

enVia

Individual Insured Program

FOR ATLAS OWNER / OPERATORS, CONTRACT, HOURLY & PART-TIME EMPLOYEES



COMPREHENSIVE PROTECTION AT COMPETITIVE COST

Atlas Canada Owner/Operators and employees can now access comprehensive individual insurance protection under the enVia Individual Insured Benefits Program - an affordable combination of the Health & Dental coverage you need plus the flexibility of personalizing your protection with Optional Benefits that are normally only available in large group programs.



FLEXIBLE COVERAGE CHOICES

With **enVia**, you can design your benefit coverage to meet your personal needs. Available coverage includes:

- Fully Insured Individual Health or Health + Dental with Pay-Direct Card
- Optional Disability Insurance (Short & Long Term)
- Optional Critical Illness Recovery Program
- Optional Life Insurance
- Optional Accidental Death & Dismemberment Insurance

As coverage is available on an individual basis, it is subject to approval of a personal health statement by the insurer of the coverage selected.

INDIVIDUAL / FAMILY HEALTH & DENTAL

An affordable yet comprehensive fully insured Health or Health + Dental Plan offering 80% reimbursement up to defined benefit maximums, with no health evidence required. If the applicant or a dependent has a pre-existing condition and is taking medication, there is a 24 month waiting period before coverage for that medication commences. See the table on reverse for full plan details...

REAL-WORLD, NEEDS-RELATED OPTIONAL BENEFITS:

DISABILITY INSURANCE

After a 30 day waiting period, a Weekly Disability Benefit of 66.7% of weekly earnings up to \$1,500/week for 104 weeks. Thereafter, if Permanently Disabled, a Lump Sum Benefit of 5X Gross Annual Earnings to a maximum of \$500,000.

XN GLOBAL® PREFERRED CARE INSURANCE

Provides personal case management in the event of critical illness and ensures prompt access to top US Hospitals for treatment of Cancer, Heart Surgery, Neurosurgery, Organ Transplants & more. 100% reimbursement of expenses up to \$2M USD per person per annum.

LIFE INSURANCE

Participants may purchase Optional Life Insurance in units of \$10,000 to \$500,000. Coverage terminates at age 65. Personal Health Declaration must be approved by Insurer.

ACCIDENTAL DEATH & DISMEMBERMENT

Participants may purchase coverage in units of \$50,000 up to a maximum of \$500,000. No health evidence is required.



CALL TODAY 905-844-8998

www.gpsconsultinggroup.com

BENEFIT SOLUTIONS FOR TODAY'S PRO-ACTIVE EMPLOYERS

enVia Individual Insured Program for Atlas Owner Operators 061510

Insurer / Administrator	Lloyd's of London / Norfolk Mobility Benefits SIACI SAINT HONORE
Eligibility	Full & Part-time, Self-employed, Contract or Casual workers working at least 20 hours / week (not available in Quebec)
Health Evidence Required?	No, Guaranteed Issue! Health evidence required only for Optional Life, Disability or Preferred Care Benefits
Effective Date	1st of the month coincident with or next following date of application (or following date of approval by the Insurer of health evidence required for Optional Life, Disability or Preferred Care)

Extended Health Care Benefits: 80% Reimbursement to Plan Maximums, No Deductible

Prescription Drugs	Generic Drug Plan <ul style="list-style-type: none"> 80% Reimbursement up to \$5,000 / policy year Exclusions: Anti-smoking, anti-obesity, fertility, lifestyle treatments & medications. Includes Esorse Pay-Direct Card 24 month waiting period for coverage of prescription drugs related to pre-existing chronic conditions. Applicants must disclose to Insurer any drugs being taken at time of application on a confidential form.
Professional Services	80% Reimbursement up to \$50/visit maximum to a combined maximum of \$1,000 per policy year for all practitioners, including: Acupuncturist, Chiropractor, Naturopath, Osteopath, Physiotherapy, Podiatrist, Psychologist, Registered Massage Therapist, Speech Therapist.
Accidental Dental	80% Reimbursement to \$2,500 / year maximum
Ambulance	80% up to \$250 / trip for services not covered by Provincial Health Plan
Medical Supplies & Services	<ul style="list-style-type: none"> 80% reimbursement to \$1,500/year for Medical Supplies and to \$2,000/year for Medical Equipment and Prosthesis Orthotics or Orthopedic Footwear 100% to \$250/year
Private Duty Nursing	80% Reimbursement to a maximum of \$5,000 per policy year
Hospital	Semi-Private room, 80% Reimbursement to \$175/day for 30 days duration
Vision / Hearing Aids	Vision Care 80%: Eye exams \$50/24 months; eyeglasses/contacts \$200/24 months after 6 month waiting period Hearing Aids 80%: up to \$500/5 years/person
Maximum per person	\$25,000 per policy year
Out-of-Country Emergency Hospital / Medical	<ul style="list-style-type: none"> 100% reimbursement to \$2,000,000 maximum per lifetime for trips of up to 30 days duration includes Emergency Travel Assistance

