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BLUE CROSS®

Health Statement

☐ New enrolment ☐ Modification Policy number: _____

☐ Blue Vision (Global Plan) ☐ Blue Flex (Flex Plan) ☐ Tangible ☐ Mortgage Plan

SECTION 1 - PERSONAL INFORMATION

INSURED 1 ☐ Primary insured ☐ Borrower	Application No.	Gender	Date of Birth	Height	Weight
Last Name		☐ M ☐ F	YYYY/MM/DD		
First Name					
INSURED 2 ☐ Spouse ☐ Co-borrower	Application No.	Gender	Date of Birth	Height	Weight
Last Name		☐ M ☐ F	YYYY/MM/DD		
First Name					

Check "Spouse" if the Primary insured applied for couple or family coverage.
Check "Co-borrower" if the person to be insured is co-borrower.

If you selected a plan with a family or single parent coverage, please complete this section.

Last Name	First Name	Height	Weight	Recent weight variation and reason

Please complete sections 2, 3 and 4 for all benefits. For Hybrid coverage and Long-term care benefits, please also complete section 5.

SECTION 2 - GENERAL INFORMATION

1. Name and address of your family doctor or attending physician: _____

2. Does this doctor have your complete medical file? ☐ yes ☐ no
   If no, please provide the name and address of the doctor with your complete file: _____

3. Date of your last consultation: ___day / month / year___ Please indicate the reason, tests performed, treatments received and results:_____

In the last five (5) years, have you:	**Insured 1** Yes	**Insured 1** No	**Insured 2** Yes	**Insured 2** No	**Dependents** Yes	**Dependents** No
4. Consulted a physician other than the one mentioned above? Specialty if any: _____	☐	☐	☐	☐	☐	☐
5. Been admitted to a hospital, a clinic or any other medical facility? Please provide reason, tests performed, treatment received and results: _____	☐	☐	☐	☐	☐	☐
6. a) Undergone an x-ray, ECG or laboratory tests, biopsy, magnetic resonance imaging (MRI) or any other diagnostic test?	☐	☐	☐	☐	☐	☐
b) Had any symptoms or troubles for which you haven't consulted a doctor yet, received any treatment for or have you been advised to undergo diagnostic tests or a surgery that has not been performed yet?	☐	☐	☐	☐	☐	☐
7. Consulted a chiropractor, physiotherapist, psychologist, psychiatrist, audiologist, occupational therapist, massage therapist, acupuncturist, osteopath or podiatrist?	☐	☐	☐	☐	☐	☐

SECTION 3 - MEDICAL QUESTIONNAIRE

	Insured 1		Insured 2		Dependents	
	Yes	No	Yes	No	Yes	No
1. Have you been treated for, had symptoms or been diagnosed with any of the following conditions?						
a) **Cardiovascular system:** chest pain, palpitations, high blood pressure, high level of cholesterol, heart murmur, heart attack, angina, rheumatic fever, transient ischemic attack, stroke or neurologic deficit or any other disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐
b) **Respiratory system:** asthma, chronic bronchitis, emphysema, cystic fibrosis, sleep apnea, chronic obstructive pulmonary disease (COPD), spitting blood, chronic and persistent cough or any other disorder of the respiratory system?	☐	☐	☐	☐	☐	☐
c) **Digestive system:** ulcers, colitis, bleeding, polyps or any other disorder of the stomach, pancreas, liver (hepatitis, cirrhosis), or intestinal system such as chronic diarrhea, ulcerative colitis, Crohn's disease, intestinal hemorrhaging or loss of bowel control?	☐	☐	☐	☐	☐	☐
d) **Genitourinary system:** sugar, protein, blood or pus in urine, kidney stones, renal disorder, renal failure, urinary tract failure, disorder of the bladder, prostate or reproductive organ, abnormal cytology, incontinence, sexually transmitted diseases?	☐	☐	☐	☐	☐	☐
e) **Neurological system:** loss of consciousness, vertigo, epilepsy, numbness, multiple sclerosis, loss of sensation, weakness in extremities, memory loss, Alzheimer's disease, Parkinson's disease, motor neuron disease, dizziness, paralysis or any other disorder affecting the brain or the spinal cord?	☐	☐	☐	☐	☐	☐
f) **Endocrine system:** diabetes, anemia, leukemia, disorder of the thyroid or pituitary gland, enlarged glands or any form of endocrine or glandular disorder?	☐	☐	☐	☐	☐	☐
g) **Musculoskeletal system:** lower back pain, disc disease, herniated disc, rheumatism or any other disorder of the muscles, bones, ligaments or joints such as amputation, arthritis, fibromyalgia or anomalies of the neck, the spine, the back or the joints, amyotrophic lateral sclerosis, Huntington's chorea, delayed physical development, muscular dystrophy or fracture?	☐	☐	☐	☐	☐	☐
h) **Immune system:** acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), HIV-positive result or any other disorder of the immune system, test indicating the presence of the AIDS virus or antibodies to the AIDS virus?	☐	☐	☐	☐	☐	☐
i) **Nervous system:** depression, burnout, anxiety, chronic fatigue, attempted suicide, bulimia, anorexia nervosa or any other eating disorder, mental illness or nervous disorder, delayed mental development, autism, attention deficit disorder with or without hyperactivity (ADD/ADHD), sleep disorder?	☐	☐	☐	☐	☐	☐
j) **Other disorders:** cancer, tumour, cyst, polyps or any other growth, nevus, skin lesions or skin disorder or any other malignant disease, gout, Behçet's syndrome or any other hereditary illness, any disease of the eyes, ears or throat, breast anomaly or abnormal mammograph?	☐	☐	☐	☐	☐	☐
2. Do you have any symptoms or have you been diagnosed or received treatment for any other physical or mental disorder not mentioned above?	☐	☐	☐	☐	☐	☐
3. Are you presently under the care of a physician or taking any medication?	☐	☐	☐	☐	☐	☐

