

Name of Employee			Telephone	Occupation:	Annual Salary
Surname	First Name	Middle Initial			
Address of Employee (number, street)					Date of Birth (dd./mm/yy)
Street	Apt.	City	Province	Postal Code	

INCOMPLETE FORMS WILL BE RETURNED

To be completed by the Employee – Statement of Health – Answer Every Question – Give Details

1. Height _____ m _____ ft b) Weight _____ kg _____ lbs.

Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:

- | | No | Yes |
|--|-----------------------|-----------------------|
| 2 a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder? | <input type="radio"/> | <input type="radio"/> |
| b) asthma, chronic cough, shortness of breath, or convulsions | <input type="radio"/> | <input type="radio"/> |
| c) high blood pressure? If yes, provide BP readings | <input type="radio"/> | <input type="radio"/> |
| d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems? | <input type="radio"/> | <input type="radio"/> |
| e) ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder? | <input type="radio"/> | <input type="radio"/> |
| f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia | <input type="radio"/> | <input type="radio"/> |
| g) cancer, tumor, leukemia, enlarged glands or lymph nodes? | <input type="radio"/> | <input type="radio"/> |
| h) diabetes, sugar in urine or thyroid disorder? | <input type="radio"/> | <input type="radio"/> |
| i) urine, kidney or bladder disorder? | <input type="radio"/> | <input type="radio"/> |
| j) anemia, bleeding or blood disorder? | <input type="radio"/> | <input type="radio"/> |
| k) difficulty with eyes or ears? | <input type="radio"/> | <input type="radio"/> |
| l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) | <input type="radio"/> | <input type="radio"/> |
| m) a positive HIV (Human Immune Deficiency Syndrome) test? | <input type="radio"/> | <input type="radio"/> |

- 3 a) Indicate your average weekly consumption of alcohol
Beer _____ oz. Wine _____ oz. Liquor _____ oz.
- b) Have you ever been advised to stop drinking alcohol or to drink less? No Yes

- 4 a) Have you ever been refused life or health insurance or been offered it on special terms? No Yes
- b) If you have recently applied for another insurance Policy, please provide:
Date: _____ Policy No. _____
Name of Insurance Company: _____

- | | No | Yes |
|--|-----------------------|-----------------------|
| 5 Do you have an annual checkup
If “Yes” provide results: _____
_____ | <input type="radio"/> | <input type="radio"/> |
| If “No” provide date and results of last check up.
Date: _____ Results: _____ | | |

In the past 5 years have you:

- | | | |
|--|-----------------------|-----------------------|
| 6 a) except for an annual check up, consulted a Doctor or other health practitioner, submitted to an ECG, blood tests, X – rays or other tests, had surgery or been treated in a hospital? | <input type="radio"/> | <input type="radio"/> |
| b) received or applied for disability benefits for 3 months or longer? | <input type="radio"/> | <input type="radio"/> |
| c) had a urinary tract infection or any sexually transmitted disease? | <input type="radio"/> | <input type="radio"/> |

Within the past 12 months, have:

- | | | |
|---|-----------------------|-----------------------|
| 7 a) your duties been modified due to health reasons? | <input type="radio"/> | <input type="radio"/> |
| b) you been off work for more than 5 consecutive days due to illness or injury? | <input type="radio"/> | <input type="radio"/> |
| c) you used tobacco products?
If “Yes”, indicate the number per day _____ | <input type="radio"/> | <input type="radio"/> |
| 8 Within the past 10 years have you used cocaine, heroin or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician? | <input type="radio"/> | <input type="radio"/> |
| 9 Are you presently under medical treatment by diet, Medicine, or other means? | <input type="radio"/> | <input type="radio"/> |
| 10 Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger? | <input type="radio"/> | <input type="radio"/> |
| 11 a) For women: are you pregnant? | <input type="radio"/> | <input type="radio"/> |
| b) Have you ever had any complications of pregnancy? | <input type="radio"/> | <input type="radio"/> |
| 12 In the past 12-months have you experienced any symptoms that you have not yet sought medical attention for ? | <input type="radio"/> | <input type="radio"/> |

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Name of Applicant: _____

For each “Yes” answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

Attending Physician Verification of the above:

Date: _____ Signature of Attending Physician _____

Authorization

I certify that the above statements and those on any attached sheet are true and complete. I authorize Special Risk International and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for Special Risk Insurance Managers Ltd., to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy or this authorization is as valid as the original.

Date: _____ Signature of Primary Insured _____
(Required in all instances)

You should keep a copy of this Health Questionnaire for your records.

Upon Completion, please scan and email to Special Risk Insurance Managers Ltd. Central Canada office:

ATT: Mr. Mark Johns, mjohns@SRIM.ca

**or if faxing
00-1-289-277 1384
Send original forms to
Mark Johns
Special Risk Insurance Managers Ltd
Unit 22, 10 Sunray Street
Whitby, ON
L1N 9B5**