Dental: 80% Reimbursement to Plan Maximums, No Deductible

Preventative Services	80% Reimbursement, max. \$1,000 per policy year <ul style="list-style-type: none"> Level 1 Basic Services with 6 month recall (Diagnostic, Preventative & General services: fillings, extractions & minor surgery, denture repair, rebase & relines.) Endodontics at 80% and Periodontics at 50% Reimbursement
Major Restorative Services	Not Included
Orthodontia	Not Included
Maximum	80% reimbursement to \$1,000 per person per policy year based on current Provincial Fee Schedule

Monthly Premium Costs - All Provinces (not available in Quebec)

Marital / Dependent Status	Ages 20 - 44		Ages 45- 54		Ages 55 - 59		Ages 60 - 65	
	EHC Only	EHC + DENTAL	EHC Only	EHC + DENTAL	EHC Only	EHC + DENTAL	EHC Only	EHC + DENTAL
Single	\$65.92	\$113.14	\$74.07	\$121.29	\$86.13	\$133.35	\$100.68	\$147.90
Couple	\$127.40	\$221.84	\$148.14	\$252.58	\$172.25	\$276.69	\$194.48	\$298.92
Family	\$200.25	\$338.30	\$215.32	\$353.37	\$250.85	\$388.90	\$283.20	\$421.25
Single Parent with 1 child	\$99.22	\$184.21	\$124.02	\$209.02	\$155.03	\$240.03	\$175.03	\$260.02

Optional Benefits: (Premium rates vary based on age, occupational class and coverage chosen. Separate Health Statement required unless noted)

Disability Insurance	Both Temporary Total Disability and Permanent Total Disability available. All Disability Benefits Tax-Free.
XN Global® Preferred Care	Better than standard Critical Illness, provides personal case management & reimbursement up to \$2M USD
Life Insurance	Units of \$10,000 to \$500,000. Coverage terminates at age 65.
AD&D	Units of \$50,000 up to a maximum of \$500,000. No health evidence required.



The GPS Consulting Group & Insurance Agencies

114 Forsythe Street, Oakville, Ontario L6K 3T3

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Errors & Omissions Excepted - GPS Consulting Group, March 1, 2010

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enVia Insured Program Application for Atlas Canada (MED 1)



Please complete and submit this Application and attached Chronic Condition Reporting Form. If applying for Optional Life or Disability, also complete the Personal Health Declaration. For more information or assistance in completing this application, please contact **GPS Consulting Group** at **905-844-8998**.

Section 1: General Information

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="radio"/> MARRIED <input type="radio"/> SINGLE <input type="radio"/> COMMON-LAW <input type="radio"/> OTHER _____		
DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	LANGUAGE <input type="radio"/> ENGLISH <input type="radio"/> FRENCH	PRIMARY OCCUPATION		
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE		WORKPLACE TELEPHONE	FAX		
EMAIL ADDRESS		DATE OF HIRE (MM/DD/YYYY)	YOUR EMPLOYMENT STATUS <input type="radio"/> OWNER/SELF-EMPLOYED <input type="radio"/> EMPLOYEE <input type="radio"/> CONTRACTOR <input type="radio"/> TEMP		
EMPLOYER	BUSINESS ADDRESS	CITY	PROVINCE	POSTAL CODE	
YOUR AGENT / BROKER'S NAME (IF APPLICABLE) The GPS Consulting Group & Insurance Agencies		AGENT / BROKER'S TELEPHONE: 905-844-8998	AGENT / BROKER'S E-MAIL ADDRESS: gord@gpsconsultinggroup.com		
AGENT / BROKER'S ADDRESS: 114 Forsythe Street		CITY Oakville	PROVINCE Ontario	POSTAL CODE L6K 3T3	

