Equitable Life of Canada®

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STATEMENT OF HEALTH FOR GROUP INSURANCE

COMPLETION OF THE APPLICATION

Please make certain that **all questions** are answered clearly and completely to avoid delays in processing your application. If you are applying for more than two children, please complete multiple forms for each child. If there is not enough room for specific details, please continue on additional blank sheets ensuring you sign and date each additional sheet.

All applicants age 16 and over are to sign in the designated areas in **Section 4.**

Please check all reasons for which you are applying:

- ☐ Late application for participation in the group plan
- ☐ Late application for a dependent to participate in the group plan
- ☐ Increase in coverage above the non-evidence maximum
- ☐ Application for optional accidental death and dismemberment

Please check all benefits for which you are applying:

- ☐ Basic life
- ☐ Dependent life (spouse/child(ren))
- ☐ Critical illness
- ☐ Accidental death and dismemberment
- ☐ Optional accidental death and dismemberment
- ☐ Short term disability
- ☐ Long term disability
- ☐ Extended health coverage - member
- ☐ Extended health coverage - spouse
- ☐ Extended health coverage - child(ren)
- ☐ Dental coverage - member
- ☐ Dental coverage - spouse
- ☐ Dental coverage - child(ren)

Section 1 STATEMENT OF HEALTH FOR GROUP INSURANCE

Applicant (first name, last name):		
Policyholder name/Employer:	Group policy number:	Certificate number:

Contact details

Please select your preferred method of contact regarding medical underwriting, including sharing personal medical information:

☐ Email (address listed below) ☐ Mail via home address ☐ Mail via work address

Email address: _____

Home address

Street: _____

City: _____ Province: _____ Postal code: _____ Tel. number: _____

Work address

Street: _____

City: _____ Province: _____ Postal code: _____ Tel. number: _____

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) 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.

Section 2 APPLICANT STATEMENT - MEMBER

Name (first, middle, last):		
☐ Male ☐ Female	Date of birth (dd/mm/yyyy):	Place of birth (province/state and country):

Are you now actively at work on a full time basis? (30 hours per week) ☐ Yes ☐ No

If no, please provide details about why, including last day worked and anticipated date of return.

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of gain:	Amount of loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine-based products, or smoking cessation aids within the last 12 months? ☐ Yes ☐ No

Products:	Frequency:	Date last used (dd/mm/yyyy):

Name and address of your usual medical practitioner: (If none, state last physician contact – i.e. clinic, emergency room visit)

Date last consulted (dd/mm/yyyy):	Reason:	Results/Diagnosis:

Treatment (include check-up results):

Any follow-up advised: (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If yes, provide full details below)

Section 2 APPLICANT STATEMENT - SPOUSE

Name (first, middle, last):

☐ Male ☐ Female	Date of birth (dd/mm/yyyy):	Place of birth (province/state and country):

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of gain:	Amount of loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine-based products, or smoking cessation aids within the last 12 months?
☐ Yes ☐ No

Products:	Frequency:	Date last used (dd/mm/yyyy):

Name and address of your usual medical practitioner: (If none, state last physician contact – i.e. clinic, emergency room visit)

Date last consulted (dd/mm/yyyy):	Reason:	Results/Diagnosis:

Treatment (include check-up results):

Any follow-up advised (e.g. tests, surgery, hospitalization): ☐ Yes ☐ No (If yes, provide full details below)

Section 2 APPLICANT STATEMENT - CHILD 1

Name (first, middle, last):

☐ Male ☐ Female	Date of birth (dd/mm/yyyy)	Place of birth (province/state and country)

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of gain:	Amount of loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine-based products, or smoking cessation aids within the last 12 months?
☐ Yes ☐ No

Products:	Frequency:	Date last used (dd/mm/yyyy):

Name and address of your usual medical practitioner (If none, state last physician contact – i.e. clinic, emergency room visit):

Date last consulted (dd/mm/yyyy):	Reason:	Results/Diagnosis:

Treatment (include check-up results):

Any follow-up advised (e.g. tests, surgery, hospitalization): ☐ Yes ☐ No (If yes, provide full details below)

