BLUE CROSS®

Short Health Statement

☐ REINSTATEMENT (90 DAYS OR LESS) ☐ NO-SMOKER'S RATES ☐ RECLASSIFICATION

IDENTIFICATION

Last name of the Insured	First name of the Insured	Date of Birth (DD-MM-YYYY)	Contract No
Occupation	Income	Height (ft/cm)	Weight (lb/kg)

QUESTIONNAIRE

Following the last declaration of insurability to Blue Cross, has the insured person:

1. Had an application or reinstatement of life, disability and/or critical illness insurance declined, modified, postponed or subject to an extra premium? If yes, specify:	☐ Yes ☐ No
2. Been convicted of any driving infractions?	☐ Yes ☐ No
3. Participated or has the intention to participate in activities such as car racing, scuba diving, parachuting, mountain climbing, bungee jumping or any other hazardous sport?	☐ Yes ☐ No
4. Flown in an aircraft or has the intention to fly an aircraft as a pilot, student or crew member?	☐ Yes ☐ No
5. Consulted or been treated by a physician or any other health professional? If yes, specify:	☐ Yes ☐ No
6. Modified his/her alcohol consumption? If yes, specify:	☐ Yes ☐ No
7. a) Used tobacco in any form: cigarettes, cigarillos, cigars, pipe or any other tobacco-derivative or nicotine-containing product? b) If he/she ceased using tobacco products, please specify the date of last consumption:	☐ Yes ☐ No
8. Used drugs or narcotics without a medical prescription?	☐ Yes ☐ No
9. Been informed of any change in his/her family medical history?	☐ Yes ☐ No
10. Had symptoms or conditions for which he/she has not yet consulted or received a treatment for?	☐ Yes ☐ No
11. Is the insured person presently under the care of a physician or under medical supervision or taking any medication?	☐ Yes ☐ No

DECLARATION

I hereby declare that the above information is complete, accurate and current. I agree that this information will be used as the basis for the assessment carried out in order to establish my eligibility for Canassurance Hospital Service Association and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada insurance coverage. I also understand that, once my application has been assessed and approved, the information contained in this form will be an integral part of the insurance policy that will be issued. Any false statements in this form will lead to legal measures, including policy cancellation.

Signature of the Insured _____ Date (DD-MM-YYYY) _____

Signature of policyholder (if different from Insured) _____ Date (DD-MM-YYYY) _____

AUTHORIZATION

I authorize any licensed physician, health professional, hospital, medical facility, insurance company, reinsurance company, MIB, Inc. or any other organization, agency, institution, holding records or knowledge on myself or on my state of health, or my dependent children, to give any such information to Canassurance Hospital Service Association and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada or their reinsurers.

A photocopy of this authorization is as valid as the original.

Signature of the Insured (signature of policyholder if the insured person is under 16 years of age in Ontario or under 14 years of age in Quebec) _____ Date (DD-MM-YYYY) _____