

Ambassador Statement of Health Declaration

Group insurance coverage is underwritten by Certain Lloyd's Underwriters (collectively the "insurer") and administered by MSH INTERNATIONAL (CANADA) LTD. (MSH INTERNATIONAL).

This form must be completed for each person (employee, spouse and child) applying for group insurance coverage.

When to complete this form:

This form must be completed **no more than 30 days prior** to the date you want coverage to start. Forms completed more than 30 days prior to the requested start date of coverage will not be accepted.

Full name of employee: _____

Name of employer (full legal name): _____

Full name of applicant for coverage: _____

Gender: Male Female Relationship of applicant to employee: Same Spouse Child

Maiden name of applicant (if applicable): _____

Effective date of coverage:

If the applicant is approved for group insurance coverage under the policy, the effective date of coverage will be the later of:

- the date approved by MSH INTERNATIONAL, and
- the date the foreign assignment starts.

Important :

Please ensure that all questions on this form are answered in full and that complete details are provided where required. If any information is missing or incomplete, processing of your application will be delayed, and coverage may not be in place on the date requested.

Where can we reach you if additional medical information or clarification of any details is required?

By email: _____

By phone: Work (____) _____ Home (____) _____ By Fax _____

By Mail: _____

Medical Information

Date of Birth _____ Height: _____ Weight: _____

Has there been a change in weight in the past year? Yes No If yes, how much? _____

Why? _____

Please ensure all questions below are answered in full, with complete details provided. Details include the exact nature of the problem, date diagnosed, the nature and duration of treatment, medication name(s) and dosage(s), current condition, residuals, and name and address of the physician with the records. **If you require additional space, please attach a separate sheet.**

1. Has anyone in your immediate family had high blood pressure, cardiac or circulatory disease prior to age 65, diabetes mellitus or any hereditary disease(s)? Yes No

If yes, what disease(s)? _____

Name and relationship to you of person afflicted: _____

2. Do you currently have any health problems? Yes No

If yes, please describe: _____

3. Is your capacity to work reduced? Yes No

If yes, why, and for how long? _____

4. Have you ever been unable to work for more than four consecutive weeks during the last five years? Yes No

If yes, when and why? _____

5. Do you suffer from, or have you ever suffered from, any illnesses, disturbances or problems connected with:

a) the respiratory organs, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders? Yes No

b) the heart or vascular system, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitation, apoplexy, phlebitis, varicose veins or other disorders? Yes No

c) the nervous system or a mental disorder, such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders? Yes No

d) the digestive system, such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, hemorrhages, hemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas? Yes No

e) the urinary tract or sexual organs, such as kidneys, urethras, bladder or prostate, urinary calculus, blood or albumin in the urine or other disorders? Yes No

f) the metabolism or blood, such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders? Yes No

g) the immune system or infectious diseases, such as AIDS, HIV infection, sexually transmitted diseases, hepatitis, tropical diseases or other disorders? Yes No

h) the skin, such as eczema, allergies, psoriasis, fungal skin diseases, skin cancer or other disorders? Yes No

i) the musculoskeletal system (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders? Yes No

5. (cont'd)

- j) the eyes, such as decreased visual acuity or refraction power, retinal disease or other disorders? Yes No
If yes, Dioptres: Left Right
- k) the ears, hearing difficulties, inflammation or other disorders? Yes No
- l) other illnesses, disturbances or problems not listed above, such as congenital defects, deformities, tumors, cancers, etc.? Yes No

If you answered Yes to any of the questions in 5 a) to l), please provide full details of the nature of each condition, including when it occurred, whether or not it has been cured, and the name and address of the attending physician.

6. Have you had any accidents, injuries or poisonings which necessitated a hospital stay or operation? Yes No

Name and address of attending physician: _____

- 7. a) Have you been examined, received treatment or been operated on in a hospital or similar institution? Yes No
- b) Have you been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned? Yes No
- c) Is a hospital stay or operation planned? Yes No
- d) Have you been treated by or consulted any of the following in the last five years:
psychotherapists (e.g. psychiatrists, psychologists), chiropractors, physiotherapists? Yes No
- e) Have you ever been given or prescribed drugs for a period in excess of four weeks? Yes No
- f) Have you ever had radiation treatment (X-ray or radioactive substances)? Yes No
- g) Have you ever attempted suicide? Yes No

If you answered Yes to any of the questions in 7 a) to g), please provide full details of the nature of each condition, including when it occurred, whether or not it has been cured, and the name and address of the attending physician.

8. Have you undergone any special examinations/tests during the last five years, such as X-rays, computed tomography, MRI (magnetic resonance images), ultrasound, echography, electrocardiogram, electroencephalogram, endoscopy or other tests? Yes No

If yes, specify which test, date completed, reason or symptoms prompting the test, and results.

9. Have you had an AIDS test which showed any HIV positive or possible positive result? Yes No

10. a) Do you participate in sports? Yes No If yes, which sports and how often? _____

- b) Do you smoke (cigarettes, cigars, pipe, etc.)? Yes No If yes, how many per day? _____

- c) Do you drink alcohol? Yes No If yes, how much per day/per week? _____

- d) Do you take painkillers, sleeping tablets, tranquilizers or other medications? Yes No

If yes, since when? _____ Amount per week: _____

Name of medication: _____

- e) Do you take, or have you ever taken, narcotics (drugs)? Yes No

If yes, type of narcotic? _____

11. a) Which physician did you last consult? Name and address: _____

When? _____ Why? _____

b) Name and address of physician most familiar with your medical history - select one of the following three:

Same as 11 a) Unknown OR Name and address _____

c) Have you consulted any physician in the last five years not already mentioned above? Yes No

If Yes, name and address: _____

12. For female applicants:

a) Are you pregnant? Yes No If Yes, expected delivery date: _____

Note: Coverage for healthcare expenses related to pregnancy, childbirth, newborn nursery and Well Baby Care (i.e. routine and preventative services) until the child reaches 15 days of age does not apply where the expected date of delivery is less than 10 months from your effective date of coverage.

Has the pregnancy been normal to date? Yes No If No, please provide details: _____

Name and address of attending physician: _____

b) Have you ever had a gynecological disorder or a disease of the breast? Yes No

If yes, please provide full details of the nature of the condition, including when it occurred, whether or not it has been cured, and the name and address of the attending physician. If additional space is required, please attach a separate sheet. _____

Declaration

I hereby declare that I have answered the above questions honestly and completely. I understand that non-disclosure or misrepresentation of a material fact will render any insurance coverage provided based on this application null and void. I understand that signing this application does not bind me to complete the insurance but I do agree that, should insurance coverage be provided, this application, and the statements made herein, will form the basis of any insurance coverage provided.

Note: A material fact is one likely to influence acceptance or assessment of this application by the Insurer. If you are in doubt as to what constitutes a material fact, please contact your Great-West Life representative.

Signature of Applicant: _____ Place and date: _____

(If Applicant is under 18 years of age, signature of parent or guardian.)

Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution, or person, that has any records or knowledge of me, or my health, to give MSH INTERNATIONAL any such information.

A photocopy of this authorization will be as valid as the original.

Signature of Applicant: _____ Place and date: _____

(If Applicant is under 18 years of age, signature of parent or guardian.)

Please return form to:

Ambassador Coordinator



Group Major Accounts Administration
Specialty Products Unit
PO Box 6000

Winnipeg MB R3C 3A5

Fax: 204.946.4594 E-mail: specialtyproductsunit@gwl.ca