4. Has any member of your family or the child's family (father, mother, brother or sister, grandparents if parents are less than 40) had or had symptoms of any of the following illnesses? ☐ yes (circle condition) ☐ no
Cardiac disease, transient ischemic attack or stroke, cancer (specify type), diabetes, kidney disease or mental illness, Huntington's choera, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), motor neuron disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, muscular dystrophy, cystic fibrosis, polycystic kidney disease or any other hereditary illness.

Family member	Medical Condition	Age at onset	Current age	Age at Death	Cause of Death

SECTION 3 - MEDICAL QUESTIONNAIRE

5. In the last twelve (12) months, have you used tobacco in any form: cigarettes, cigarillos, cigars, pipe, chewing tobacco or snuff, shisha, betel nuts, or any other tobacco-derivative or nicotine-containing product? ☐ yes ☐ no

   If yes, specify: Type _____ Daily consumption _____ If you have ever used tobacco products, when did you stop? day/month/year

SECTION 4 - GENERAL QUESTIONNAIRE

	Insured 1		Insured 2		Dependents	
	Yes	No	Yes	No	Yes	No
1. Do you have another insurance application under assessment or have you applied for coverage with other insurance companies in the past six (6) months?	☐	☐	☐	☐	☐	☐
2. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, modified, postponed or subject to an extra premium?	☐	☐	☐	☐	☐	☐
3. Have you ever been on leave of absence, received disability benefits or any other benefit due to an accident or an illness? If so, do you have any after-effects? Please specify: _____ _____	☐	☐	☐	☐	☐	☐
4. In the last two (2) years, have you participated or are you planning to participate in activities such as car racing, scuba diving, parachuting, ultralight flying, hang gliding, mountain climbing, bungee jumping or any other hazardous sport?	☐	☐	☐	☐	☐	☐
5. In the last five (5) years, have you flown in an aircraft as a pilot, student or crew member? If yes, please complete the questionnaire related to aviation.	☐	☐	☐	☐	☐	☐
6. a) In the past three (3) years, have you been convicted of two (2) or more driving infractions or had your driver's license suspended? If yes, provide dates and details: _____ _____	☐	☐	☐	☐	☐	☐
b) In the last ten (10) years, have you been convicted of driving while impaired or dangerous driving, refused a breathalyzer test or has your driver's license been suspended for one of the above reasons? If yes, please provide dates and details: _____ _____	☐	☐	☐	☐	☐	☐
7. a) Do you consume alcoholic beverages? If yes, please specify the type of alcohol and your weekly consumption: _____ _____	☐	☐	☐	☐	☐	☐
b) Has your alcohol consumption been greater in the past? If yes, please specify the type of alcohol and your weekly consumption: _____	☐	☐	☐	☐	☐	☐
8. a) Do you use drugs such as morphine, cocaine, steroids or narcotics? If yes, please specify the type, frequency and duration: _____	☐	☐	☐	☐	☐	☐
b) Has your drug consumption been greater in the past? If yes, please specify the type, frequency and duration: _____	☐	☐	☐	☐	☐	☐
9. Have you ever received or been advised to undergo treatment or received counselling for alcohol or drug abuse? If yes, complete the Alcohol Usage Questionnaire.	☐	☐	☐	☐	☐	☐
10. Have you ever been charged, convicted or are you awaiting a trial for a criminal offence?	☐	☐	☐	☐	☐	☐
11. a) In the past twelve (12) months, have you travelled or lived outside of North America? If yes, please complete the Foreign Travel Questionnaire.	☐	☐	☐	☐	☐	☐
b) In the next twelve (12) months, are you planning to travel or live outside North America? If yes, please complete the Foreign Travel Questionnaire.	☐	☐	☐	☐	☐	☐
12. In the last three (3) years, have you declared bankruptcy? Indicate the date of release: day/month/year	☐	☐	☐	☐	☐	☐

