Canada Life™

Application / policy number

Paramedical / Medical exam

In this form, the terms *you* or *your* mean the person to be insured unless stated otherwise. The terms *we* and *us* mean The Canada Life Assurance Company.

Name of the person to be insured

First name	Middle name	Last name
Date of birth (dd/mmm/yyyy)		

1. Lifestyle questions

1.1 In the **past 5 years**, have you used tobacco or any nicotine products?

☐ Yes – provide details below ☐ No

Product (check all that apply)	How many you used and how often	Date last used (mmm/yyyy)
☐ Cigarettes / e-cigarettes	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigarillos	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	
☐ Pipe	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigars	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	
☐ Nicotine patch or gum	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	
☐ Other (for example, chewing tobacco, hookah, vaping, snuff, betel nuts, etc.):	# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	

1.2 Do you drink alcoholic beverages?
(Examples of serving sizes: bottle of beer, glass of wine, or ounce of liquor)

☐ Yes – **complete right column** ☐ No | How many drinks in total do you have weekly (wine, beer, liquor)? ☐

1.3 In the **past 5 years**, have you used marijuana or hashish?

☐ Yes – provide details below ☐ No

How many you used and how often	Date last used (mmm/yyyy)
# Used ☐ every: ☐ Day ☐ Week ☐ Month ☐ Year	

1.4 Have you ever been treated, counselled or gone to meetings for alcohol or drug abuse? ☐ Yes ☐ No

1.5 Has a healthcare or other professional ever recommended that you get treatment or counselling or limit the amount of alcohol or drugs you use? ☐ Yes ☐ No

1.6 In the **past 10 years**, have you ever used any drugs or narcotics that weren't prescribed to you (for example, cocaine, LSD, anabolic steroids or amphetamines)? ☐ Yes ☐ No

If you answered yes to questions 1.4, 1.5 or 1.6, complete question 1.7.

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1. Lifestyle questions (continued)

1.7 Provide details for all yes answers in 1.4, 1.5 or 1.6.

Question answered yes to	Details

2. Medical questions

2.1 Healthcare provider details

Full name of regular healthcare provider or the clinic you visit		
Type of healthcare provider ☐ Physician ☐ Other (specify):	Address (street number and name)	
City	Province	Phone number

2.2 Tell us about your **last visit** to a healthcare provider

When was your last visit?	Reason you visited	State the tests, results, and treatment

2.3 Answer the following and for all yes answers, complete 2.7 *Details of your health history*

Have you ever been investigated or treated for or had (or currently have) any known indication of disease or disorder of:

a) The heart, such as: • High blood pressure • Bypass or angioplasty • Abnormal ECG	• Pacemaker • Chest pain • Shortness of breath	• Angina • Irregular heart beat / palpitations • Heart attack	• Heart murmur • Any other disease or disorder of the heart	☐ Yes ☐ No
b) The blood vessels, such as: • Aneurysm • Arteriosclerosis • Stroke	• Blood clot • Peripheral vascular disease	• Transient ischemic attack (TIA) • Circulatory problems	• Any other disease or disorder of the blood vessels	☐ Yes ☐ No
c) The endocrine system, blood or glands, such as: • Diabetes • Gestational diabetes • Anemia	• Enlarged lymph glands • Disease or disorder of the adrenal, pituitary or thyroid glands	• Elevated (high) cholesterol or triglycerides • Abnormal blood sugar	• Any other disease or disorder of glands, blood or endocrine system	☐ Yes ☐ No

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2. Medical questions (continued)

2.3 Answer the following and for all yes answers, complete 2.7 *Details of your health history* (continued)

Have you ever been investigated or treated for or had (or currently have) any known indication of disease or disorder of:

d) The body, such as: • Cancer • Cyst	• Polyp • Tumour	• Growth, lesion, or lump of any type		☐ Yes ☐ No
e) **The skin**, such as: • Psoriasis	• Dysplastic nevus syndrome • Dermatitis	• Skin sores or ulcers • Abnormal Moles	• Any other disease or disorder of the skin	☐ Yes ☐ No
f) The brain or nervous system, such as: • Epilepsy • Loss of speech • Tremors • Numbness or tingling • Loss of sensation • Loss of balance	• Alzheimer's disease • Migraines • Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) • Motor neuron disease • Memory loss or impairment	• Convulsions • Parkinson's disease • Paralysis • Weakness of the extremities • Seizures • Headaches	• Dizziness or fainting • Multiple sclerosis • Neuritis • Any other disease or disorder of the brain or nervous system	☐ Yes ☐ No
g) The lungs or respiratory system, or disorders such as: • Asthma • Persistent cough or pleurisy • Chronic Bronchitis	• Tuberculosis • Chronic obstructive pulmonary disease - COPD	• Sarcoidosis • Sleep apnea or sleep disorder • Emphysema	• Any other disease or disorder of the lungs or respiratory system	☐ Yes ☐ No
h) The gastrointestinal or digestive tract, such as: • Ulcerative colitis • Recurrent indigestion • Rectal bleeding	• Ulcers • Crohn's disease • Hernia	• Any other disease or disorder of the mouth, throat or esophagus	• Any other disease or disorder of the stomach, intestines or rectum	☐ Yes ☐ No
i) **Mental health**, such as: • Anxiety • ADD / ADHD • Autism spectrum disorder • Depression	• Attempted suicide • Bipolar disorder • Schizophrenia • Burnout or stress	• Other psychological, behavioural, eating or emotional disorder	• Developmentally/intellectually disabled • Any other psychiatric disease or disorder	☐ Yes ☐ No
j) The immune system, such as: • Acquired immunodeficiency syndrome (AIDS) or tested positive for HIV, the virus that causes AIDS		• Lupus • Scleroderma	• Any other disease or disorder of the immune system	☐ Yes ☐ No
k) The ears, eyes, nose, or throat, such as: • Blindness	• Deafness • Allergies	• Optic neuritis or other visual disturbance	• Any other disease or disorder of the eyes, ears, nose, or throat	☐ Yes ☐ No
l) The pancreas, gall bladder or liver, such as: • Cirrhosis of the liver • Pancreatitis	• Hepatitis or hepatitis carrier • Jaundice	• Any other disease or disorder of the pancreas, gall bladder or liver		☐ Yes ☐ No
m) The kidney, bladder, breast or reproductive organs, such as: • Blood or protein in the urine • Nephritis	• Abnormal pap or mammogram • Breast lump • Kidney stones	• Venereal disease or other sexually transmitted infection • Elevated prostate specific antigen (PSA)	• Any other disease or disorder of the kidney, bladder, prostate, breast or reproductive system	☐ Yes ☐ No
n) The spine, back, neck, muscles or bones including soft tissue disorders or injuries, such as: • Chronic fatigue • Osteoarthritis • Chronic pain	• Repetitive strain injury • Fibromyalgia • Rheumatoid arthritis	• Conditions causing crippling, limited motion, or requiring adaptive devices	• Any other disease or disorder of the back, muscles or bones including joints, neck and spine or a hip, knee, or other joint replacement	☐ Yes ☐ No

2.4 Have you ever received treatment or counselling or had any time off work for any disease or disorder listed in question **2.3 i)**? ☐ Yes ☐ No

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2. Medical questions (continued)

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which you may have had. You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

2.5 Answer the following and for all yes answers, complete 2.7 *Details of your health history*

a) In the **past 3 months**, have you undergone a medical or diagnostic test (other than a genetic test) for which you have not received the results?	☐ Yes ☐ No
b) Are you currently scheduled for, or have you ever been advised to have, any test (other than a genetic test) or procedure that has not been completed?	☐ Yes ☐ No
c) Other than for a regular annual checkup, are you currently scheduled for or have you been advised to return for a follow-up visit?	☐ Yes ☐ No
d) Are you aware of any indications or complaints for which you have not yet consulted a healthcare provider or received treatment?	☐ Yes ☐ No

2.6 Answer the following and for all yes answers, complete 2.7 *Details of your health history*

In the **past 5 years**	
a) Have you consulted with more than one healthcare provider or clinic?	☐ Yes ☐ No
b) Have you had an illness, surgery, injury or disease not mentioned elsewhere in this application?	☐ Yes ☐ No
c) Have you had any diagnostic tests (other than a genetic test) that were not part of a routine examination and are not mentioned elsewhere in this application, **for example** an electrocardiogram, mammogram, X-ray or blood test?	☐ Yes ☐ No
d) Have you been a patient in a hospital, clinic, or other healthcare facility?	☐ Yes ☐ No
e) Have you been absent from work or school for more than **15 days in a row** for health reasons or injury?	☐ Yes ☐ No

2.7 Details of your health history

If you answered yes to any questions in 2.3 to 2.6, provide details below. Don't include annual physicals. If you've already given us the information in 2.2 *Your last visit to a healthcare provider*, you don't have to give it to us again.