Section 2: Coverage Selection & Plan Choice

1. Please indicate your coverage level:

Single
 Couple
 Family
 Single Parent with 1 child (if more than 1 child, select "Family")

2. Please indicate the Benefit Coverage you have selected:

Health & Dental Benefits:

enVia Extended Health Care ONLY OR
 enVia Extended Health Care + Dental

Use the table below to find the monthly rate for your chosen coverage, marital/family status and the age band of the oldest person to be insured:

enVia Individual Insured Program Monthly Rates - All Provinces								
Marital/Family Status	Age 20 - 44		Age 45 - 54		Age 55 - 59		Age 60 - 65	
	EHC ONLY	EHC + DENTAL	EHC ONLY	EHC + DENTAL	EHC ONLY	EHC + DENTAL	EHC ONLY	EHC + DENTAL
Single	<input type="radio"/> \$65.92	<input type="radio"/> \$113.14	<input type="radio"/> \$74.07	<input type="radio"/> \$121.29	<input type="radio"/> \$86.13	<input type="radio"/> \$133.35	<input type="radio"/> \$100.68	<input type="radio"/> \$147.90
Couple	<input type="radio"/> \$127.40	<input type="radio"/> \$221.84	<input type="radio"/> \$148.14	<input type="radio"/> \$252.58	<input type="radio"/> \$172.25	<input type="radio"/> \$276.69	<input type="radio"/> \$194.48	<input type="radio"/> \$298.92
Family	<input type="radio"/> \$200.25	<input type="radio"/> \$338.30	<input type="radio"/> \$215.32	<input type="radio"/> \$353.37	<input type="radio"/> \$250.85	<input type="radio"/> \$388.90	<input type="radio"/> \$283.20	<input type="radio"/> \$421.25
Single Parent w/1 child	<input type="radio"/> \$99.22	<input type="radio"/> \$184.21	<input type="radio"/> \$124.02	<input type="radio"/> \$209.02	<input type="radio"/> \$155.03	<input type="radio"/> \$240.03	<input type="radio"/> \$175.03	<input type="radio"/> \$260.02

Health / Dental Monthly Cost: \$ _____ / month (a)

Note: There is NO HEALTH EVIDENCE REQUIRED for either EHC or Dental coverage. You must, however, certify any pre-existing conditions on a confidential form as there is a 24 month waiting period from time of application before coverage for pre-existing chronic conditions will commence.

Section 3: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (MM/DD/YYYY)	If Child Over 19
Spouse:				
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED

If a Child is over age 19, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
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Section 4: Optional Benefits

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. In some cases, a separate application form may be required.

Determine your Occupational Class: Insurers base their rates for some coverage in part on the nature of the work being performed as part of your regular duties. Use the table below to determine your Occupational Class for Life, TTD, PTD and AD&D Coverage. Please contact us if it's not clear what category matches your particular job.

<input type="radio"/> Class 1	All Administrative Office Staff, Office based Managers, Accountants, Sales Staff, IT Staff, Graphic Designers, Real Estate Agents, Lawyers, Retail Sales Staff.
<input type="radio"/> Class 2	All on-site Managers and Superintendents at Mining & similar Operations, Lab Technicians.
<input type="radio"/> Class 3	Nurse, Physiotherapist, Massage Therapist, Personal Support Worker, Nannies, Hospital Cleaning Staff, Light Industrial Workers.
<input type="radio"/> Class 4	All on-site manual workers not exposed to unusual accident risks such as Foreman, Electricians, Finish Carpenters, Plumbers, Cooks, Courier Drivers, Short Haul Truck Drivers, Auto Body Painters, Daycare Worker, Flooring Installers, Cement Layers & Finishers, Painters, and Other Skilled Trades.
<input type="radio"/> Class 5	All on-site heavy manual workers exposed to considerable accident risks, such as Rough Carpenters, Industrial Mechanics, Auto Mechanics, Steamfitters, Farmer, Movers , Restaurant Server, Long Haul Truck Driver , Landscape Workers, and Bricklayers.

