seCUREme Catastrophic Insurance Medical Declaration

SECTION 1: General Information

SURNAME	GIVEN NAME	INITIAL

DATE OF BIRTH (MM/DD/YYYY)	**NAME OF EMPLOYER** (If applicable)

SECTION 2: Health Declaration (Please answer each section below, incomplete forms will be returned)

In the past 10 years have you or any of your dependents ever been diagnosed or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide details in Section 2.	Applicant	Spouse	Dependents
1. Have you ever been treated for, counseled for, received advice for or ever had any known indication of:			
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
c) Diabetes, Colitis or Crohn's?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
h) Chronic Headaches, Migraines or recurrent infections?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
n) Skin Disorder (including Acne)?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
o) Alcoholism or Drug Abuse/Dependency?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
p) Other Condition/Disease/Disorder/Injury – Please specify: _____	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

In the past 10 years have you or any of your dependents ever been diagnosed or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide details in Section 2.	Applicant	Spouse	Dependents
2. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Positive HIV test results or other virus or any sexually transmitted disease?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
4. Are you currently taking or have you been prescribed any prescription medications?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
7. Are you currently pregnant? Expected Due Date_____ Have you ever had a history of pregnancy complications?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

SECTION 3: Details for questions answered "Yes" in Section 2

Question #	Name of Applicant, Spouse or Dependent	Illness/Condition	Treatment Date From/To	Date of Recovery	Treating Physician	Medication/Treatment	Daily Dosage

SECTION 4: Medical Practitioner. Please provide details of your family doctor or attending physician

Name:	Mailing Address:	Phone Number:

Authorizations and Declarations

I authorize:

Health Risk Services Inc., any health care provider, my plan administrator, other insurance companies or reinsurance companies, the Medical Information Bureau, administrators of government benefits or other benefit programs, other organization, or service providers working with Health Risk Services Inc. to exchange personal information, when necessary to determine my insurability and to administer the benefits plan.

I certify or confirm that:

- I have retained a copy of this application.
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date the Insurer makes a decision must be reported to Health Risk Services Inc. I understand that failure to do so could result in coverage being voided.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be voided. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of the Insurer or it underwriters, I am not insurable for all or part of that benefit.

Plan Member Signature (Electronic Signature)	**Date** (MM/DD/YYYY)
Please forward completed forms to: **Health Risk Services Inc.** **#50, 12221 44 St. SE** **Calgary, Alberta, Canada T2Z 4H3**	**INSURER USE ONLY**: **Policy No.**

Protecting your Privacy:

At Health Risk Services Inc. we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Health Risk Services Inc. or the offices of an organization authorized by us (located within or outside of Canada). We limit access to personal information in your file to Health Risk Services Inc. staff or persons authorized by Health Risk Services Inc. who require it to perform their duties, to persons to whom you have granted access and to persons authorized by law. We use the personal information to determine your insurability and to administer the benefits plan.

Reset Form