RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, ON N3B 3B1
Fax: 519-669-1923

# Group Health Evidence Form
# Employee Application

Group/Div # 20320
Certificate # ____________
Insurer(s) COSA Central Ontario Standardbred Assocation

**TO BE COMPLETED BY EMPLOYEE** **Entire Application to be completed in ink. PLEASE PRINT**

| Name of Employee | | email Address | Phone Number: |
|---|---|---|---|
| Address of Employee<br>No. & Street / City / Prov. / Postal Code | | | Work ( )<br>Home ( ) |
| Name of policyholder/employer | Occupation | | Are you Actively at Work? ☐ Yes ☐ No<br>If No, why? |
| Date of Birth<br>Day Month Year | Height | Weight | ☐ Male<br>☐ Female |

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?
   ☐ No ☐ Yes, If 'Yes', specify:

2. Have any of your parents, brothers or sisters had any hereditary disorder (e.g. Huntington's chorea, polycystic kidney disease, etc.)?
   ☐ No ☐ Yes, If 'Yes', specify:

| | 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): | | |
| a) Disorder of eyes, ears, nose, or throat? | ☐ | ☐ |
| b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of the brain or nervous system? | ☐ | ☐ |
| c) Nervous disorders, including depression, severe 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, anemia, hemophilia, or any other disorder/abnormality of the blood? | ☐ | ☐ |
| k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of pituitary, adrenals or other glands or unexplained infections? | ☐ | ☐ |
| l) Thyroid or other endocrine disorders? | ☐ | ☐ |
| m) Venereal disease or any other sexually transmitted disease or disorder of prostate or reproductive organs? | ☐ | ☐ |
| n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above? | ☐ | ☐ |
| 4. In the past ten years have you: | | |
| 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? | ☐ | ☐ |

**Details of "Yes" answers:**

Identify question number, 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.

(CONTINUED OVER....)

| | Yes | No |
|---|---|---|
| 5. Has an application for insurance on your life/health ever been declined, rated, or modified in any way? If ‘Yes’, detail When? Why? Company? | ☐ | ☐ |
| 6. Do you currently have an individual life policy that has been issued within the last two years? If 'Yes', Issued by which insurance company? | ☐ | ☐ |
| 7. Have you ever applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury? If 'Yes', provide details and dates. | ☐ | ☐ |
| 8. Have you lost any time from work during the last 12 months because of illness or injury? If 'Yes', provide date, duration and reason. | ☐ | ☐ |
| 9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? If 'Yes', provide date and details. | ☐ | ☐ |
| 10. Are you receiving any other treatment/medication from any physician or alternative healthcare provider as previously not defined? If 'Yes', provide 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. Over the past three years have you ever had your driver's license suspended or revoked for any medical reason, or for driving under the influence of drugs or alcohol? If 'Yes', detail reason. | ☐ | ☐ |
| 14. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)? If 'Yes', indicate date. | ☐ | ☐ |
| 15. Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If 'Yes', complete the following: | ☐ | ☐ |
| a) Type of drug ____________ | | |
| b) Frequency of use (daily, weekly, monthly) ____________ | | |
| c) Date last used ____________ | | |
| 16. Have you ever used any form of tobacco, nicotine products or substitutes (including nicotine patch and gum)? If 'Yes' for how long and how often have you been smoking? | ☐ | ☐ |

**Details of "Yes" answers:**

Identify question number, 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.

17. Who is your regular family physician? (If none, name Walk In Clinic used) ____________

Address ____________

Approximate date last seen ____________ Reason/Outcome ____________

**RWAM Privacy Statement** RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.

### Applicant Employee's 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 RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities. I acknowledge receiving the Notice regarding the Medical Information Bureau and authorize the relevant insurer(s) to obtain information from the Medical Information Bureau.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical 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 fact that is material to the insurance being applied for or material to the insurability of the person(s) to be insured, shall render the insurance coverage voidable by RWAM and/or the relevant insured(s). This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

**Employee Signature** X ____________ **Date** ____________

## **COPY AND RETAIN FOR YOUR RECORDS**

### Notice Regarding the MIB, INC:

Information regarding the insurability of the Person(s) to be insured will be treated as confidential. We or our reinsurer may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction. The address of MIB’s Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590, or privacy@mib.com for privacy questions. We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured may apply for life, critical illness 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

**This form must be received at RWAM's office within 60 days of the date signed above. Otherwise a new form must be submitted.**

RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, ON N3B 3B1
Fax: 519-669-1923

# Group Health Evidence Form
# Application for Dependents

Group/Div # 20320
Certificate # ____________
Insurer(s) COSA Central Ontario Standardbred Assocation

**Entire Application to be completed in ink. PLEASE PRINT**

Name of Employee ______________________ email of Applicant ______________________

Address of Applicant ______________________

| Proposed Dependents To Be Insured | Date of Birth | | | Height | Weight |
|---|---|---|---|---|---|
| | Day | Month | Year | | |
| Spouse: | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| Child: | | | | | |

| | Yes | No |
|---|---|---|
| 1. Is the employee Actively at Work?<br>If "No", why? ______________________ | ☐ | ☐ |
| 2. Do all the dependents named above reside with the employee?<br>If "No", give details and identify each dependent. | ☐ | ☐ |
| 3. Was any child born prematurely? If 'Yes', Identify child, premature by how many months and birth weight. | ☐ | ☐ |
| 4. Is any child less than one year old? If 'Yes', Identify child and birth weight. | ☐ | ☐ |
| 5. Has any dependent 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): | | |
| a) Disorder of eyes, ears, nose, or throat? | ☐ | ☐ |
| b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of the brain or nervous system? | ☐ | ☐ |
| c) Nervous disorders, including depression, severe 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, anemia, hemophilia, or any other disorder/abnormality of the blood? | ☐ | ☐ |
| k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of pituitary, adrenals or other glands or unexplained infections? | ☐ | ☐ |
| l) Thyroid or other endocrine disorders? | ☐ | ☐ |
| m) Venereal disease or any other sexually transmitted disease or disorder of prostate or reproductive organs? | ☐ | ☐ |
| n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above? | ☐ | ☐ |
| 6. Female Dependents: | | |
| a) Has any dependent ever had any disease of the breasts, ovaries, cervix or uterus? | ☐ | ☐ |
| b) Have any pregnancies or labours been abnormal? | ☐ | ☐ |
| c) Is any dependent pregnant? If "Yes" give expected delivery date. | ☐ | ☐ |
| 7. Does any dependent have any condition for which hospitalization or surgery has been advised or is contemplated? If 'Yes', give details and dates. | ☐ | ☐ |

**Details of "Yes" answers:**

Identify question number, 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.

(CONTINUED OVER....)

| | Yes | No | Details of "Yes" answers: |
|---|---|---|---|
| 8. Has any dependent ever had an application for insurance on their life/health declined, rated, or modified in any way? If 'Yes', detail When? Why? Company? | ☐ | ☐ | |
| 9. In the past ten years has any dependent: | | | |
| a) Had or been told they 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 9.a)? | ☐ | ☐ | |
| c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus? | ☐ | ☐ | |

10. Spouse's regular family physician (If none, name Walk In Clinic used): ____________________

Address ____________________

Approximate date last seen ____________________ Reason/Outcome ____________________

11. Name of Child: ____________________ Approximate date last seen ____________________

Child's regular family physician (If none, name Walk In Clinic used): ____________________

Address ____________________

Reason/Outcome ____________________

12. Name of Child: ____________________ Approximate date last seen ____________________

Child's regular family physician (If none, name Walk In Clinic used): ____________________

Address ____________________

Reason/Outcome ____________________

13. Name of Child: ____________________ Approximate date last seen ____________________

Child's regular family physician (If none, name Walk In Clinic used): ____________________

Address ____________________

Reason/Outcome ____________________

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## Applicant Declaration and Authorization:

I declare that any dependent children who are not my natural, step-children or adopted children have been residing with me for at least 12 consecutive months.

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 RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities. I acknowledge receiving the Notice regarding the Medical Information Bureau and authorize the relevant insurer(s) to obtain information from the Medical Information Bureau.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical 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 fact that is material to the insurance being applied for or material to the insurability of the person(s) to be insured, shall render the insurance coverage voidable by RWAM and/or the relevant insured(s). This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

**Date** ____________________ **Employee Signature** ✕ ____________________

**Date** ____________________ **Spouse's Signature** ✕ ____________________

**Date** ____________________ **Child's Signature** (If age 16 or more) ✕ ____________________

**Date** ____________________ **Child's Signature** (If age 16 or more) ✕ ____________________

**Date** ____________________ **Child's Signature** (If age 16 or more) ✕ ____________________

**Any expense incurred in providing this or additional information is the responsibility of the employee.**

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