Question answered yes to	Describe the: 1. Condition or symptoms 2. When the symptoms first occurred 3. The tests, results and treatment	Name and address of healthcare provider
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:

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2. Medical questions (continued)

2.8 Has anyone in your biological family (father, mother, brothers or sisters) had heart disease, cancer or stroke **before age 65**?

☐ Yes ☐ No

If you answer yes, complete 2.10 *Details of your biological family health history.*

2.9 Has anyone in your biological family (father, mother, brothers or sisters) ever been diagnosed **before age 70** with the following?

If you answer yes, complete 2.10 *Details of your biological family health history.*

- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Chronic kidney disease
- Dementia
- Diabetes
- Huntington's chorea
- Motor neuron disease
- Multiple sclerosis
- Parkinson's disease
- Polycystic kidney disease
- Any other hereditary disease or disorder?

☐ Yes ☐ No

2.10 Details of your biological family health history
Complete for all yes answers in 2.8 and 2.9.

Person with condition (Check **one** box):	Description of the condition	Age when diagnosed	Current age, if living	If not living, age at death and cause
☐ Father ☐ Mother ☐ Brother ☐ Sister				
☐ Father ☐ Mother ☐ Brother ☐ Sister				
☐ Father ☐ Mother ☐ Brother ☐ Sister				
☐ Father ☐ Mother ☐ Brother ☐ Sister				
☐ Father ☐ Mother ☐ Brother ☐ Sister				

2.11 **If yes**, to family history of breast or ovarian cancer in question 2.8, have you seen a healthcare provider for a breast examination, mammogram or other form of monitoring?

☐ Yes – complete 2.14 ☐ No

2.12 **If yes**, to family history of colon cancer in question 2.8, have you had a colonoscopy?

☐ Yes ☐ No

2.13 Answer the following and for all yes answers, complete 2.14 *Details of your health history*

a) In the **past 3 years**, have you fallen or been injured? ☐ Yes ☐ No

b) Are you currently, or within the **past 5 years**, have you been unable to perform activities of daily living on your own, such as bathing, dressing, toileting, eating, transferring from bed to chair, or controlling bladder or bowel function? ☐ Yes ☐ No

c) Are you currently receiving, or within the **past 5 years**, have you received home care or adult care, or been confined to a home for the aged, nursing home or other institution, or recommended to receive any such care? ☐ Yes ☐ No

d) Are you currently, or within the **past 5 years**, have you been a user of any medical equipment such as a respirator, oxygen device, walker, wheelchair, cane or any other type of mobility assistance? ☐ Yes ☐ No

e) For physical or psychological reasons, do you currently need or use the help or supervision of another person to perform any of the following activities: driving, arranging transportation, using the telephone, managing finances, doing housework or laundry, shopping or meal preparation? ☐ Yes ☐ No

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2. Medical questions (continued)

2.14 Details of your health history

If you answered yes to any questions in 2.11, 2.12 or 2.13, provide details below. Don't include annual physicals. If you've already given us the information in 2.2 *Your last visit to a healthcare provider*, you don't have to give it to us again.

Question answered yes to	Describe the: 1. Condition or symptoms 2. When the symptoms first occurred 3. The tests, results and treatment	Name and address of healthcare provider
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:
		☐ Same as 2.1 ☐ As below:

You have read this form and confirm the information you've provided in this form is complete, current and accurate, to the best of your knowledge. If you fail to provide the required information, we could decline a future claim and cancel any policy we've issued. You agree to notify us immediately of any errors, omissions or changes in the information you've provided in this form.

You agree that this form is a part of the application to The Canada Life Assurance Company, identified by reference to the application or policy number above. You have read, understood and agreed with the contents of the *Notice regarding your personal information* and *Agreements and signatures* section in the application for insurance.

You agree that a copy of this agreement is as valid as the original.

