Coughlin & Associates Ltd. | PO BOX 3517, Station C | Ottawa, ON K1Y 4H5 | tel: 613-231-2266 | fax: 613-231-2345 | 1-888-613-1234 | www.coughlin.ca

Privileged SELECTION™

CRITICAL ILLNESS INSURANCE

Questionnaire for critical illness insurance

Print Form

ACE INA Life Insurance

Policy CO10367301

OFFICE USE ONLY

ID # _____

Division # _____

EMPLOYEE INFORMATION (Complete the form in ink, sign and date the form. Please print clearly).

Name (first, middle initial, last) _____

Home address _____

City _____ Province _____ Postal code _____

Telephone _____

Gender ☐ Male ☐ Female Smoking status ☐ Smoker ☐ Non-smoker

Birthdate (YY/MM/DD)

SPOUSAL INFORMATION

Name (first, middle initial, last) _____

Gender ☐ Male ☐ Female Smoking status ☐ Smoker ☐ Non-smoker

Birthdate (YY/MM/DD)

CHILD INFORMATION – IF APPLICABLE – (Please indicate your youngest child's name and date of birth only)

Name (first, middle initial, last) _____

Birthdate (YY/MM/DD)

HEALTH QUESTIONNAIRE

		EMPLOYEE		SPOUSE	
		Yes	No	Yes	No
1)	Have you ever sought advice or received treatment for, or had any known indication of:				
	(a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?	☐	☐	☐	☐
	(b) Cancer, tumour or malignancy?	☐	☐	☐	☐
	(c) Advanced ophthalmic disease?	☐	☐	☐	☐
	(d) Multiple sclerosis or paralysis?	☐	☐	☐	☐
	(e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	☐	☐	☐	☐
	(f) AIDS, HIV, chronic or unexplained infections?	☐	☐	☐	☐
2)	Within the last five years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following:				
	(a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	☐	☐	☐	☐
	(b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	☐	☐	☐	☐
	(c) Hospitalized due to a medical problem with respect to severe respiratory disorder?	☐	☐	☐	☐
	(d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?	☐	☐	☐	☐
3)	Have you ever been declined for life insurance or offered coverage only at higher than standard rates?	☐	☐	☐	☐
4)	Does your height and weight fall outside the chart noted below?	☐	☐	☐	☐

Males

Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4' 8"	95	145	5' 8"	132	207
4' 9"	98	150	5' 9"	137	213
4' 10"	100	155	5' 10"	141	219
4' 11"	103	160	5' 11"	145	225
5' 0"	105	165	6' 0"	150	233
5' 1"	108	170	6' 1"	155	241
5' 2"	111	175	6' 2"	160	249
5' 3"	114	180	6' 3"	165	257
5' 4"	118	185	6' 4"	170	265
5' 5"	121	190	6' 5"	175	272
5' 6"	124	195	6' 6"	180	279
5' 7"	128	201	6' 7"	185	285

Females

Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4' 8"	86	145	5' 8"	119	207
4' 9"	88	150	5' 9"	123	213
4' 10"	90	155	5' 10"	127	219
4' 11"	93	160	5' 11"	131	225
5' 0"	95	165	6' 0"	135	233
5' 1"	97	170	6' 1"	140	241
5' 2"	100	175	6' 2"	144	249
5' 3"	103	180	6' 3"	149	257
5' 4"	106	185	6' 4"	153	265
5' 5"	109	190	6' 5"	158	272
5' 6"	112	195	6' 6"	162	279
5' 7"	115	201	6' 7"	167	285

over

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	EMPLOYEE Yes	EMPLOYEE No	SPOUSE Yes	SPOUSE No
5) Have you ever sought advice or received treatment for, or had any known indication of:				
a) Advanced loss of hearing?	☐	☐	☐	☐
b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?	☐	☐	☐	☐
c) Any psychiatric disorder, mental deterioration or loss of intellectual ability?	☐	☐	☐	☐
d) Gout, arthritis, scleroderma, muscular dystrophy, ataxia, systemic lupus erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?	☐	☐	☐	☐
e) Amputation due to disease?	☐	☐	☐	☐
6) Do you currently:				
a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?	☐	☐	☐	☐
b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?	☐	☐	☐	☐
c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?	☐	☐	☐	☐

OPTIONAL BENEFIT AMOUNT SELECTION

(Units of $5,000)

☐ Employee coverage $_____

☐ Spousal coverage $_____

Maximum available coverage for employee and spouse is $150,000 each and must be in units of $5,000.

☐ **I apply for coverage on my child(ren) in the amount of $5,000 for each child and attest that he/she is in good health. An eligible child is over 14 days but under 21 years of age, or at least 21 of age but less than 25 years of age if full-time student. The total cost of critical illness insurance is $0.75 per month per family.**

Age	Male non-smoker	Male smoker	Female non-smoker	Female smoker
18-24	$0.53	$0.71	$0.53	$0.71
25-29	0.53	0.71	0.53	0.71
30-34	0.75	1.08	0.93	1.27
35-39	1.01	1.55	1.21	1.81
40-44	1.52	2.57	1.70	2.99
45-49	2.55	4.97	2.65	4.88
50-54	4.76	9.06	3.74	8.04
55-59	7.03	15.29	4.85	12.17
60-64	10.71	24.99	6.32	13.91

BENEFICIARY DESIGNATION

I hereby name the following revocable beneficiary (irrevocable in the province of Quebec) for any benefits payable as a result of my participation in this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Please note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check the box below:

I hereby make the beneficiary designated below:

☐ **Revocable**, I may elect to change this beneficiary designation at any time.

Beneficiary's full name _____

Relationship to you _____

Trustee's name (if applicable) _____

AUTHORIZATION

Privacy Statement: When you apply to enroll in the group insurance plan, underwritten by ACE INA Life Insurance ("ACE Life"), the information in ACE Life's existing insurance files and the information requested on your application is required by ACE Life, its reinsurers and authorized agents to process your application (and if approved), administer your insurance policy, assess claims and investigate misrepresentation. ACE Life will create a file with your insurance information, and in the event of a claim, with such information as ACE Life obtains from you and other sources, for the purpose of considering your claim and administering benefits under the plan. Access to this file will be restricted to those ACE Life employees, authorized agents and reinsurers who require access to administer the Plan and process claims and persons authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer; ACE INA Life Insurance, The Exchange Tower, 130 King Street West, 12th floor, Toronto, ON, M5X 1A6.

I hereby apply for coverage under the Group Life Insurance Plan, underwritten by ACE INA Life Insurance, for which I am or may become eligible and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under this plan and have not applied for any.

I hereby declare that the above answers and statements are complete and true and I agree that any coverage issued in consequence of this application shall not take effect, unless, on the date the insurance is to become effective, I am actively engaged in my occupation on a full-time basis. I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital or clinic or medically related facility, insurance company or other organization, institution or person, with any records or knowledge of me or my health, to give any such information to the Insurer or its Reinsurer(s). A photocopy of this authorization shall be valid as the original.

Signed at _____ this _____ day of _____ 20 _____

Employee's signature You must print THEN sign this form

Spouse's signature (if applicable) You must print THEN sign this form

Information about your insurability and your dependants' insurability will be treated as confidential.