MDM Insurance Services Inc.
P.O. Box 970
Guelph, Ontario N1H 6N1

DEPENDENT HEALTH EVIDENCE QUESTIONNAIRE

Group #/ Acct #

PID # _____

Entire application to be completed in ink. PLEASE PRINT. **Please initial all changes. Fax copies not acceptable.**

Privacy Statement

MDM Insurance Services Inc. ("MDM") and Co-operators Life Insurance Company ("Co-operators") are committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that they collect, use, retain, and disclose in the course of conducting business.

Employee name: _____ Employer: _____

Address of employee: _____
Street City Prov. Postal Code

Phone: Work ( ) Home ( )

Proposed lives to be insured	Gender	Date of Birth			Height ❒ ft./in. ❒ cm	Weight ❒ lbs. ❒ kg
		Day	Month	Year		
Spouse:	❒ M ❒ F					
Child:	❒ M ❒ F					
Child:	❒ M ❒ F					
Child:	❒ M ❒ F					

		Yes	No
1.	Is the employee actively at work? If "No", why not?	❒	❒
2.	Do all the dependents named above reside with the employee? If "No", give details. Identify child.	❒	❒
3.	Was any child born prematurely? If "Yes", identify child and state how many months.	❒	❒
4.	If any child is less than one year old, give name and birth weight.		
5.	Has any dependent ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which):		
a.	Disorder of eyes, ears, nose, or throat?	❒	❒
b.	Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, or disorder of brain or nervous system?	❒	❒
c.	Nervous disorders, including depression, severe anxiety, or suicidal thoughts?	❒	❒
d.	High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels?	❒	❒
e.	Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease, or other disorder of the lungs?	❒	❒
f.	Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding, or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system?	❒	❒
g.	Hepatitis A, B, C, or "type unknown"?	❒	❒
h.	Albumin, sugar, pus, or blood in urine, diabetes, kidney stone, or colic, or any other disorder of kidney or bladder?	❒	❒
i.	Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia, or chronic fatigue syndrome?	❒	❒
j.	Leukemia, anaemia, hemophilia, or any other disorder/abnormality of the blood?	❒	❒
k.	Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of thyroid, pituitary, adrenals, or other glands or unexplained infections?	❒	❒
l.	Thyroid or other endocrine disorders?	❒	❒
m.	Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	❒	❒
n.	Any other conditions, illnesses, diseases, injuries, or operations not mentioned above?	❒	❒

Details of "Yes" answers:
Identify question number and circle applicable items. Include name of dependent, date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

		Yes	No
6.	Has any dependent ever had advice that surgery is required?	❒	❒
7.	Has any dependent ever had an application for insurance declined, postponed, or modified in any way? If "Yes", when, why, and by what company.	❒	❒
8.	Female Dependents:		
a.	Has any dependent ever had any disease of the breasts, ovaries, cervix, or uterus?	❒	❒
b.	Have any pregnancies or labours been abnormal?	❒	❒
c.	Is any dependent pregnant? If "Yes", give expected delivery date.	❒	❒
9.	In the past 10 years has any dependent:		
a.	Had or been told they had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions?	❒	❒
b.	Received advice or treatment in connection with any of the categories mentioned above in 9.a.?	❒	❒
c.	Tested positive for antibodies to AIDS (Human T-cell Lymphotrophic, TYPE III); HIV virus? If "Yes", give details.	❒	❒

Details of "Yes" answers:
Identify question number and circle applicable items. Include name of dependent, date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

10. SPOUSE:
Regular physician/family doctor or walk-in clinic/hospital/doctor last seen: _____
Address: _____
Approximate date last seen: _____ Reason/Outcome: _____

CHILD: _____
Regular physician/family doctor or walk-in clinic/hospital/doctor last seen: _____
Address: _____
Approximate date last seen: _____ Reason/Outcome: _____

CHILD: _____
Regular physician/family doctor or walk-in clinic/hospital/doctor last seen: _____
Address: _____
Approximate date last seen: _____ Reason/Outcome: _____

CHILD: _____
Regular physician/family doctor or walk-in clinic/hospital/doctor last seen: _____
Address: _____
Approximate date last seen: _____ Reason/Outcome: _____

Applicant Declaration and Authorization

I declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months.

I hereby authorize any physician, hospital, clinic, or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me, my spouse, or dependent(s) to release to and exchange with MDM, Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite this Application for insurance coverage, evaluate the eligibility for coverage, and adjudicate all claims.

I confirm that I am authorized to act on behalf of my spouse and dependent(s). I authorize the release by MDM and Co-operators of information obtained during the underwriting process to my personal physician and to Co-operators's re-insurers, and when required to Public Health Authorities. I further authorize MDM, Co-operators, the group plan administrator or their representatives and/or agents to request me or my dependent(s) to undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this Application.

I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s), or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete, and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy. This authorization shall remain valid until revoked in writing by me. Any copy of this authorization shall be as valid as the original.

SIGNATURE OF EMPLOYEE (in ink) _____ DATE _____

SIGNATURE OF SPOUSE _____ DATE _____

SIGNATURE OF CHILD (16 years or older) _____ DATE _____

SIGNATURE OF CHILD (16 years or older) _____ DATE _____

SIGNATURE OF CHILD (16 years or older) _____ DATE _____

The employee/ employer is responsible for any expense incurred in providing this or additional information.
This form must be received in our office within 60 days of the above date, otherwise a new form must be completed.