Signed at (city or town and province)	Date (dd/mmm/yyyy)
Signature of **person to be insured** X	Signature of **medical examiner/paramedical technician** X

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Name of the person to be insured

First name	Middle name	Last name

3. Medical examiner's / paramedical technician's report

In this section, *you* and *my* refer to the medical examiner or paramedical technician.
Questions 3.1 to 3.3 are to be completed on the person to be insured by a medical examiner or paramedical technician

3.1 Height and weight

Height: ☐ feet ☐ inches, or ☐ centimetres	Weight: ☐ pounds, or ☐ kilograms
Waist circumference: ☐ inches, **or** ☐ centimetres	
Did you measure? ☐ Yes ☐ No	Did you weigh? ☐ Yes ☐ No
In the **past 12 months**, has the insured person lost more than 10 pounds (4.5 kilograms)? ☐ Yes ☐ No	
If yes, how much and why?	

3.2 Vitals

Blood pressure
Take three readings, five minutes apart:

	First reading	Second reading	Third reading
Systolic			
Diastolic (at cessation of sound)			

Pulse per minute

	Rate	Irregularities
Pulse at rest		
If pulse at rest is over 100 or under 60, recheck pulse five minutes later		

3.3 If a specimen is collected as part of the routine requirements, place lab barcode sticker here.

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3. Medical examiner's / paramedical technician's report (continued)

Questions 3.4 to 3.7 are to be completed by a medical examiner only

3.4 Is there evidence of past or present disease or abnormality of the following:

a) Eyes, ears, nose, mouth, pharynx? (if vision or hearing markedly impaired, indicate degree and correction in question 3.7)	☐ Yes ☐ No
b) Skin (include scars), lymph nodes, varicose veins or peripheral arteries?	☐ Yes ☐ No
c) Nervous system? (include reflexes, gait, paralysis)	☐ Yes ☐ No
d) Chest and respiratory system?	☐ Yes ☐ No
e) Abdomen? (include scars, herniae)	☐ Yes ☐ No
f) Genitourinary system?	☐ Yes ☐ No
g) Endocrine system?	☐ Yes ☐ No
h) Musculoskeletal system? (include spine, joints, amputations, deformities)	☐ Yes ☐ No

3.5 Answer the following questions

a) Do you find any evidence of past or present disease or impairment of the heart or cardiovascular system? If you answered yes, indicate on the diagram below the position of the apex beat and any murmurs.	☐ Yes ☐ No
b) Are there any abnormalities of the peripheral pulses?	☐ Yes ☐ No
c) Is there any cardiac enlargement?	☐ Yes ☐ No
d) Are there any arrhythmias? If you answered yes, please describe:	☐ Yes ☐ No
e) Is there any cyanosis, dyspnea or edema?	☐ Yes ☐ No
f) Is there any evidence of varicose veins or phlebitis?	☐ Yes ☐ No

g) Cardiac diagnosis (if any):

Indicate on diagram:

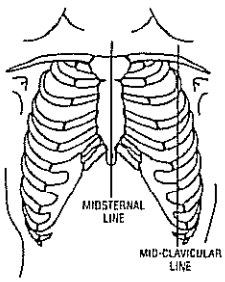
Position of apex beat X

If murmur is present:

Area of audibility ⬭

Point of greatest intensity O

Direction of transmission →



3.6 Are you aware of any additional medical history? ☐ Yes ☐ No

3.7 For questions 3.4 to 3.6, provide full details of any abnormal findings and details for any questions answered yes.

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3. Medical examiner's / paramedical technician's report (continued)

Print full name and address of medical examiner or paramedical technician, and paramedical facility below.

First name	Middle name	Last name

Name of paramedical facility

Address (street number and name)

City	Province	Phone number

Date examination completed (dd/mmm/yyyy):		Time:	☐ AM ☐ PM

At: ☐ My office ☐ Other (specify):

Person to be insured identification – documentation **must** be original and valid.
Check the type of government-issued photo ID the insured person chooses to show:

☐ Driver's licence ☐ Passport ☐ Other (excluding health insurance cards) – specify which:

Document number	Jurisdiction of issue	Date of issue (dd/mmm/yyyy)	Expiry date (dd/mmm/yyyy)

Signature of **medical examiner or paramedical technician**

X

Mailing information:
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Canada Life New Business, T-019
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London, ON N6A 4K1

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