SECTION 5 - QUESTIONS RELATED TO HYBRID COVERAGE AND TO LONG-TERM CARE BENEFITS

Long-term care: facility care, home care, hospitalization and loss of autonomy	Insured 1		Insured 2		Dependents	
	Yes	No	Yes	No	Yes	No
1. Over the course of the past five (5) years, have you been diagnosed, consulted a health professional (physician or specialist), or been treated for one of the following conditions:						
a) Amputation due to an illness or other medical condition?	☐	☐	☐	☐	☐	☐
b) Disease, surgery, amputation of knee, hip, shoulder or any other joint?	☐	☐	☐	☐	☐	☐
c) Platelet condition, hemophilia, hemochromatosis, leukemia, Epstein-Barr virus?	☐	☐	☐	☐	☐	☐
d) Ataxia, transverse myelitis, myasthenia gravis, post-polio syndrome?	☐	☐	☐	☐	☐	☐
2. Over the course of the past five (5) years, have you received or been advised to receive:						
a) Care in a hospital, psychiatric care center or physiotherapy center, convalescent center or rehabilitation center?	☐	☐	☐	☐	☐	☐
b) Assistance or physiotherapy at home, medical accessories required for rehabilitation or convalescence or any other home care?	☐	☐	☐	☐	☐	☐
c) Assistance for personal activities of daily living (standing up, eating, dressing, using the toilet, transferring and bathing/showering) and/or instrumental activities of daily living (ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medication, ability to handle finances)?	☐	☐	☐	☐	☐	☐
3. Over the course of the past twenty-four (24) months, have you taken any medication?	☐	☐	☐	☐	☐	☐

For the persons to be insured of less than 16 years of age:

4. How many siblings does the person to be insured have?
Brother(s)_____ Sister(s) _____

5. Will all of the children be insured for the same amount? ☐ yes ☐ no
If not, indicate why: _____

6. a) If the person to be insured is aged less than twelve (12) months, was he/she born premature? If yes, indicate weight at birth _____ lb/kg. ☐ yes ☐ no

b) Did the person to be insured present a delayed physical or mental development? If yes, provide details: _____ ☐ yes ☐ no
_____

7. Has the person to be insured received treatment, presented symptoms or been diagnosed with autism, cerebral palsy, cystic fibrosis, Down's Syndrome or muscular dystrophy? If yes, provide details: ☐ yes ☐ no
_____

SECTION 6 HEALTH STATEMENT

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS, PLEASE PROVIDE DETAILS BELOW.

Question No.	First name of the person	Details on diagnosis, treatment, medication and current condition	Date of each occurrence	Duration of symptoms	Duration of absence from work	Names and addresses of doctors and medical establishments

STATEMENT

Each of the persons to be insured hereby declares that all answers and explanations given in this declaration of health, and in any other document which by agreement forms an integral part, are true and complete. We, the persons to be insured, understand that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might be otherwise be valid. We also understand that any injury on the date or prior to this application, or any illness for which signs appeared on the date of this application or before are not covered, unless completely disclosed in this declaration of health.

Each of the persons to be insured requests that Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter referred to as the Insurer, issue a contract as specified herein.

This declaration offers no guarantee of insurance. The benefits take effect on the date of approval by th Insurer, provided the first premium has been paid in full and no changes in the insurability of the persons to be insured have occurred since the signing of the application.

Signed in: _____ this _____day_____ day of _____month_____ 20 ___year___.

_____ _____ _____

Signature of the Insured 1 Signature of Insured 2 Signature of Representative

_____

Signature of the policyholder if the person to be insured is less than 16 years of age.

* No representative is authorized to establish or modify the Insurer's contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of the Insurer.