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

Group Health Evidence Form
Employee Application

Group/Div # _____
Certificate # _____
Insurer(s) _____

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

DO NOT DISCLOSE INFORMATION ABOUT ANY GENETIC TEST (ANALYSIS OF DNA OR RNA CHROMOSOMES) WHICH YOU HAVE TAKEN OR PLAN TO TAKE. YOU MUST, HOWEVER, DISCLOSE IF YOU ARE HAVING TREATMENT FOR OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Name of Employee	email Address	Phone Number: Work ( ) Home ( ) Cell ( )
Address of Employee No. & Street City Prov. Postal Code		
Name of policyholder/employer	Occupation	Are you Actively at Work? ☐ Yes ☐ No If No, why?
Date of Birth Day Month Year	Height	Weight ☐ lb. ☐ kg.
☐ Male ☐ 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. – **excluding genetic testing**) 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, 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 been absent from work for 10+ consecutive days during the last 5 years 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 (including e-cigarettes) 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 reviewing the Notice below 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 insurer(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 ✘ _____ **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

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

Group Health Evidence Form
Application for Dependents

Group/Div # _____
Certificate # _____
Insurer(s) _____

Entire Application to be completed in ink. PLEASE PRINT

Name of Employee _____ email of Applicant _____

Address of Applicant _____

DO NOT DISCLOSE INFORMATION ABOUT ANY GENETIC TEST (ANALYSIS OF DNA OR RNA CHROMOSOMES) WHICH YOU HAVE TAKEN OR PLAN TO TAKE. YOU MUST, HOWEVER, DISCLOSE IF YOU ARE HAVING TREATMENT FOR OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Proposed Dependents To Be Insured	Date of Birth			Height	Weight
	Day	Month	Year		
Spouse:					☐ lb. ☐ kg.
Child:					☐ lb. ☐ kg.
Child:					☐ lb. ☐ kg.
Child:					☐ lb. ☐ kg.

	Yes	No
1. Is the employee Actively at Work? If "No", why? _____	☐	☐
2. Do all the dependents named above reside with the employee? 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, 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. Has any dependent ever used any form of tobacco, nicotine products (including e-cigarettes) or substitutes (including nicotine patch and gum)? If 'Yes', for how long and how often has the dependent been smoking?	☐	☐	

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

Address _____

Approximate date last seen _____ 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 _____

14. 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 or reinsurance company, the MIB Inc., 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, or if applicable, concerning my minor aged child(ren) 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 reviewing the Notice below 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 insurer(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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