Section 2 APPLICANT STATEMENT - CHILD 2

Name (first, middle, last):

☐ Male ☐ Female	Date of birth (dd/mm/yyyy):	Place of birth (province/state and country):

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of gain:	Amount of loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine-based products, or smoking cessation aids within the last 12 months?
☐ Yes ☐ No

Products:	Frequency:	Date last used (dd/mm/yyyy):

Name and address of your usual medical practitioner: (If none, state last physician contact – i.e. clinic, emergency room visit)

Date last consulted (dd/mm/yyyy):	Reason:	Results/Diagnosis:

Treatment (include check-up results):

Any follow-up advised (e.g. tests, surgery, hospitalization): ☐ Yes ☐ No (If yes, provide full details below)

Section 3 APPLICANT QUESTIONS

Please complete <u>all</u> questions below. Where the answer is "Yes", please provide all details including diagnosis, treatment dates, duration, current status and complete names and addresses of <u>all</u> physicians and/or medical facilities below.

	Plan Member	Spouse	Child 1	Child 2
1. Has your driver's license ever been suspended and/or have you had two or more moving violations within the last year? (If yes, please provide details including current driver's license number)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past two years, have you or do you intend to: a) Make any flights as a pilot?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Engage in a hazardous sport or hobby e.g. hang gliding, sky diving, motor racing, mountain climbing or other?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Engage in scuba diving? (If yes, answer questions below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Where do you dive? ☐ Inland waters ☐ Ocean ☐ Other

Indicate if you participate in: ☐ Night diving ☐ Salvage ☐ Wreck ☐ Caves ☐ Under ice ☐ Search and rescue ☐ Other_____

Are you certified?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you a member of an organized club?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you dive alone?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Dive particulars	Past 12 months			Expected – next 12 months	
Depth of dive	Number of dives	Average time per dive		Number of dives	Average ime per dive
< 100 feet (30.8 meters)					
100 to 125 feet (30.48 - 38.1 meters)					
> 125 feet (38.1 meters)					

Section 3 APPLICANT QUESTIONS (CONTINUED)

	Plan Member	Spouse	Child 1	Child 2
3. Has any immediate family member (whether living or deceased) ever suffered from or been diagnosed with, high blood pressure, heart disease, stroke, cancer (specify type), diabetes, kidney disease, mental illness, Huntington's chorea, amyotrophic lateral sclerosis, (ALS or Lou Gehrig's disease), motor neuron disease, multiple sclerosis, alzheimer's disease, Parkinson's disease or any other hereditary disease? (If yes, indicate family member, age at diagnosis and condition)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Within the past 5 years, have you received disability benefits from any source or missed 5 or more consecutive days from work due to illness or injury or had any company decline, modify, cancel or rescind any life, disability income or critical illness insurance? (If yes, please provide full details)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever had symptoms of, been treated for, or been advised to receive treatment or investigation of any of the following:				
5. Heart attack, angina, chest pain, rheumatic fever, stroke, transient ischemic attack (TIA), elevated blood pressure – (include last blood pressure reading known and date), cholesterol (include last known levels), heart murmur or other heart or blood vessel disease or disorder? (If yes, please provide details)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Plan Member	Spouse	Child 1	Child 2
6. Asthma, respiratory, sleep apnea or other lung disorder? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Respiratory disorder

Do you have a history of: ☐ Asthma ☐ Recurrent bronchitis ☐ Emphysema ☐ Other _____

Date of first episode: _____ Date of last episode: _____ Frequency of episodes: _____

Do you consider severity of episodes ☐ Mild ☐ Moderate ☐ Severe

Have you ever been hospitalized or gone to an emergency room because of respiratory distress? ☐ Yes ☐ No (If "Yes", details)

Have you ever undergone respiratory tests (Pulmonary function tests, chest x-rays, other)? ☐ Yes ☐ No (If "Yes", details)

Indicate all medications used (inhalers, oral, other):

	At time of flare-up	Maintenance medications
Type		
Dosage		
Frequency		

Section 3 APPLICANT QUESTIONS (CONTINUED)

