HAVE YOU EVER HAD, BEEN TOLD YOU HAVE, BEEN TREATED, TESTED OR COUNSELLED FOR:	Applicant 1 YES	Applicant 1 NO	Applicant 2 YES	Applicant 2 NO	*Particulars of Yes Answers with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.*
1. *Chest pain, angina, palpitations, high blood pressure, heart murmur, heart attack, aneurysm, stroke abnormal electrocardiogram (ECG), peripheral vascular disease, elevated cholesterol or any other disease or disorder of the heart or blood vessels?*	☐	☐	☐	☐	
2. *Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, bronchitis, emphysema, pleurisy, tuberculosis or any other disease or disorder of the lungs or respiratory tract?*	☐	☐	☐	☐	
3. *Dizziness, fainting spells, convulsions, epilepsy, paralysis, a neurological disorder or disease, numbness or tingling of the limbs, persistent headaches, stress, anxiety, depression or any other mental illness?*	☐	☐	☐	☐	
4. *Cancer, tumor or cyst?*	☐	☐	☐	☐	
5. *Ulcerative colitis, Crohn's disease, ulcer or any other disease or disorder of the stomach or intestines?*	☐	☐	☐	☐	
6. *Jaundice, hepatitis, cirrhosis or any other disease or disorder of the liver?*	☐	☐	☐	☐	
7. *Kidney disease or disorder, venereal or any other sexually transmitted disease?*	☐	☐	☐	☐	
8. *Diabetes, disorder of the thyroid, pancreatitis or other endocrine disorder?*	☐	☐	☐	☐	
9. *Frequent or difficult urination, protein, sugar, blood or pus in urine or any other disorder of the bladder, prostate, breast or reproductive organs?*	☐	☐	☐	☐	
10. *Anemia or any other disease or disorder of the blood?*	☐	☐	☐	☐	
11. *Any disease or disorder of the skin, muscles including muscle weakness, bones or joints including arthritis, amputation or deformity?*	☐	☐	☐	☐	
12. *Any disease or disorder of the eyes, ears, nose or throat?*	☐	☐	☐	☐	
13. *Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Human Immune Deficiency Virus (HIV), enlargement of lymph nodes, chronic diarrhea, unexplained infections or any other immunological disorder?*	☐	☐	☐	☐	
14. *Any disease, disorder, ailment or injury not already mentioned?*	☐	☐	☐	☐	
15. *Females only. Surgery on breast, ovary or uterus? If you are pregnant, provide your due date.*	☐	☐	☐	☐	
16. *Have you ever been treated for or advised to seek treatment for drug and/or alcohol usage?*	☐	☐	☐	☐	
17. *Have you been a patient in a hospital or other medical facility?*	☐	☐	☐	☐	
18. *Are you currently under observation, having any special examinations or tests or taking prescribed medication?*	☐	☐	☐	☐	
19. *In the last 10 years have you used drugs that were not prescribed by your doctor? (Includes marijuana, LSD, cocaine, heroin, barbiturates or other narcotics.)*	☐	☐	☐	☐	
20. *Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?*	☐	☐	☐	☐	
21. *Have you smoked any cigarettes, cigars, cigarillos, pipe or used chewing tobacco or nicotine products (patch, gum etc.) within the past 12 months? If 'Yes', indicate amount used per day.*	☐	☐	☐	☐	
22. *Has your weight changed by more than 10 pounds within the past year? If 'Yes', please state number of pounds, a gain or a loss and reason?*	☐	☐	☐	☐	
23. *Have any of your natural parents, brothers or sisters ever suffered from any of the following conditions: heart disease, stroke, high blood pressure, diabetes, polycystic or other kidney disease, cancer or tumors, Huntington's Chorea, multiple sclerosis or any inherited disease?*	☐	☐	☐	☐	

HERE'S THE FINE PRINT. PLEASE GIVE US YOUR AUTHORIZATION.

I acknowledge receipt of the Disclosure Notice describing the operation of the Medical Information Bureau. I authorize:

i) any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Industrial Alliance Pacific Life Insurance Company or their reinsurers any such information. A copy of this authorization shall be as valid as the original.

ii) Industrial Alliance Pacific Life Insurance Company to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing me as an insurance risk. This analysis includes testing for HIV infection.

iii) Industrial Alliance Pacific Life Insurance Company to release any abnormal test results to my personal physician.

I understand that no coverage will be in effect until my Application, this Questionnaire and any other medical information required is approved by Industrial Alliance Pacific Life Insurance Company. I have fully and truthfully answered all questions in this Questionnaire and confirm that the answers are correct and complete. I understand that if they are not, my Application may be void.

X			X		
APPLICANT 1	DATE	WITNESS	APPLICANT 2	DATE	WITNESS

App. No. :