Code
<input type="checkbox"/> <b>SPOUSE</b> Height    Weight <input type="checkbox"/> lbs.    Gender <input type="checkbox"/> kg <input type="checkbox"/> M <input type="checkbox"/> F Surname (1) Given Name Date of Birth Name of Attending Physician (first, initial, last)    Phone Number Address of Attending Physician    No.    Street    City    Postal Code	

## Participant Statement – Medical Questionnaire

All questions should be fully completed to avoid delays in the assessment. For questions with **bold** print answered 'Yes', please complete appropriate questionnaire in the following section. For all other questions answered 'Yes', use the details section to explain.

If 'Yes' to any questions for a dependent, please provide dependent number.

	Employee	Dependents		Employee	Dependents
1. Have you ever been tested for, or told you had: a) <b>abnormal blood pressure</b> , chest pain, heart attack, phlebitis, or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	2. a) Have you ever had or been diagnosed or told you had AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus), ARC (AIDS Related Complex) or any other immunological disease or disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
b) ulcers, jaundice, chronic diarrhea, gallbladder, hepatitis or liver disease, or any other disease of the stomach, intestines, or rectum?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	b) consulted a physician or received advice or treatment for any of the above in 2 a)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
c) asthma, bronchitis, emphysema, tuberculosis or any other respiratory disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	c) had a positive test for exposure to the AIDS virus including the HTLV III/LAV/HIV Antibody?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
d) abnormal urine, venereal disease, or any disease of the kidneys, bladder, prostate or reproductive organs?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	3. Have you any impairment or condition for which medical treatment, hospitalization or surgery has been advised within the next year?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
e) <b>arthritis</b> , ruptured disc, back or neck pain, knee problems, whiplash, amputation or any other disease, injury, or deformity of the spine, joints, bones, or muscles?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	4. Have you ever had an application for insurance declined, postponed, or rated? If 'Yes', state insurance company and reason.	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
f) epilepsy, paralysis, stroke, recurrent headaches, or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	5. If female, are you currently pregnant? If 'Yes', indicate expected date of confinement.	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
g) <b>anxiety, depression</b> or any other mental illness?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	6. Have you or any dependent taken medication or been treated for or told that you had any physical impairment, condition, disease or disorder not stated in this questionnaire?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
h) <b>diabetes</b> , thyroid or any other glandular disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	7. Have any persons applying for coverage lost or gained more than 10 lbs during the last 12 months? What was the amount of weight change? _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Reason: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
i) cancer, cyst, tumor, or skin disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			
j) anemia, leukemia, or any other disease of the blood or lymph glands?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			
k) any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act ([www.privcom.gc.ca](http://www.privcom.gc.ca)). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our web site: [www.westernfgis.ca](http://www.westernfgis.ca)

## Participant Statement – Questionnaires

If you have answered "yes" to any of the following conditions, please complete the corresponding questionnaire(s) below.

### Blood Pressure

Name and Relationship (employee/dependent)			
Date first advised blood pressure elevated (yy/mm/dd)	Treatment <input type="checkbox"/> Diet <input type="checkbox"/> Medicine <input type="checkbox"/> Other If Medicine, please list names, dosages, frequency: _____	How long on treatment?	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 2 years have special test been done? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type of test, date(s) and results _____		Are you aware of any recent readings? <input type="checkbox"/> No <input type="checkbox"/> Yes, give readings _____	

### Diabetes

Name and Relationship (employee/dependent)		
Type of Diabetes	Age of Diagnosis	Is diagnosis related to any other physical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details: _____
Treatment <input type="checkbox"/> Diet _____ <input type="checkbox"/> Oral medicine, given name(s), dosage, frequency _____ <input type="checkbox"/> Insulin, specific type & dosage _____	Have you experienced any of the following? <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Trouble with Blood Vessels <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetic Coma <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Hypoglycemic Shock	

### Arthritis

Name and Relationship (employee/dependent)	
Type <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other, specify: _____	What joints were involved?
Is there swelling or deformity? <input type="checkbox"/> No <input type="checkbox"/> Yes, give details: _____	Date problem began (yy/mm/dd)
In the past 2 years how frequent was the pain?	Duration
Treatment <input type="checkbox"/> Medicine, given name(s), dosages, frequency: _____ <input type="checkbox"/> Other, specify _____	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No, give date treatment last received: _____

### Anxiety or Depression

Name and Relationship (employee/dependent)		
Type <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	Date problem began (yy/mm/dd)	Date(s) of further occurrence(s)
Treatment <input type="checkbox"/> Hospitalization <input type="checkbox"/> Psychiatrist consulted <input type="checkbox"/> Medicine, given name(s), dosages, frequency _____ <input type="checkbox"/> Other, specify _____	Is condition still present? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Participant Statement – Details

Please use this section to fully explain all questions answered "Yes" in the Medical Questionnaire which has not been covered in the section above.

Please list all current medications – specify names, dosages, frequency and duration of medication.

Question Number	Name and Relationship (employee/dependents)	Health Details	Date (yy/mm/dd)	Attending Physician's Name and Address

## Authorization to Provide Information

A photocopy of this authorization will be as valid as the original.

I HEREBY AUTHORIZE any physician, practitioner, hospital, medical or paramedical clinic, insurance company, or any other organization, institution or person having any information about me or my children concerning our health or our insurability, to provide such information in order to evaluate my eligibility and insurability or that of my spouse and my dependents, if any, under this plan. I agree that an investigation report regarding myself, my spouse and my children may be requested.

Participant Signature (if to be insured)	Spouse's Signature (if to be insured)	Signature of Children over 18	Date (yy/mm/dd)
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