



ace life

CAPRI CRITICAL ILLNESS PROGRAM

Please fill out and submit with your application if applying for more than \$25,000 worth of coverage

Email: ci@capri.ca

Fax: (250)860-1213

Mail: Suite 100-1500 Hardy St., Kelowna BC, V1Y 8H2

CRITICAL ILLNESS STATEMENT OF HEALTH

CLIENT INFORMATION (Please answer all questions in ink)

Last Name _____ Policy # _____
 First Name _____ Telephone _____
 Home Address _____ Language Preference English French
 City _____ Province _____ Postal Code _____ Birthdate (D/M/Y) _____
 Spouse's Name _____ (if applicable) Spouse Birthdate (D/M/Y) _____

DEPENDENT INFORMATION (Please list minor dependents named in the application – if applicable)

Relation	Last Name	First Name	Birthdate (D/M/Y)	Sex (M/F)	Dependent Child(ren) (< age 21)
Spouse	_____	_____	_____	_____	
Child	_____	_____	_____	_____	<input type="checkbox"/>
Child	_____	_____	_____	_____	<input type="checkbox"/>
Child	_____	_____	_____	_____	<input type="checkbox"/>
Child	_____	_____	_____	_____	<input type="checkbox"/>

HEALTH QUESTIONNAIRE

	Client		Spouse		Dependant1		Dependant2 *	
	Yes	No	Yes	No	Yes	No	Yes	No
1) Have you ever sought advice or received treatment for, or had any known indication of:								
(a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cancer, tumour or malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
© Advanced ophthalmic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Multiple sclerosis or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) AIDS, HIV, chronic or unexplained infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Within the last five years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following:								
(a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
© Hospitalized due to a medical problem with respect to severe respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you ever been declined for life insurance or offered coverage only at higher than standard rates?								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If more than two dependents are named in the application, please complete additional Health Questionnaire section and attach to this application.

						Client	Spouse	Dependant1	Dependant2		
						Yes	No	Yes	No	Yes	No
4) Does your height and weight fall outside the chart noted below?						Y	N	Y	N	Y	N
Males			Females								
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4' 8"	95	145	5' 8"	132	207	4' 8"	86	145	5' 8"	119	207
4' 9"	98	150	5' 9"	137	213	4' 9"	88	150	5' 9"	123	213
4' 10"	100	155	5' 10"	141	219	4' 10"	90	155	5' 10"	127	219
4' 11"	103	160	5' 11"	145	225	4' 11"	93	160	5' 11"	131	225
5' 0"	105	165	6' 0"	150	233	5' 0"	95	165	6' 0"	135	233
5' 1"	108	170	6' 1"	155	241	5' 1"	97	170	6' 1"	140	241
5' 2"	111	175	6' 2"	160	249	5' 2"	100	175	6' 2"	144	249
5' 3"	114	180	6' 3"	165	257	5' 3"	103	180	6' 3"	149	257
5' 4"	118	185	6' 4"	170	265	5' 4"	106	185	6' 4"	153	265
5' 5"	121	190	6' 5"	175	272	5' 5"	109	190	6' 5"	158	272
5' 6"	124	195	6' 6"	180	279	5' 6"	112	195	6' 6"	162	279
5' 7"	128	201	6' 7"	185	285	5' 7"	115	201	6' 7"	167	285

						Client	Spouse	Dependant1	Dependant2		
						Yes	No	Yes	No	Yes	No
5) Have you ever sought advice or received treatment for, or had any known indication of:						Y	N	Y	N	Y	N
(a) Advanced loss of hearing?						Y	N	Y	N	Y	N
(b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?						Y	N	Y	N	Y	N
(c) any psychiatric disorder, mental deterioration or loss of intellectual ability?						Y	N	Y	N	Y	N
(d) Gout, Arthritis, Scleroderma, Muscular Dystrophy, Ataxia, Systemic Lupus Erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?						Y	N	Y	N	Y	N
(e) Amputation due to disease?						Y	N	Y	N	Y	N
6) Do you currently:						Y	N	Y	N	Y	N
a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?						Y	N	Y	N	Y	N
b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?						Y	N	Y	N	Y	N
c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?						Y	N	Y	N	Y	N

Privacy Statement: When you apply to enroll in the ACE Life Group Insurance Plan, underwritten by ACE INA Life Insurance ("ACE Life"), the information in ACE Life's existing insurance files and the information requested on your application is required by ACE Life, its reinsurers and authorized agents to process your application (and if approved), administer your insurance policy, assess claims and investigate misrepresentation. ACE Life will create a file with your insurance information, and in the event of a claim, with such information as ACE Life obtains from you and other sources, for the purpose of considering your claim and administering benefits under the Plan. Access to this file will be restricted to those ACE Life employees, authorized agents and reinsurers who require access to administer the Plan and process claims and persons authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer, ACE INA Life Insurance, 1400 – 25 York Street, Toronto, ON, M5J 2V5.

AUTHORIZATION

I hereby declare that the above answers and statements are complete and true and I agree that any coverage issued in consequence of this application shall not take effect, unless, on the date the insurance is to become effective, I am actively engaged in my occupation on a full-time basis. I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital or clinic or medically related facility, insurance company or other organization, institution or person, with any records or knowledge of me or my health, to give any such information to the Insurer or its Reinsurer(s). A photocopy of this authorization shall be valid as the original.

Signed at _____ this _____ Day of _____ 20 _____

Client's signature _____

Spouse's Signature (if applicable) _____

Information about your insurability and your dependents insurability will be treated as confidential.