a) XN Global® Preferred Care Program: Requires separate Application Form & Health Statement, but please indicate here if you will be purchasing coverage.

b) Temporary Total Disability Benefits (TTD): Following a 30 day waiting period, benefit payable is 66.67% of weekly earnings to a maximum of \$1,500 week.

Occupational Class (from table above)	Rate per \$10 of benefit per month	Monthly Cost per \$500 of weekly benefit	Monthly Cost per \$750 of weekly benefit	Monthly Cost per \$1,000 of weekly benefit	Monthly Cost per \$1,500 of weekly benefit (maximum)
Class 1	\$0.458	\$22.90	\$34.35	\$45.80	\$68.70
Class 2	\$0.488	\$24.40	\$36.60	\$48.80	\$73.20
Class 3	\$0.614	\$30.70	\$46.05	\$61.40	\$92.10
Class 4	\$0.663	\$33.15	\$49.73	\$66.30	\$99.45
Class 5	\$0.780	\$39.00	\$58.50	\$78.00	\$117.00

Weekly Earnings \$ _____ X 66.67% = Weekly Benefit \$ _____ ÷ 10 = _____ X Class Rate per \$10 _____ = **Monthly Cost \$** _____ (b)
(MAXIMUM \$1,500)

c) Permanent Total Disability Benefits (PTD): Provides a benefit of up to 5X annual earnings after 25 months

Occupational Class (from table above)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000
Class 1	\$0.040	\$2.00	\$10.00	\$20.00
Class 2	\$0.056	\$2.80	\$14.00	\$28.00
Class 3	\$0.079	\$3.95	\$19.75	\$39.50
Class 4	\$0.110	\$5.50	\$27.50	\$55.00
Class 5	\$0.154	\$7.70	\$38.50	\$77.00

Annual Earnings \$ _____ X 5 = PTD Benefit \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$** _____ (c)
(MAXIMUM \$500,000)

d) Life Insurance: Optional Life Insurance in units of \$10,000 to \$500,000. Coverage terminates at age 65. Please complete attached Personal Health Declaration.

Age Band	Premium rates per \$1,000 per month				
	Class 1	Class 2	Class 3	Class 4	Class 5
18-39	\$0.143	\$0.168	\$0.204	\$0.281	\$0.346
40-44	\$0.270	\$0.295	\$0.331	\$0.408	\$0.473
45-49	\$0.477	\$0.502	\$0.538	\$0.614	\$0.680
50-54	\$0.763	\$0.788	\$0.823	\$0.900	\$0.965
55-59	\$1.085	\$1.110	\$1.146	\$1.223	\$1.288
60-64	\$1.720	\$1.744	\$1.780	\$1.857	\$1.922

Additional Medical Information may be requested by the Insurer for amounts over \$100,000.

rate per \$1,000 per month

Coverage Required: \$ _____ ÷ 1,000 = _____ X _____ = **Monthly Cost \$** _____ (d)
example: \$100,000 example: 100 example: \$0.295 for age 43 Class 2 example: \$29.50 per month

e) Accidental Death & Dismemberment: No Health Statement required. Available in multiples of \$50,000 to a maximum of \$500,000.

Occupational Class (from table above)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000 (maximum benefit)
Class 1	\$0.09	\$4.50	\$22.50	\$45.00
Class 2	\$0.10	\$5.00	\$25.00	\$50.00
Class 3	\$0.12	\$6.00	\$30.00	\$60.00
Class 4	\$0.15	\$7.50	\$37.50	\$75.00
Class 5	\$0.20	\$10.00	\$50.00	\$100.00

Coverage required \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$ _____ (e)**
(MAXIMUM \$500,000)

Section 5: Beneficiary Designation for Life Insurance and/or AD&D ONLY

In all provinces except Quebec, your beneficiary appointment is REVOCABLE (can be changed without referral to the named beneficiary). In Quebec, the designation of your spouse is IRREVOCABLE (cannot be changed unless your spouse agrees in writing to relinquish the appointment) unless otherwise specified. If the appointed beneficiary is a minor you will need to appoint a Trustee (not applicable in Quebec).

