

NOTICE: Any uncompleted request or unanswered question shall delay the study of your file.

(A) CONTRACT NO.		SECTION NO		IDENTIFICATION NO.	
(B) SUBSCRIBER					
NAME:			PLACE OF BIRTH:		
GIVEN NAME:			OCCUPATION:		
ADDRESS			SOCIAL INSURANCE NUMBER		DATE OF BIRTH
No.	Street	Apt.		Day	Month Year
City Province Postal Code			HEIGHT ft. in./cm	PRESENT WEIGHT lb./kilo	SEX AGE
TEL.: HOME: () OFF.: ()					<input type="checkbox"/> M <input type="checkbox"/> F
(C) PLEASE COMPLETE IF THE INSURANCE REQUESTED IS FOR DEPENDENTS					
SPOUSE					
NAME:			PLACE OF BIRTH:		
GIVEN NAME:			OCCUPATION:		
SEX: <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	Day Month Year	AGE	HEIGHT ft. in./cm	PRESENT WEIGHT lb./kilo
CHILD / CHILDREN					
NAME	GIVEN NAME	SEX	DATE OF BIRTH	AGE	HEIGHT ft. in./cm PRESENT WEIGHT lb./kilo
		M F	Day Month Year		
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			

FOR EACH OF THE FOLLOWING QUESTIONS ANSWERED "YES", IDENTIFY THE PERSON AND GIVE DETAILS IN SECTION H.

(D) IN YOUR LIFETIME, HAVE YOU BEEN TREATED FOR, OR SHOWN SYMPTOMS OF THE FOLLOWING DISEASES?	SUBSCRIBER DEPENDENT/S			
	Yes	No	Yes	No
1. Cardiovascular system: Chest pain, palpitations, high blood pressure, acute rheumatoid arthritis, heart murmur, heart seizure, or any impairment of the heart or blood vessels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Respiratory system: Asthma, chronic bronchitis, spitting of blood, tuberculosis, emphysema or any impairment of the respiratory system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Digestive system: Colitis, ulcer, bleeding from stomach or bowel, or other impairment of the stomach, gall-bladder, liver (hepatitis, cirrhosis), or the intestines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Genito-urinary system: Sugar, albumine, blood or pus in the urine, or any impairment of the kidneys, bladder, prostate or reproductive organs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Endocrine system: Diabetes, impairment of the thyroid or any other impairment of endocrine system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Musculo-skeletal system: Rheumatism, arthritis, gout, muscle or bone disease including spinal chord, back and joints.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervous system: Convulsions, epilepsy, cephalaea, paralysis, degenerative disease, depression or other mental or nervous disorder.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Immunological system: Have you ever had or been told that you had one of the following ailment, or have you undergone tests or received medical counsel for these:				
a) AIDS (Acquired Immune Deficiency Syndrome), Para-AIDS (ARC) or any other immunological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Hypertrophy of lymphatic ganglions (glands), chronic diarrhea, less common or persistent lesions, infections of unknown origins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. General: Alcohol or drug abuse, anemia or other blood disease, cyst, tumor, cancer, or other physical or mental disorder not mentioned previously.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(E) DETAILS OF "YES" ANSWERS

Question number	Name of person	Disease, operation, examinations, treatments, drugs, results	Date	Duration of illness	Name and address of doctors and hospitals. Specify: if hospitalized (how long), treated in an outpatient clinic or in a doctor's office.