	Plan Member	Spouse	Child 1	Child 2
7. Diabetes, impaired sugar levels or ever had sugar, blood or protein in your urine (include age at diagnosis, date and last known hemoglobin A1C)? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Gastrointestinal disorder (includes esophageal, stomach, liver, colon, colitis, crohns or bowel/intestinal disorders)? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Any eye or ear disorder, hearing loss, dizziness, fainting, convulsions, stroke, blurred vision or optic neuritis? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Thyroid, glandular disorder, lupus, multiple sclerosis, amytrophic lateral sclerosis (ALS or Lou Gehrig's disease), or epilepsy? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11. Cancer, tumor, cyst, polyp, nodule, mole, lump or other growth, breast disorder or abnormal mammogram, ultrasound or pap smear? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12. Abnormal mole, lupus, skin lesion, chronic skin infection, psoriasis, dysplastic nevi, scleroderma or any other skin disease or disorder? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 3 APPLICANT QUESTIONS (CONTINUED)

13. Anxiety, stress, depression, fatigue, attempted suicide, nervous breakdown, eating disorder, or other nervous system disorder? (If yes, complete questions below) .....

Plan Member	Spouse	Child 1	Child 2
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Nervous disorder

Have you ever had any indication of the following:

Depression ☐ Yes ☐ No Eating disorder ☐ Yes ☐ No Weight loss, fatigue, stress ☐ Yes ☐ No

Insomnia ☐ Yes ☐ No Suicidal thoughts/attempt ☐ Yes ☐ No Anxiety ☐ Yes ☐ No

(If yes, provide details)

When did you first consult a doctor/therapist and what was the diagnosis?

Name of medications both prescription or non-prescription with dates, dosage and frequency:

Are you still taking medication or receiving counselling? ☐ Yes ☐ No If yes, date of last medication and treatment?

Have you ever been hospitalized or gone to an emergency room because of a nervous disorder? ☐ Yes ☐ No If "Yes", details:

Are your symptoms: ☐ Resolved ☐ Unchanged ☐ Less severe ☐ More severe Provide date of last symptoms _____

Any time off work? ☐ Yes ☐ No If "Yes" details: _____

Describe any current symptoms: _____

14. Muscles, bones and joints, e.g. Arthritis, back or neck pain, paralysis, deformity, etc. (if yes, complete questions below) .....

Plan Member	Spouse	Child 1	Child 2
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Musculoskeletal disorder

☐ Headaches ☐ Back ☐ Neck ☐ Arthritis ☐ Other Pain Disorder _____

Location of symptoms _____ Radiating to (if applicable) _____

Duration of symptoms _____

First episode _____ Most recent episode _____ How often does pain occur _____

Longest duration of discomfort _____

If back or neck involved check box: ☐ Neck (cervical) ☐ Middle (thoracic) ☐ Low (lumbo sacral)
☐ Muscular ☐ Disc disorder

Diagnosis/Cause: _____

Name(s) of doctor(s) consulted with dates and full addresses:

	Plan Member	Spouse	Child 1	Child 2
a)	History of medications (list names, dates, dosage and frequency of use):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b)	History of treatment (i.e. physiotherapy, massage)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c)	Have you been advised to undergo any tests, investigations or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d)	Have you ever been hospitalized, unable to work or restricted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please provide details:

Section 3 APPLICANT QUESTIONS (CONTINUED)

	Plan Member	Spouse	Child 1	Child 2
15. a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you ever had a positive test result indicating exposure to the AIDS Virus (Positive HIV)? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Within the past 5 years, have you had any indication or been treated for a sexually transmitted disease? (If yes, please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16. Do you regularly take any medication? (If yes, specify type, dosage, when and by whom prescribed below) ...	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17. Do you have any symptoms or are you aware of any problems for which you have not yet consulted a doctor or other health practitioner, or that have not already been listed above? (If yes, please provide details below).....	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18. Have you ever or do you currently drink alcoholic beverages and/or use marijuana, cocaine or any illegal or addictive drugs? (If yes, complete the Alcohol and drug use questions on the next page)...	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a) Have you ever received advice or treatment pertaining to your use of alcohol? (If yes, complete Alcohol and drug use questions on the next page) ...	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs? (If yes, complete Alcohol and drug use questions on the next page) ...	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 3 APPLICANT QUESTIONS (CONTINUED)

