Extended Health Care Evidence of Insurability

TotalGUARD

Employer Statement

Employee Name (first, initial, last)

Firm Name

What is the reason for completing this form?

❑ **Late request for health and dental benefits.** State the Reason

❑ **Late request for coverage of dependents**

Was the spouse (and children, if any) covered under another employer's group plan? ❑ **Yes** ❑ **No** **If "Yes", please answer the following:**

Name of Employer | Name of Insurer | Date of Termination of Coverage (yy/mm/dd)

Is the employee effectively at work and physically able to perform each and every duty of her/his employment?

❑ **Yes** ❑ **No** If "No", please explain:

Store Owner/Manager Signature | Date (yy/mm/dd)

Employee Statement

Complete for all persons to be insured.

❑ **EMPLOYEE** Height ❑ in ❑ cm Weight ❑ lbs. ❑ kg Sex ❑ M ❑ F

Place of Birth | Date of Birth

Occupation

Home Address No. Street City Postal Code

Name of Personal Physician (first, initial, last) | Phone Number

Address of Personal Physician No. Street City Postal Code

❑ **SPOUSE** Height ❑ in ❑ cm Weight ❑ lbs. ❑ kg Sex ❑ M ❑ F

Surname

Given Name

Place of Birth | Date of Birth

Name of Personal Physician (first, initial, last) | Phone Number

Address of Personal Physician No. Street City Postal Code

❑ **CHILDREN**

Surname | Given Name | Date of Birth

Height ❑ in ❑ cm | Weight ❑ lbs. ❑ kg | Relationship to Employee | Sex ❑ M ❑ F

Surname | Given Name | Date of Birth

Height ❑ in ❑ cm | Weight ❑ lbs. ❑ kg | Relationship to Employee | Sex ❑ M ❑ F

Surname | Given Name | Date of Birth

Height ❑ in ❑ cm | Weight ❑ lbs. ❑ kg | Relationship to Employee | Sex ❑ M ❑ F

Surname | Given Name | Date of Birth

Height ❑ in ❑ cm | Weight ❑ lbs. ❑ kg | Relationship to Employee | Sex ❑ M ❑ F

Name of Personal Physician (first, initial, last) | Phone Number

Address of Personal Physician No. Street City Postal Code

Please complete both sides of this form. An incomplete questionnaire will delay the processing of the insurance application.
NOTE: Signature required on reverse side.

Please complete reverse side.

Employee Statement

Have any of the persons to be insured (including the spouse and children, if applicable):

	Employee		Dependents			Employee		Dependents	
	YES	NO	YES	NO		YES	NO	YES	NO
1. had cancer, a tumor, diabetes, a heart problem, circulatory or blood disorder, or high blood pressure?	❑	❑	❑	❑	10. had, bowel or stomach disorders, disorder of the genitals or any urine abnormality?	❑	❑	❑	❑
2. had epilepsy, a nervous disorder, a liver, lung or kidney disorder, ulcer or an intestinal disorder, glandular disorder, including thyroid disorders?	❑	❑	❑	❑	11. had an application for life or health insurance declined, rated or postponed?	❑	❑	❑	❑
3. had arthritis, rheumatism, a disorder of the bones or joints, or backaches?	❑	❑	❑	❑	12. been taking any medication, following a diet or receiving medical care or treatment?	❑	❑	❑	❑
4. developed AIDS or an AIDS-related complex, or had a positive reaction to a test designed to reveal the presence of the virus that causes these diseases?	❑	❑	❑	❑	13. been expecting to receive medical treatment or to undergo an operation in the next twelve months?	❑	❑	❑	❑
5. been absent from work 10 days or more because of illness or injury in the past two years?	❑	❑	❑	❑	14. had allergies or skin disorders, including growths or cysts?	❑	❑	❑	❑
6. submitted to an electrocardiogram, an X-Ray, a blood test or any other test for diagnostic purposes, or been advised to do so in the past five years?	❑	❑	❑	❑	15. ever applied for or received benefits, compensation or pension because of sickness or injury?	❑	❑	❑	❑
7. used drugs without a physician's prescription, been advised to make a more moderate use of alcohol, or been treated for drug or alcohol abuse?	❑	❑	❑	❑	16. had any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	❑	❑	❑	❑
8. suffered from a physical abnormality or deformity?	❑	❑	❑	❑	17. smoked cigarettes, cigars pipes or used any tobacco products within the past 12 months?	❑	❑	❑	❑
9. been examined by a physician or received treatment in a hospital, clinic or sanatorium in the last five years, for any reason other than those mentioned above?	❑	❑	❑	❑					

For each affirmative answer, give details below.

Question Number	Given Name	Illness, Injury	Tests, Operations, Treatment, Medicine	Onset of Illness	Date of Complete Recovery	Name and Address of Physicians and Hospitals
				(yy/mm/dd)	(yy/mm/dd)	
				(yy/mm/dd)	(yy/mm/dd)	
				(yy/mm/dd)	(yy/mm/dd)	
				(yy/mm/dd)	(yy/mm/dd)	
				(yy/mm/dd)	(yy/mm/dd)	

Have any of the persons to be insured lost or gained more than 10 lbs. during the last 12 months? ❑ **Yes** ❑ **No** **If "Yes", please answer the following:**

❑ Gained ❑ Lost	What was the amount of the weight change? ❑ lbs. ❑ kg	Reason

Do any of the persons to be insured participate in any hazardous sport activities, such as SCUBA diving, piloting aircraft, auto racing, etc.? ❑ **Yes** ❑ **No**

If "Yes", please specify which activities:

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our web site: www.westernfgis.ca

Employee's Signature	Spouse's Signature	Signature of Children over 18	Date (yy/mm/dd)

Western FINANCIAL GROUP

Complete and send to:
TotalGUARD, Western Financial Group Insurance Solutions
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Toll Free: 1-800-665-8990

Western Financial Group (Network) Inc.
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