

# Medical Application

The completion of this Medical Application does not guarantee insurance coverage.

If space is insufficient for any question, print the answer on additional paper, sign, date and attach the paper to this form.

## Part 1 - Applicant Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street: \_\_\_\_\_ Unit/Apt Number: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth date (mmm/dd/yy): \_\_\_\_\_ Gender:  M  F  
 Business Phone: \_\_\_\_\_ Height (feet & inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_  
 Place of Birth (Country/Province): \_\_\_\_\_ Hire Date (mmm/dd/yy): \_\_\_\_\_

## Part 2 - Dependent Information: Single Couple Family

Please complete the following for your Spouse and/or Dependent Children to be covered

	Name of Dependent (First Name & Last Name)	Date of Birth (mmm/dd/yy)	Relationship to Applicant	Height (feet & inches)	Weight (lbs)	Gender M or F
1						
2						
3						
4						

Do you have dependents listed above who are over 18 and attending full-time education?  Yes  No

If "yes", proof of enrolment in full-time accredited facility is required. Please submit current documentation with this application. Coverage is limited to dependents under age 25.

## Part 3 - Medical Conditions:

Have you or any of your Dependents (if dependent coverage is required) ever been diagnosed with; received medical treatment for; or consulted with a physician for, any of the following? Please place a checkmark in the appropriate box, circle the applicable condition and indicate who each condition applies to. If "Yes", please provide details in space below.

Condition	No	Yes	Name of Person
Heart Chest Pain, Angina, Heart Attack, Arrhythmia, Murmur, Congestive Heart Failure, Atrial Fibrillation, Dizziness, Fainting, or Blood Disorder?			
Huntington's Chorea, Amyotrophic Lateral Sclerosis or Motor Neuron Disease?			
Diabetes, Diverticulitis, Colitis or Crohn's?			
Immune Disorders including testing for Immune Deficiency Syndrome (AIDS) or Human Immune Syndrome (HIV).			
Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?			
Skin Disorder (including Acne)?			
Any use of recreational drugs, or been advised to reduce alcohol consumption or received treatment for drug addiction or alcoholism?			
Any physical or mental condition, disease, or disorder not listed on this form?			

  

Condition	No	Yes	Name of Person
High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Aneurysm or Circulatory Disorder?			
Digestive System Disorder or Liver Disease or Disorder including Hepatitis, Kidney disorder?			
Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD or Emphysema?			
Auto-Immune Disorders- Systemic Lupus Erythematosus (S.L.E) or Scleroderma?			
Nervous, Mental or Emotional Disorders, Alzheimer, Parkinson's, Memory Loss or Seizure Disorder?			
Cancer, Tumor or Growth (except Basal Cell Carcinoma)?			
Infertility or Reproductive Disorder, Menopause or Prostate Disorder?			
Chronic Headaches, Migraines or recurrent infections?			

Details to "Yes" Answer(s) - Name of Person, Name of Condition, Date of Diagnosis, etc.


Applicant's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Part 4 - Medications:**

Are you or any of your Dependents (if dependent coverage is required) currently taking any medication?  Yes  No  
**If "Yes", please complete the following:** (include home oxygen, if prescribed)

Name of Person	Medical Condition	Medication	Daily Dosage	Taken for how long?	Monthly Cost

**Part 5 - Hospitalization or Surgery:**

Have you or any of your Dependents (if dependent coverage is required) been hospitalized or had any surgery in the past five (5) years?  Yes  No **If "Yes", please complete the following:**

Name of Person	Medical Condition	Surgery or Treatment	Date of Hospitalization or Surgery

**Part 6 - Family Physician:**

1. Please complete the following information: (list multiple physicians if applicable)

Physician's Name	Address	Phone Number	Date of Last Visit

2. Any future visits scheduled with any medical or paramedical professional (chiropractor, physiotherapist, etc.)?  Yes  No

If "Yes", what type of practitioner is to be seen? \_\_\_\_\_

Reason for the the visit? \_\_\_\_\_ Expected date of future visit (mmm/yy)? \_\_\_\_\_

3. Have you or any of your Dependents (if dependent coverage is required) been advised to have any test, investigation, or surgery which has not yet been completed?  Yes  No If "Yes", please provide details: \_\_\_\_\_

**Part 7 - Beneficiary Election:** To designate more than one beneficiary, please use form U-105.

First name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship \_\_\_\_\_ Age of beneficiary \_\_\_\_\_ If under age 18, trustee is: \_\_\_\_\_

**Authorization, Declaration and Acknowledgement**

I hereby declare that I am currently in good health and that the information provided is complete and true to the best of my knowledge. I understand that this Application Form is part of insurance coverage provided through the Used Car Dealer's Association of Ontario. I acknowledge that if at the time of claim it is discovered that any question in this Medical Application was not answered truthfully, accurately and completely, it will result in the non-payment of any claim and/or my coverage will be null and void. I authorize The Capital Group Insurance and their representatives to share my medical information disclosed on this application with any insurer providing insurance protection under the UCDA Plan, including but not limited to Echelon General Insurance Company, ACE-INA Life Insurance, American Bankers Life Assurance Company of Florida and Unistar International Inc., Canadian Benefit Administrators, and Industrial Alliance *Pacific* Life Insurance Company, for the purpose of underwriting my participation.

I hereby declare that I am actively engaged in my occupation on a full-time basis. I hereby authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution, or person, with any records or knowledge of me or my health, or the health of my dependents, to give such information to The Capital Group Insurance. A photocopy of this authorization shall be as valid as the original.

**Your Privacy is Protected:** The insurance coverage you are applying for is underwritten by various insurers and administered by The Capital Group Insurance Inc. The insurers and The Capital Group Insurance Inc. collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. Your information may be disclosed to others in the medical, investigative and insurance fields as necessary to underwrite and administer the insurance and pay benefits. Full details regarding how your privacy is protected can be obtained by asking your representative for a copy of our privacy policy.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse (if coverage req'd): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dependent Child(ren) (if over 18) \_\_\_\_\_ Date: \_\_\_\_\_