Alcohol and drug use

Please answer all questions

	Plan Member	Spouse	Child 1	Child 2
a) Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Cocaine (includes crack)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Marijuana and/or hashish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Amphetamines (ecstasy etc)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Barbiturates type: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Heroin, morphine, demerol, methadone	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Hallucinogens (LSD)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Other similar narcotics	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

i) Give details regarding "Yes" answers: ("Type" refers to alcohol and/or drugs)

	Type	Daily amount	Weekly amount	Monthly amount
Use at present				
Previous 1-2 yrs.				
Previous 3-5 Yrs.				
Other (include dates)				

	Plan Member	Spouse	Child 1	Child 2
j) Have you ever attended or been referred to a support group or organization i.e. AA, for alcohol abuse or drug use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Have you ever been advised to reduce consumption of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please provide details:

Additional application information

Section 4 LEGAL INFORMATION

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER, DECLARE, AGREE AND CERTIFY THAT:

1. All the statements, information and answers provided in all sections of this Application are true, complete, accurate and correctly recorded.
2. The personal information willingly provided by the member to the member's employer, the independent broker/sales advisor and The Equitable Life Insurance Company of Canada (Equitable), collected on this Application and held in their files, will be used by Equitable for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Policy and all benefits under the Policy, and any supplementary documents. The member understands and authorizes that for the above purposes the personal information on file is accessible to and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable, any industry drug pooling entity, participating reinsurer(s), other insurance companies, investigative parties, health care providers, including, but not limited to pharmacies, physicians and dentists, and any other person or party whom the member authorizes. If applying for the member's spouse and/or dependents, the member confirms that the member is authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. The member understands that all claims made under the Policy are submitted through the member as insured plan member. The member therefore authorizes Equitable to exchange information about these claims with the member or any person acting on the member's behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing a claim.

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER:

1. Agree that the insurance being applied for in this Application or such insurance as issued by Equitable shall not take effect until the first premium for the insurance coverage has been paid by the plan sponsor.
2. Acknowledge receiving the Notice regarding the Medical Information Bureau and authorize Equitable to obtain information from the Medical Information Bureau.
3. Authorize Equitable to perform all tests, including, without limitation, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this Application. Such tests may include tests to determine the presence of various diseases including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS). Equitable may disclose to its reinsurer(s), your attending physician(s), health service providers, and the Medical Information Bureau, the results of all such tests and personal information necessary to fulfill any of the identified purposes in this Application. I/we understand and agree that any positive results for HIV, hepatitis, or any other communicable diseases will be reported to the appropriate Public Health Authority. Your personal information collected by the testing facility may be processed and stored by such facility in Canada and/or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
4. Authorize the Motor Vehicle Division in any province requiring such authorization to permit Equitable or any investigative agency on behalf of Equitable, to be given a copy of all driving record information relevant to this Application.
5. Authorize any physician, practitioner, hospital, clinic, or other medical-related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any record or knowledge of the person(s) this insurance is applied for, or their health, to give full particulars of such information, including any prior medical history, to Equitable or its reinsurers.
6. Agree that this Application may be transmitted to Equitable electronically and received by Equitable as the Applicant's original application for insurance.
7. Acknowledge that a photostatic copy of these authorizations shall be as valid as the original.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT MEMBER'S KNOWLEDGE AND WITHIN THE KNOWLEDGE OF THE PERSON(S) AGED 16 YEARS OR OLDER, THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY AND HEALTH OF ALL PERSON(S) TO BE INSURED OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY EQUITABLE.

Signed at _____ this _____ day of _____ 20 _____

Signature of member (employee)	Signature of spouse of member (when applicable)
Signature of dependent child(ren) (when applicable) age 16 or older	Signature of dependent child(ren) (when applicable) age 16 or older

Detach and retain

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NOTICE REGARDING THE MIB, INC

Information regarding the insurability of the Person(s) to be Insured will be treated as confidential. We or our reinsurer may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws.
Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590, or privacy@mib.com for privacy questions. We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured may apply for life, critical illness or health insurance or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com