LIBERTY HEALTH™/MC

Liberty Centre, 3500 Steeles Ave. East, Markham, Ontario, L3R 0X4
Tel: (905) 946-4050 OR 1-800-COVER ME®(1-800-268-3763)
Web Site: www.coverme.com

Statement of Health for Medical Underwriting

1. Name: ______ Date of Birth (D/M/Y): ______ Sex: ❑ Male ❑ Female

Home Address: ______ Home Phone No.: ( )

Employer: ______ Bus. Phone No.: ( )

Group No.: ______ Occupation: ______

2. a) Personal Physician: Name and address (if none, please state none): ______

b) Date last consulted: ______ Reason: ______

c) If reason given is checkup, what problems/symptoms did you have? ______

d) Findings, treatment and any medication(s) prescribed: ______

3. a) Family History

Family Member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death

b) Have any of your immediate family members (parents, brothers or sisters) ever had heart or kidney disease, stroke, mental illness, high blood pressure, diabetes, multiple sclerosis, cancer (specify type) or any inheritable disorder (such as Huntington's chorea or polycystic disease)? ❑ Yes ❑ No
Details: ______

4. Height: ______ ❑ cm ❑ ft./in. Weight: ______ ❑ kg ❑ lbs Weight changes in past 12 months (❑gain/❑loss): ______ ❑ kg ❑ lbs

Reason for weight change: ______

HEALTH QUESTIONNAIRE	YES	NO	REMARKS
5. Have you ever consulted a doctor, suffered from, been treated for, or had any known indication of a medical condition of:			Details of "Yes" answers (Date, duration, results, names of doctors, and name of dependant)
(a) brain or nervous system? (such as epilepsy, fainting spells, mental illness, anxiety or depression, stroke, paralysis, TIA or multiple sclerosis)	❑	❑	
(b) throat or lungs? (such as tuberculosis, pleurisy, asthma, bronchitis)	❑	❑	
(c) heart or blood vessels? (such as heart murmur, heart attack, angina, chest pain, increased blood pressure, varicose veins, rheumatic fever)	❑	❑	
(d) digestive organs? (such as stomach ulcer, jaundice, gall bladder, liver disease, colitis, Crohn's, hernia, intestinal disorder, hepatitis or hepatitis B carrier)	❑	❑	
(e) urinary or reproductive organs? (such as kidney stone, kidney disease, prostate enlargement, sugar or albumin in urine)	❑	❑	
(f) bones or joints? (such as rheumatism, arthritis, back problems)	❑	❑	
(g) sight or hearing? (such as impaired eyesight, loss of an eye, deafness)	❑	❑	
(h) endocrine system or blood? (such as diabetes, allergies, thyroid problem, anemia)	❑	❑	
6. Have you ever had cancer, tumors or any other growth? If yes, specify type of cancer or growth.	❑	❑	
7. Have you used cigarettes or any other tobacco product in the past 12 months?	❑	❑	
8. Are you currently taking any prescription medication. If yes, please indicate name, strength, quantity taken per month and condition being treated.	❑	❑	
9. Have you ever been unable to work on a full time basis of at least 24 hours per week for your employer?	❑	❑	
10. Have you, during the past 5 years, been attended by a physician, health care worker or therapist, other than stated above or had any x-rays, electrocardiograms, or other special medical tests performed?	❑	❑	
11. Have you ever used narcotics, hallucinogens or similar drugs, except as prescribed by a physician or been advised to reduce your consumption of alcohol or to take treatment for alcoholism or drug abuse?	❑	❑	
12. Have you ever been tested, treated for, consulted a physician about or told you had Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), any other immune disorder, enlargement of lymph glands, or sexually transmitted disease?	❑	❑	
13. Have you engaged or do you intend to engage in any hazardous sports such as auto racing, scuba diving or hang gliding, or have flown in an aircraft other than as a fare paying passenger?	❑	❑	
14. Have you had any known indication, been treated or hospitalized for any physical impairment, condition or disorder not stated above?	❑	❑	
15. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received medical treatment	❑	❑	

I, the undersigned, declare that the answers to the above questions are full, complete, true, are correctly recorded, and are in continuance of and form part of an application for insurance to Liberty Life Assurance Company of Boston and/or Liberty Mutual Insurance Company. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of me or my health, medical history, and any hospitalization, advice, diagnosis, treatment, disease or ailment to give Liberty Life Assurance Company of Boston, Liberty Mutual Insurance Company, their reinsurer(s) or authorized representative any such information. A photographic copy of this authorization shall be as valid as the original.