Beneficiary Name	Relationship	Date of Birth (yyyy/mm/dd)	Revocable or Irrevocable (please hand write)	Percentage

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec)

Section 6: Calculate your Monthly Cost:

1. enVia Extended Health Care ONLY or Extended Health Care + Dental:

Enter amount from line (a) on page 1

\$ _____ (1)

2. Optional Benefits Cost:

Total the amounts from lines (b) through (e) to determine your monthly Optional Benefits cost.

\$ _____ (2)

3. Your Total Monthly Cost:

Total lines 1 and 2 to determine your Total Monthly Benefits Cost. This is the amount that will be withdrawn monthly from either your financial institution or your pay, if applicable.

\$ _____
Total Monthly Benefits Cost

IMPORTANT: Please attach two cheques and submit with your application. One in the amount of your Total Monthly Benefits Cost and a second cheque marked "VOID" to enable subsequent monthly automatic withdrawals from your financial institution.

Section 7: Declaration & Authorization

I hereby apply for coverage ("Coverage") under the Health & Dental plan underwritten by Lloyd's of London. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the willful or negligent provision of false, incomplete, or misleading information. **I authorize** the Program Administrator to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my employer to make deductions from my pay for my plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I designate** the person(s) named above under Beneficiary Designation, as my beneficiary.

I understand that any Information provided to or collected by the Program Administrator in accordance with this authorization, will be kept in a health or disability file. Access to my Information will be limited to:

- Program Administrator employees, representatives, and service providers in the performance of their jobs to the extent required for the Purposes;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

X

Signature of Plan Member (in full)

Date (yyyy/mm/dd)

Mail or Fax your completed application to:

enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

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Phone: (416) 446-0115

Fax: (416) 446-7371

E-mail: info@maclagan.ca



PRIVATE & CONFIDENTIAL
Pre-Existing / Chronic Condition Reporting Form

Purpose: To report confidentially any chronic or pre-existing conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed.

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Administrator, Norfolk Mobility Benefits, Calgary, Alberta and Esorse Corporation, the provider of the enVia Pay-Direct Drug Card.

Name: _____ Employer: _____

Email: _____ Home Tel: _____ Work or Mobile Tel: _____

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

 (Signed)

 (Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
 enVia Benefits Program
 P.O. Box 47509
 946 Lawrence Ave. East
 Don Mills, ON M3C 3S7

Or FAX this form to: 416-446-7371

If you have any questions or require assistance please contact:

John Maclagan at: 416-446-0115; email: jmaclagan@sympatico.ca OR Scott Maclagan at: 905-554-0875; email: esmaclagan@rogers.com



Personal Health Declaration

Please complete this Personal Health Declaration accurately and in full. In particular, if you answer "YES" to any of the medical questions below, please provide details on reverse. If you have questions or need further assistance, please call us at (905) 554-0875

Section 1: Applicant Information

APPLICANT NAME	DATE OF BIRTH (DAY / MONTH / YEAR)	APPLICANT'S HEIGHT _____ ft/in or _____ cm	APPLICANT'S WEIGHT _____ lbs or _____ kg
NAME OF APPLICANT'S EMPLOYER	DATE EMPLOYED (DAY / MONTH / YEAR)	CERTIFICATE OR PAYROLL NUMBER (OFFICE USE ONLY)	
OCCUPATION	NORMAL NUMBER OF HOURS WORKED PER WEEK	DIVISION / CLASS (OFFICE USE ONLY)	

Section 2: Health Declaration

Have you ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on reverse.

	APPLICANT
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematous (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you currently taking or have you been prescribed any prescription medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing piloting aircraft, or bungee jumping?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Full name and address of your regular attending physician:

If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. **If the answer is "none", state "none"**

NAME OF APPLICANT'S PHYSICIAN	ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT

For each "YES" answer to any of the questions above, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on the next page.

