Equitable Life of Canada®

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SHORT FORM MEDICAL QUESTIONNAIRE FOR COVERAGE2GO PLAN

Section 1 STATEMENT OF HEALTH FOR GROUP INSURANCE

Applicant (first name, last name):	
Date of birth:	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: _____

Work address

Street: _____

City: _____ Province: _____ Postal code: _____

Section 2 MEDICAL QUESTIONNAIRE

Please answer the following questions in order to be considered for group benefits. Further information may be required and you will be contacted if necessary.

1. Are you or any of your eligible dependents currently taking two or more medications.? ◯ Yes ◯ No

If "Yes", name of the prescription, the dosage, and the date prescribed.

Section 2 MEDICAL QUESTIONNAIRE (Continued)

2. Have you or any of your eligible dependents ever had a positive HIV test or been diagnosed or treated for, or had any indication of, AIDS or AIDS related complex? If "Yes", please provide additional information:

◯ Yes ◯ No

3. Do you or any of your eligible dependents now have a condition for which advice has been given to undergo treatment or a surgical procedure within the next 12 months? If "Yes", what is the condition and treatment that has been recommended?

◯ Yes ◯ No

4. In the past 5 years have you or any of your dependents who are applying for coverage suffered from any serious illness including mental health, muskoskeltal challenges due to any accidents, injuries or on-going pain, which has lasted two or more weeks?

◯ Yes ◯ No

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Notice to Applicants for Insurance

Information regarding your insurability will be treated as confidential. The Equitable Life Insurance Company of Canada or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information Office is 330 University Avenue, Toronto, Ontario, M5G 1R7, telephone number (416) 597-0590.

The Equitable Life Insurance Company of Canada or its reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Declaration

I certify that I have read the answers to the foregoing questions and that they are correctly recorded as I have made them and that I know nothing not disclosed herein affecting my insurability. I agree that they shall be part of my application for insurance. I certify that I have read the above Notice to Applicants for Insurance.

I understand that coverage commences only after the Plan Administrator confirms Equitable's acceptance in writing.

Privacy

The personal information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of underwriting, claims processing and adjudication. I understand and authorize 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 Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am 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.

I certify that the information given on this form is true, correct and complete to the best of my knowledge.

Applicant's Signature:_____

Witness:_____ Date:_____

Please note: Equitable Life cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.265.4556.