Declaration of Insurability for Group Coverage

(Please print and answer **ALL** questions, both pages)

#105, 1209 – 59th Avenue SE
Calgary, AB T2H 2P6
Phone: (403) 297-0252
Toll Free Phone: (800) 292-9066
Toll-free Fax: (800) 364-0754

SECTION I

THIRD PARTY ADMINISTRATOR:______________ **PLAN ADMINISTRATOR'S NAME:** ______________

EMPLOYER: ______________ **OCCUPATION:** ______________

UNISTAR POLICY NO.:__________ **DIVISION NO.:**__________ **BENEFIT CLASS:**__________ **ID #:** __________

DATE OF FULL-TIME EMPLOYMENT:_____/_____/_____ (MM DD YYYY) **DATE ELIGIBLE FOR BENEFITS:**_____/_____/_____ (MM DD YYYY)

EARNINGS: $__________**per** ☐**YEAR** ☐**MONTH** ☐**WEEK** ☐**HOUR** **NUMBER OF HOURS PER WEEK:** __________

For Third Party Administrator Use Only
****Do not write in this box****

☐Late Entrant Application **OR** ☐Excess Insurance Application

BENEFIT TO BE UNDERWRITTEN	NON-EVIDENCE MAXIMUM	CURRENT INSURED BENEFIT AMOUNT	OVERALL MAXIMUM	NEW ELIGIBLE INSURED AMOUNT
☐ Employee Life / AD&D	$__________	$__________	$__________	$__________
☐ Dependent Life	$__________	$__________	$__________	$__________
☐ Short Term Disability	$__________	$__________	$__________	$__________
☐ Long Term Disability	$__________	$__________	$__________	$__________
☐ Critical Illness	$__________	$__________	$__________	$__________

APPLICANT NAME: ______________ (First Name) ______________ (Last Name)

DATE OF BIRTH:_____/_____/_____ (MM DD YYYY) **PHONE NUMBER:** (_____)_____-_____

MAILING ADDRESS: ______________ (Street Address), __________ (City), __________ (Province), _____ - _____ (Postal Code)

	First Name	Last Name	Sex	Date of Birth	Height	Weight	Weight one year ago	Reason for change in weight (IF APPLICABLE)
EMPLOYEE			☐M ☐F	MM/DD/YYYY				
SPOUSE			☐M ☐F	MM/DD/YYYY				
CHILDREN			☐M ☐F	MM/DD/YYYY				
			☐M ☐F	MM/DD/YYYY				
			☐M ☐F	MM/DD/YYYY				

SECTION II – Please answer all questions completely to avoid delays in processing

Question	Employee YES	Employee NO	Spouse YES	Spouse NO
1. Within the past 12 months have you consulted a physician or any medical practitioner, been treated for, taken medication for, or had any known indication of any of the following conditions (if yes, circle the applicable condition(s)): Chest pain or discomfort, high cholesterol or blood pressure, circulatory problems, fainting or dizziness, diabetes, hepatitis, disorder of the stomach, ulcer, indigestion, gall bladder, neuritis, bronchitis , tuberculosis, paralysis, intestines, lungs, respiratory system, asthma, shortness of breath, sleep apnea, disorder of the eyes, (excluding near and far sightedness) ears (excluding infection that has resolved) skin (excluding minor rash or irritation) back, neck, knees, hips, muscles, bones, joints, fibromyalgia, chronic fatigue, mental or emotional disorder, bladder, urinary tract, prostate, breast, reproductive system, nervous system disorder, allergies, arthritis, rheumatism or been advised that a medical test was abnormal or follow-up is required?	☐	☐	☐	☐
2. Do you have any symptoms or complaints for which you have not yet sought treatment?	☐	☐	☐	☐
3. Have you ever undergone an electrocardiogram, an X-ray, a mammography, a blood test, or any other examination?	☐	☐	☐	☐
4. Within the last 5 years have you:				
a) been confined in a hospital or other institution, been off work, received disability or Worker's Compensation benefits for more than 5 days or disability pension due to an accident or illness?	☐	☐	☐	☐
b) had an application for insurance declined, postponed, rated or modified in any way?	☐	☐	☐	☐
5. Have you ever consulted a physician or any medical practitioner, been treated for or had any known indication of :				
a) heart or circulatory problems including heart attack, stroke, cancer or tumor, epilepsy, multiple sclerosis, disorder of the liver, intestines, kidney, blood or immune system?	☐	☐	☐	☐
b) drug or alcohol abuse, used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, taken drugs for other than medical purposes, been advised to drink less alcohol, received treatment for drug addiction or alcoholism, or been charged with driving while impaired?	☐	☐	☐	☐
c) AIDS, ARC, HIV, enlargement of lymph nodes (glands) chronic diarrhea, unusual skin lesions or unexplained infections or other immunological disorder?	☐	☐	☐	☐
d) For any physical or mental disorder not mentioned above?	☐	☐	☐	☐
6. Within the past three years have you had any disease or disorder which has limited or interfered with your ability to perform your daily activities for more than 10 consecutive days?	☐	☐	☐	☐

