

Supplemental Health Questionnaire



You are being asked to complete this Questionnaire because either a question on the Group Insurance Application was answered 'Yes', or the amount of Life Insurance for which you have applied exceeds the maximum amount of insurance indicated on your application. Industrial Alliance Pacific Life Insurance Company requests this additional information for further consideration of your Application.

Is the Insurance Application attached?

 Y

 N

If 'No', give date Insurance Application was completed:

M		D		Y
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TELL US ABOUT YOURSELF

(Please Print)

APPLICANT 1			APPLICANT 2		
SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	DATE OF BIRTH M D Y	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	DATE OF BIRTH M D Y
HEIGHT	WEIGHT	PLACE OF BIRTH**	HEIGHT	WEIGHT	PLACE OF BIRTH**
TELEPHONE NUMBER		OCCUPATION	TELEPHONE NUMBER		OCCUPATION
APPLICATION NO.		H.O. USE ONLY	APPLICATION NO.		H.O. USE ONLY
NAME AND ADDRESS OF PERSONAL PHYSICIAN			NAME AND ADDRESS OF PERSONAL PHYSICIAN		
DATE AND REASON LAST CONSULTED ANY DOCTOR			DATE AND REASON LAST CONSULTED ANY DOCTOR		
DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED			DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED		

** Province, State or Country

Initials: _____ Date: _____

Initials: _____ Date: _____

HAVE YOU EVER HAD, BEEN TOLD YOU HAVE, BEEN TREATED, TESTED OR COUNSELLED FOR:	Applicant 1		Applicant 2		Particulars of Yes Answers with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.
	YES	NO	YES	NO	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Ulcerative colitis, Crohn's disease, ulcer or any other disease or disorder of the stomach or intestines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Jaundice, hepatitis, cirrhosis or any other disease or disorder of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Kidney disease or disorder, venereal or any other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Diabetes, disorder of the thyroid, pancreatitis or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Frequent or difficult urination, protein, sugar, blood or pus in urine or any other disorder of the bladder, prostate, breast or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Anemia or any other disease or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Any disease or disorder of the skin, muscles including muscle weakness, bones or joints including arthritis, amputation or deformity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease, disorder, ailment or injury not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Females only. Surgery on breast, ovary or uterus? If you are pregnant, provide your due date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Have you ever been treated for or advised to seek treatment for drug and/or alcohol usage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Have you been a patient in a hospital or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Are you currently under observation, having any special examinations or tests or taking prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Disclosure Notice - Medical Information Bureau

Please Read Carefully, and Keep a Duplicate Copy With Your Records

Information regarding your insurability will be treated as confidential. Industrial Alliance Pacific Life Insurance Company ("IA Pacific Life") or its reinsurers may, however, make a brief report to the Medical Information Bureau, 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 a member company, the Bureau, upon request, will supply that 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 information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information office is 330 University Avenue, Suite 102, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

IA Pacific Life or its reinsurers may also release information in the file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits is submitted.

Request for Further Information

As part of our procedure to assess your eligibility for insurance you may receive a telephone call from a member of our staff. This interview, if required, will be of short duration and will take place at a time convenient to you. If you are not available when we call, we will try and arrange that you return our call at no expense to you.

This information will be held in strictest confidence. Inquiries concerning this notice should be directed to the Underwriting Department of IA Pacific Life.

Money Back Guarantee

You have thirty days after you receive your Certificate to decide if it meets your needs. If it does not, return it to our Head Office or to the Mortgage Broker from whom you bought it. We will cancel your coverage from the Effective Date of Insurance and will refund any premium paid by you.

App. No. : _____

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