CPA INSURANCE PLANS WEST
Plans designed exclusively for CPAs.

GROUP BENEFIT PLAN
DEPENDENT EXTENDED HEALTHCARE QUESTIONNAIRE

This form must be completed if application is for family extended healthcare coverage.

INSTRUCTIONS: 1. Complete, sign, and date the form.
2. Send by email to info@cpaipw.ca or by fax to 780-997-6467.

Name of Employer		
Employee Last Name	First Name	Middle Name

Spouse/children information: If you require more space, complete additional details form.

	First Name	Last Name	Sex		Date of Birth			Height	Weight
					Month	Day	Year		
Spouse			❑ M	❑ F				❑ m/cm ❑ ft/in	❑ kg ❑ lb
Child 1			❑ M	❑ F				❑ m/cm ❑ ft/in	❑ kg ❑ lb
Child 2			❑ M	❑ F				❑ m/cm ❑ ft/in	❑ kg ❑ lb
Child 3			❑ M	❑ F				❑ m/cm ❑ ft/in	❑ kg ❑ lb

The following questions should be answered for your dependants who are applying for coverage. If the answer is yes to any of the questions, give full details below: (*if more space is required, attach another sheet*)

Has your spouse or your children ever been tested for, treated for, or told they had:	SPOUSE Yes	SPOUSE No	CHILDREN Yes	CHILDREN No
1. Abnormal blood pressure, ECG, chest pain, angina, heart murmur, heart attack, phlebitis, elevated cholesterol, or any other disease or disorder of the heart or blood vessels?	☐	☐	☐	☐
2. Ulcers, jaundice, chronic diarrhea, intestinal bleeding, pancreatitis, hepatitis, liver disease, or any other disease of the stomach, intestines, rectum or liver?	☐	☐	☐	☐
3. Asthma, bronchitis, shortness of breath, emphysema, tuberculosis or any other respiratory disease?	☐	☐	☐	☐
4. Abnormal urine, veneral disease, or any disease of the kidneys, bladder, prostate or reproductive organs or breasts?	☐	☐	☐	☐
5. Arthritis, back pain, fibromyalgia, system lupus, erythematosis, or any other disease, or disorder of the joints, bones, or muscles?	☐	☐	☐	☐
6. Epilepsy, paralysis, stroke, Transient Ischemic Attacks, recurrent headaches, dizziness, aneurysm, mutliple sclerosis, tingling of limbs, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or nervous system?	☐	☐	☐	☐
7. Anxiety, stress, depression, fatigue or burnout or any other mental illness?	☐	☐	☐	☐
8. Diabetes, thyroid or any other glandular disease?	☐	☐	☐	☐
9. Cancer, cyst, tumor, polyp or other growth, skin lesion or any form of malignant disease?	☐	☐	☐	☐
10. Anemia, leukemia, or any other disease of the blood or lymph glands?	☐	☐	☐	☐
11. Loss of speech or any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐
12. AIDS or other disorder of the immune system, or test results indicating exposure of the AIDS virus (HIV)?	☐	☐	☐	☐
13. Ever been in a hospital, sanitarium or other institution for treatment or observation?	☐	☐	☐	☐
14. Any reason to believe medical or surgical treatment will be required during the next 12 months?	☐	☐	☐	☐
15. X-rays, electrocardiograms, blood, or other special tests, for other than regular medical checkups in the last five years? (Indicate the test results below.)	☐	☐	☐	☐
16. In the past 5 years, any use of marijuana, cocaine, narcotics, hallucinogenics, or other habit-forming drugs?	☐	☐	☐	☐
17. A) **Indicated type and average weekly consumption of alcohol:** _____				
B) Ever been advised to reduce the intake or been treated for excessive use of alcohol?	☐	☐	☐	☐
18. Had any illness or injury within the past two years which resulted in a continuous absence from work of 10 days or more? If "Yes," then state reason and duration of absence in Details section.	☐	☐	☐	☐
19. Taken medication or been treated for or told that there is any physical impairment, condition, disease or disorder not stated in this questionnaire?	☐	☐	☐	☐
20. **Please give date and reason physician was last consulted:** _____				

QUES. NO.	NAME	TEST, INJURY, ILLNESS OPERATION OR COMPLICATION	DATE OF		FULL DETAILS (INCLUDING DOCTORS' NAMES AND ADDRESSES)
			ONSET	RECOVERY	

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NOTICE ABOUT MEDICAL INFORMATION BUREAU

IMPORTANT NOTICE: Your personal information will be treated as confidential. Desjardins Group or its reinsurer(s) 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 or submit a claim for benefits to such a company, the Bureau will upon request supply the company with the information it may have.

Desjardins Group or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the Bureau, the action taken on the basis of your current request for insurance.

If you wish to see the information in your Bureau File or have it corrected, please contact the Bureau's Information Office at: Suite 501, 330 University Avenue, Toronto, Ontario, M5G 1R7, Phone: 416-597-0590.

PROTECTING YOUR PERSONAL INFORMATION

CPAIPW and Desjardins Group recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of CPAIPW and/or Desjardins Group. We limit access to personal information in your file to CPAIPW and/or Desjardins Group staff or persons authorized by CPAIPW and/or Desjardins Group who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your insurability and to administer the group benefits plan.

AUTHORIZATION AND DECLARATION

I authorize:

- Desjardins Group, any healthcare provider, CPAIPW, other insurance companies or reinsurance companies, the Medical Information Bureau, administrators of government benefits or other benefits programs, other organizations, or service providers working with Desjardins Group to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan.
- Desjardins Group to have performed tests, examinations, blood profiles, and urinalysis tests as may be required to determine my insurability in connection with this application.

I certify or confirm that:

- I am actively at work (including homemaking) on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the Medical Information Bureau;
- 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 any of the statements and answers on the form between the date this form is signed and the date Desjardins Group makes a decision must be reported to Desjardins Group. I understand that if I fail to do so, any coverage granted may be void. 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 void. I understand that I may be refused coverage for all or part of the benefit if, in the opinion of Desjardins Group, I am not insurable for all or part of that benefit.

Employee Signature: _____ **Date Signed:** _____

Spouse Signature: _____ **Date Signed:** _____

Extended Healthcare Benefits are underwritten by Desjardins Group.