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7. What is your weekly consumption or use of:
Tobacco: ________________ Alcoholic Beverages: ________________ Narcotics or Recreational Drugs: ________________

	Employee YES	Employee NO	Spouse YES	Spouse NO
8. Is there any history in your family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron disease, or other hereditary diseases? (If yes, please describe which illness, which family member, age at onset of the illness, current age if alive or age at death on the following page. Please attach a separate sheet of paper if more space is needed)	☐	☐	☐	☐

If the answer to question number 8 is yes, please describe which illness, which family member, age at onset of the illness, current age if alive or age at death on the table provided below. Please attach separate sheet if more space is needed.

Circle the family member		Illness(es) (if cancer: type)	Age at onset of the illness	Age if alive	Age at death
EMPLOYEE	Father Mother Brother Sister				
	Father Mother Brother Sister				
SPOUSE	Father Mother Brother Sister				
	Father Mother Brother Sister				
CHILDREN	Father Mother Brother Sister				
	Father Mother Brother Sister				

SECTION III

		Employee YES	Employee NO	Spouse YES	Spouse NO
1.	Do you or any of your family members have any other physical impairment or deformity; or health problems or symptoms of illness or disease not listed in Section II? *(If Yes, please provide details below)*	☐	☐	☐	☐
2.	Have any of the children to be insured ever suffered from heart, lung, neurological or mental problems, cancer or diabetes or had an application for insurance rejected, rated, modified or deferred? *(If Yes, please provide details below)*			YES ☐	NO ☐

3. Name and address of your personal physician or any medical practitioner(s) or chiropractor consulted in the past 5 years:
____

4. Date and reason for last consultation:
____

5. Provide details of any medication or treatment prescribed, or advice recommended:
____

Provide details of all "Yes" answers to any questions in Section II or Section III (Please attach separate sheet if more space is needed):

Question Number	Nature of Disorder	Date of Onset/Recovery	Medication and/or Treatment	Approximate Monthly Cost	Attending Physician or Hospital (name & address)	Details pertaining to the Employee, Spouse or Child

SECTION IV (all applicants must complete this section)

MIB PRE-NOTICE

MIB receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws.

If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at privacy@mib.com. Information regarding your insurability will be treated as confidential. The Wawanesa Life Insurance Company, Desjardins Financial Security Life Assurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members.

If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will also arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is: MIB Information Office 330 University Avenue, Suite 501 Toronto, Ontario, M5G 1R7 Telephone Number: (416) 597-0590

The Wawanesa Life Insurance Company and/or Desjardins Financial Security Life Assurance Company or their reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Information for consumers about MIB may be obtained on its website at www.mib.com.

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Declaration and Authorization to obtain Medical Information

I, hereby declare that the above answers and statements are complete and true, and that any misstatements or failure to report information may be used as the basis for rescission of this insurance, as issued to me. I understand that if the insurance applied for becomes effective, I will be subject to all the terms of the group policy. I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance would have become effective, I am actively engaged in my occupation on a full-time basis (full-time is defined as 24 hours per week or more).

I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company. I understand the information provided on this document will be treated as confidential and is gathered for the purpose of underwriting the insurance applied for.

I further understand that additional information including medical testing, may be required as part of the underwriting process and that this information, including medical test results, will not be shared with my employer.

I authorize The Wawanesa Life Insurance Company and/or Desjardins Financial Security Life Assurance Company or their reinsurers to make a brief report of my personal health information to MIB, Inc. (“MIB”).

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. (“MIB”) or other organization, institution or person, that has any records or knowledge of me or my health, to give to The Wawanesa Life Insurance Company and/or Desjardins Financial Security Life Assurance Company or their reinsurers, any such information.

A photocopy of this authorization shall be as valid as the original.

I have read and understand the MIB Pre-Notice.

Dated at (city) ____ **this** ________________ **day of** ________________ **20**________ **.**

Signature of Applicant ____

Dated at (city) ____ **this** ________________ **day of** ________________ **20**________ **.**

Signature of Applicant’s Spouse____