

## Insurability inquiry

To be submitted when medical history would appear to place acceptance of the risk in question or in a highly substandard category.

Name of proposed insured \_\_\_\_\_ Date of birth (month/day/year) \_\_\_\_\_

Present occupation and duties \_\_\_\_\_ Country of birth and province or state \_\_\_\_\_

Address (number and street, city, province, postal code) \_\_\_\_\_

**Personal and medical information** (attach a separate sheet if additional space is required)

Has the proposed insured ever been declined or rated?  Yes  No

If yes, state year, company, reason and rate, if known. Year: \_\_\_\_\_

Name of company: \_\_\_\_\_

Reason and rate: \_\_\_\_\_

Illness, injury, operation	Year	Result	Name and address of attendants

Name and address of personal physician(s)	Date of last visit (month, year)	Reason

Has the proposed insured smoked or otherwise used tobacco or nicotine products in the last 12 months?  Yes  No

If stopped, on what date? (month/year) \_\_\_\_\_

Height: \_\_\_\_\_ ft & \_\_\_\_\_ ins or \_\_\_\_\_ cms    Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kgs

Any changes within the last six months? Gain: \_\_\_\_\_ lbs or \_\_\_\_\_ kgs    Loss: \_\_\_\_\_ lbs or \_\_\_\_\_ kgs

**Declaration and authorization**

I declare that the answers recorded above are given by me and are, to the best of my knowledge and belief, complete and true. I acknowledge receipt of the *Consumer notice, Notification to proposed insured regarding Medical Information Bureau (MIB, Inc.) and Notice of personal information*. I authorize and consent to:

- (a) the performance of any medical tests that Canada Life may require to medically underwrite this inquiry. The tests may include, but are not limited to, tests for, diabetes, immune disorders, infection by the human immunodeficiency virus (HIV, the AIDS virus) and the presence of drugs, nicotine or their by-products.
- (b) any physician, medical practitioner, hospital or other medically related facility, insurance company, medical information bureau (e.g. MIB, Inc.), motor vehicle department, or other organization, institution or person that has information concerning me or my health giving Canada Life and its reinsurers any such information (including record copies), and Canada Life and its reinsurers collecting such information, for underwriting, administration and claim purposes.

I am aware of the reasons the personal information covered by my authorizations and consents are needed, and of the benefits of, and the risks of not, authorizing/consenting. I authorize and consent to Canada Life's collecting, using, and disclosing personal information concerning me, including health information, for the purposes above (including those set out in the *Notice of personal information*) and as otherwise identified to or known by me. This and all authorizations and consents concerning my personal information are given in accordance with applicable law. They will begin the date they are given (the date of this inquiry, unless indicated otherwise) and end when no longer required. They may be revoked at any time by either written or electronic notification to Canada Life, subject to legal or contractual considerations.

**A reproduction of the above authorizations and consents will be as valid as the original.**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City Province Month Day Year

Witness \_\_\_\_\_ Signature of proposed insured \_\_\_\_\_

**Authorization for release of medical information**

I authorize The Canada Life Assurance Company to release any medically related information concerning me, obtained during the insurability assessment process:

- (a) To me, or my usual personal physician designated in this form, otherwise a licensed medical practitioner as designated below, or whom I subsequently designate, for communication of such information to me.

Usual personal physician: \_\_\_\_\_

Address: \_\_\_\_\_  
Number and street City Province Postal code

Or Name of other medical practitioner: \_\_\_\_\_

Address: \_\_\_\_\_  
Number and street City Province Postal code

- (b) To my associate/broker, in the form of a brief summary, for explanation to me of any adverse assessment of my insurability.  Yes  No

If yes, indicate associate/broker name:

\_\_\_\_\_

**Canada Life reserves the right, in its sole discretion, to release any such medically related information only to the personal physician or other licensed medical practitioner designated by a person proposed for insurance.**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City Province Month Day Year

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of proposed insured

**Associate/broker report**

Do you know of any information not recorded which might influence the insurability?  Yes  No

If yes, give details (attach a separate sheet if additional space is required):

\_\_\_\_\_



## **Notification to proposed insured regarding Medical Information Bureau (MIB, Inc.)**

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Information regarding your insurability will be treated as confidential. However, we and our reinsurers may make a brief report thereon to the Medical Information Bureau (MIB, Inc.), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its Members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction, either by writing the Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7 or by telephoning 416-597-0590.

## **Consumer notice**

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As part of our procedure for processing your inquiry, we may obtain a consumer report and an investigation containing personal information about a proposed insured, from a reporting agency.

## **Notice of personal information**

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Further to an insurability inquiry for any product or service, Canada Life establishes a confidential file that contains personal information concerning you. You have rights of access to, and correction of, this information. These rights may be exercised by writing to the "Ombudsman, The Canada Life Assurance Company, 255 Dufferin Avenue, London, Ontario, Canada N6A 4K1". The file is kept in the offices of Canada Life or in premises of a third party acting on our behalf. Rights of access to personal information in the file are limited to our staff or persons we authorize who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We collect, use and disclose your personal information to:

- (1) process this inquiry and, if this ~~an~~ application is approved, provide and service the financial product(s) and/or service(s) applied for,
- (2) advise you of products and services to help you plan for financial security,
- (3) respond to, investigate and process claims,
- (4) create and maintain records concerning our relationship as appropriate, and
- (5) fulfill such other purposes as are directly related to the preceding.

**Note:** In accordance with legal requirements, a copy of the entire application, including personal information, may be included with the policy as delivered or be provided separately to the owner or a subsequent owner.

**To be given to the proposed insured**