______ Witness to Signature ______ Signature of Applicant ______ Date (D/M/Y)

IF YOU ARE A LATE APPLICANT AND APPLYING FOR DEPENDANT LIFE AND/OR HEALTH COVERAGE PLEASE COMPLETE REVERSE SIDE

LIBERTY HEALTH™/MC

PLEASE DETACH AND RETAIN

Information regarding your insurability will be treated as confidential. Liberty Life Assurance Company of Boston, Liberty Mutual Insurance Company, their reinsurer(s) or authorized representative, may, however, make a brief report thereon to the Medical Information Bureau. The Bureau is a nonprofit 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 coverage, or a claim for benefits is submitted to such company, the Bureau, on request, will supply such company with the information in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you wish to question the accuracy of information in the Bureau's files, you may contact the Bureau and seek a correction. The address of the bureau is:

Medical Information Bureau, 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7 Telephone: (416) 597-0590

Liberty Life Assurance Company of Boston, Liberty Mutual Insurance Company or their reinsurer 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.

TM/MC® Trademarks held by Liberty Mutual Insurance Company. Liberty Health/Liberty Life Assurance Company of Boston are divisions of Liberty Mutual Insurance Company. Benefits underwritten by Liberty Life Assurance Company of Boston. © 2002 Liberty Mutual Group. All rights reserved.

LML-122 (04/02)

COMPLETE ONLY IF YOU ARE A LATE APPLICANT APPLYING FOR BASIC INSURANCE COVERAGE FOR YOUR DEPENDANTS
A full Statement of Health (see reverse) is required for Optional Life and Critical Illness Benefits

16. Name (Last, First, Initial)	Sex (Male/Female)	Birth Date (D/M/Y)	Height ❑ cm ❑ ft./in.	Weight ❑ kg ❑ lbs
Spouse				
Children				

PHYSICIAN INFORMATION

17. Personal Physician
   a) Name and address (if none, please state none): ______________________
   b) Date last consulted: ______________ Reason: ______________________
   c) If reason given is checkup, what problems/symptoms did you have? ______________________
   d) Findings, treatment and any medication(s) prescribed: ______________________

HEALTH QUESTIONNAIRE	YES	NO	REMARKS
18. Has any listed dependant ever consulted a doctor, suffered from, been treated for, or had any indication of a medical condition of:			Details of "Yes" answers (Date, duration, results, names of doctors, and name of dependant)
(a) Brain or nervous system?	❑	❑	
(b) Throat or lungs?	❑	❑	
(c) Heart or blood vessels?	❑	❑	
(d) Digestive organs?	❑	❑	
(e) Urinary or reproductive organs?	❑	❑	
(f) Bones or joints?	❑	❑	
(g) Sight or hearing?	❑	❑	
(h) Endocrine system or blood?	❑	❑	
19. Has any listed dependant ever had cancer, tumors or any other growth? If yes, specify type of cancer or growth.	❑	❑	
20. Has any listed dependant ever been tested, treated for, consulted a physician about or told they had Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), any other immune disorder, enlargement of lymph glands, or sexually transmitted disease?	❑	❑	
21. Does any listed dependant have any impairments, diseases or illnesses not covered in questions 17, 18 and 19?	❑	❑	
22. Does any listed dependant have any condition or illness for which consultation or treatment is contemplated or has been advised?	❑	❑	
23. Are any listed dependants currently taking any prescription medication? (If yes, please indicate name, strength, and quantity taken per month.)	❑	❑	

I, the undersigned, declare that the answers to the above questions are full, complete, and true, are correctly recorded, and are in continuance of and form part of an application for benefits to Liberty Life Assurance Company of Boston and/or Liberty Mutual Insurance Company. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of the health of my dependant(s), to give Liberty Life Assurance Company of Boston, Liberty Mutual Insurance Company, their reinsurer or authorized representative any such information. A photographic copy of this authorization shall be as valid as the original.

______________________	______________________	______________
Witness to Signature	Signature of Applicant	Date (D/M/Y)
______________________	______________________	______________
Witness to Signature	Signature of Spouse (if applicable)	Date (D/M/Y)

TM/MC® Trademarks held by Liberty Mutual Insurance Company. Liberty Health/Liberty Life Assurance Company of Boston are divisions of Liberty Mutual Insurance Company. Benefits underwritten by Liberty Life Assurance Company of Boston. © 2002 Liberty Mutual Group. All rights reserved.