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

# HEALTH EVIDENCE QUESTIONNAIRE

Group # _____
PID # _____

**TO BE COMPLETED BY EMPLOYEE.** **ALL QUESTIONS MUST BE ANSWERED OR FORM WILL BE RETURNED.**
**PLEASE PRINT IN INK AND INITIAL ALL CHANGES.**

**Privacy Statement**

MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Name of employee _____

Address of employee _____
Street City Prov. Postal Code

Phone: Work ( ) Home ( )

| Name of policyholder/employer | Monthly salary $ | Occupation |
|---|---|---|
| | | |

| Date of birth | Height | Weight | Gender |
|---|---|---|---|
| Day Month Year | ❒ ft./in. ❒ cm | ❒ lbs. ❒ kg | ❒ Male ❒ Female |

Are you actively at work? ❒ Yes ❒ No If "No", why not?

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, Multiple Sclerosis (MS), or had a stroke? If "Yes", specify condition, relationship, age at diagnosis, and age at death: ❒ Yes ❒ No

2. Have any of your parents, brothers, or sisters had any hereditary disorder (e.g., Huntington's chorea, polycystic kidney disease, etc.)? If "Yes", specify condition, relationship, age at diagnosis, and age at death: ❒ Yes ❒ No

| 3. Have you ever consulted a physician or alternative healthcare provider (including herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which): | Yes | No |
|---|---|---|
| **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, 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, 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.** Have you had any other conditions, illnesses, ailments, diseases, injuries, or operations or visited any other doctor or had any other diagnostic tests not mentioned above? | ❒ | ❒ |

**Details of "Yes" answers:**
Identify question number and circle applicable items. Include 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 | Details of "Yes" answers: |
|---|---|---|---|---|
| 4. | In the past 10 years have you: | | | Identify question number and circle applicable items. Include 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. |
| **a.** | Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions? | ❒ | ❒ | |
| **b.** | Received advice or treatment in connection with any of the categories mentioned in 4.a.? | ❒ | ❒ | |
| **c.** | Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus? | ❒ | ❒ | |
| 5. | Has an application for insurance on your life/health ever been declined, rated, or modified in any way? | ❒ | ❒ | When?<br>Why?<br>Company? |
| 6. | Do you currently have an individual life insurance policy with The Co-operators that has been issued within the last year? | ❒ | ❒ | |
| 7. | Have you applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury? | ❒ | ❒ | When?<br>Why? |
| 8. | Have you lost any time from work during the last 12 months because of sickness or illness? | ❒ | ❒ | When?<br>Amount of time?<br>Why? |
| 9. | Are you in need of surgical operation or do you expect to receive any health care (including attention due to pregnancy) in the future? *If "Yes", give details and dates.* | ❒ | ❒ | |
| 10. | Are you receiving any treatment and/or medication from any physician or alternative healthcare provider (as defined in Question #3), which you have not mentioned in any other question on this form? | ❒ | ❒ | State type and frequency |
| 11. | Female Applicant | | | |
| **a.** | Have you ever had any disease of the breasts, ovaries, cervix, or uterus? | ❒ | ❒ | |
| **b.** | Have any pregnancies or labours been abnormal? | ❒ | ❒ | |
| **c.** | Are you pregnant? If "Yes", give expected delivery date. | ❒ | ❒ | |
| 12. | Do you now or have you ever used alcohol? If "Yes", complete the following: | ❒ | ❒ | |
| **a.** | Frequency of use (daily, weekly, monthly) _____ | | | |
| **b.** | Amount consumed on each occasion _____ | | | |
| **c.** | Date last used _____ | | | |
| 13. | Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)? | ❒ | ❒ | |
| 14. | Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative, or tranquillizing drugs (including marijuana or cocaine)? If "Yes", complete the following: | ❒ | ❒ | |
| **a.** | Type of drug _____ | | | |
| **b.** | Frequency of use: _____ # / day _____ # / week _____ # / month | | | |
| **c.** | Date last used _____ | | | |
| 15. | Smoking History: Have you used any form of tobacco, marijuana, nicotine products, or nicotine substitutes in the past 12 months? | ❒ | ❒ | If "Yes", for how long and how may per day? |

16. Who is your regular family physician? If none, provide the name of the walk-in clinic, hospital, or doctor last seen:

_____ Approximate date last seen: _____

Address: _____

Reason and outcome of last visit: _____

**Applicant Declaration and Authorization**

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 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 my Application for insurance coverage, evaluate my eligibility for coverage, and adjudicate all claims. 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 I 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 my 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.

EMPLOYEE SIGNATURE (in ink) _____ DATE _____

**For late applicants, 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.**