BC Life British Columbia Life & Casualty Company

DO NOT WRITE IN THIS SPACE

APPLICATION FOR OPTIONAL LIFE INSURANCE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2990

PART 1 — EMPLOYER INFORMATION

Group name	Division	Sub-division	Policy number	ID number	Class number

PART 2 — APPLICANT TO COMPLETE

Application for Employee

Name		Sex ☐M ☐F
Date of birth (mm-dd-yyyy)	Occupation	
Height (inch/cm)	Weight (lbs/kg)	
Employment status ☐ Active ☐ On leave or disability	Amount of optional life insurance being applied for $	

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so.

Beneficiary (full legal name)	Relationship
Employee signature X	Date (mm/dd/yyyy)

Application for Spouse (if applying)

Name		Sex ☐F ☐M
Date of birth (mm-dd-yyyy)	Occupation	
Height (inch/cm)	Weight (lbs/kg)	
	Amount of optional life insurance being applied for $	

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so.

Beneficiary (full legal name)	Relationship
Spouse signature X	**Date (mm-dd-yyyy)**

PART 3 — APPLICANT'S STATEMENT OF HEALTH - Pease tick "Y" (yes) or "N" (no) in the appropriate column for each person applying for coverage

If you answer yes to any of these questions, please give complete details in the space provided on page 2.

	applicant YES	applicant NO	spouse YES	spouse NO
1. Have you ever consulted a physician, ever been treated for, or had any known indication of:				
a) Chest pain or heart disorders?	☐	☐	☐	☐
b) High blood pressure?	☐	☐	☐	☐
c) Cancer or tumors?	☐	☐	☐	☐
d) Diabetes?	☐	☐	☐	☐
e) Arthritis or rheumatism?	☐	☐	☐	☐
f) Nervous or mental disorder?	☐	☐	☐	☐
g) Lung disorder?	☐	☐	☐	☐
h) Small or large bowel disorder?	☐	☐	☐	☐
i) Stomach or liver disorder?	☐	☐	☐	☐
j) Kidney or urinary disorder?	☐	☐	☐	☐
k) Hernia?	☐	☐	☐	☐
l) Back, limb or joint disorder?	☐	☐	☐	☐
m)Blood or circulatory disorder?	☐	☐	☐	☐
n) Hepatitis B or C or B carrier state?	☐	☐	☐	☐
o) Neurological disorder, seizure or multiple sclerosis?	☐	☐	☐	☐
2. Have you:				
a) ever applied for or received benefits, compensation or pension because of sickness or injury?	☐	☐	☐	☐
b) been absent from work because of sickness or injury during the last six months?	☐	☐	☐	☐
c) undergone treatment for alcoholism or drug habit?	☐	☐	☐	☐
3. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐	☐	☐	☐
4. Are you, your spouse or dependents taking any prescribed medication? If yes, provide name of medication(s) and reason for use in space provided on the back.	☐	☐	☐	☐
5. Have you:				
a) ever been treated for or had any known indication of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immunological disorder?	☐	☐	☐	☐
b) had any positive test results indicating exposure to the AIDS virus?	☐	☐	☐	☐
6. Have you any physical impairments, deformities, or illness not covered in questions 1-5?	☐	☐	☐	☐

Question				
7. Have you consulted any physician in the last two years apart from basic checkups?	☐	☐	☐	☐
8. Have you had any weight change within the last 12 months? If yes, state number of lbs/kgs gained or lost and reason for change in space provided on the back.	☐	☐	☐	☐
9. Have you:				
a) used any tobacco products within in the past 12 months (cigarettes, patch, chewing tobacco, gum, etc.)?	☐	☐	☐	☐
If yes, indicate type, amount and frequency				
b) ever used marijuana, cocaine, hallucinogenic or narcotic drugs, sedatives or tranquilizers, except as prescribed by a physician?	☐	☐	☐	☐
10. Have you engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hang gliding or have you flown in an aircraft other than as a fare-paying passenger?	☐	☐	☐	☐
a) Blood or circulatory disorder?	☐	☐	☐	☐
b) Hepatitis B or C or B carrier state?	☐	☐	☐	☐
c) Neurological disorder, seizure or multiple sclerosis?	☐	☐	☐	☐
11. Have you or your spouse had a request for life or health insurance declined, postponed, rated, or restricted in any way?	☐	☐	☐	☐
12. Do you or your spouse now have or are you applying for other life or disability income insurance? If yes, indicate type of insurance, amount, benefit and elimination periods as applicable in space provided on the back.	☐	☐	☐	☐

Please tick "Employee" or "Spouse" on the left and give complete details of all questions answered "Y" (yes) on previous page.
If additional space is needed, use separate sheet.

	Illness/Condition and/or Medication	Dates and Duration	Treatments and Results (fully recovered or remaining effects)	Names and full address of doctor(s) or hospital(s)
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				
☐ Employee ☐ Spouse Question#				

PART 4 — FAMILY MEDICAL HISTORY

	applicant		spouse	
	YES	NO	YES	NO
Have your parents or siblings ever had cancer, high blood pressure, heart or kidney disease, diabetes, mental or nervous disorder? If yes, give complete details in the space provided:	☐	☐	☐	☐

		Age (if living or age at death)	Details of any health disorder	Cause of death (if applicable)
☐ Employee ☐ Spouse	Father			
☐ Employee ☐ Spouse	Mother			
☐ Employee ☐ Spouse	Siblings			

PART 5 — AUTHORIZATION

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health to give BC Life and its reinsurers any such information. I understand this information will be used by BC Life to determine my eligibility for coverage and may be used in connection with any claim filed with BC Life. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

I, the employee, authorize the necessary payroll deductions.

Address	Postal code	Phone
Employee's signature **X**		Date (mm-dd-yyyy)
Spouse's signature **X**		Date (mm-dd-yyyy)

Please recheck the form and make sure all questions on both sides have been answered. If all the requested information is not provided, this form will be returned to you for further completion. Mail to: PO Box 7000, Vancouver, BC V6B 4E1.

NOTIFICATION – Please read carefully and detach for your own records.

Information regarding your insurability will be treated as confidential. British Columbia Life & Casualty Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction.
Their address is: Medical Information Bureau,
330 University Avenue, Toronto, Ontario, Canada, M5G 1R7.

British Columbia Life & Casualty Company may also release information in its 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.

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