Equitable Life of Canada®

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SHORT FORM MEDICAL QUESTIONNAIRE FOR COVERAGE2GO PLAN

Section 1 STATEMENT OF HEALTH FOR COVERAGE2GO INSURANCE

Applicant (first name, last name):	
Date of birth:	Policyholder name/Employer who provided Group Benefits Coverage:
Group policy number:	Certificate number:

Contact details

Please select your preferred method of contact regarding medical underwriting, including sharing personal medical information:

☐ Email (address listed below) ☐ Mail via home address

Email address: _____

Home address

Street: _____

City: _____ Province: _____ Postal code: _____

Section 2 MEDICAL QUESTIONNAIRE

Please answer the following questions in order to be considered for Coverage2go benefits. Further information may be required and you will be contacted if necessary.

1. Are you or any of your eligible dependents who are applying for coverage (if applicable) currently taking two or more medications daily. ☐ Yes ☐ No

   If "Yes", name of the prescription, the dosage, and the date prescribed.

2. Have you or any of your eligible dependents who are applying for coverage (if applicable) ever had a positive HIV test or been diagnosed or treated for, or had any indication of, AIDS or AIDS related complex? ☐ Yes ☐ No

   If "Yes", please provide additional information:

Section 2 MEDICAL QUESTIONNAIRE (Continued)

3. Do you or any of your eligible dependents who are applying for coverage (if applicable) now have a condition for which advice has been given to undergo treatment or a surgical procedure within the next 12 months? ☐ Yes ☐ No

   If "Yes", what is the condition and treatment that has been recommended?

4. In the past 36 months have you or any of your eligible dependents who are applying for coverage (if applicable) suffered from any serious illness including acute diabetes, Alzheimer disease, vascular dementia, Parkinson disease, hepatitis, epilepsy, renal failure requiring dialysis, severe lung problem that requires oxygen at home, alcoholism, drug addition, mental health, musculoskeletal challenges due to any accidents, injuries, or on-going pain, which has lasted two or more weeks? ☐ Yes ☐ No

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Notice Regarding the MIB, Inc.

Information regarding the insurability of the Person(s) to be Insured will be treated as confidential. We or our reinsurer may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590, or privacy@mib.com for privacy questions.

We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured may apply for life, critical illness or health insurance or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com

Declaration

I certify that the answers and information provided on this form is current, correct and complete, and I know of nothing not disclosed herein affecting my insurability. I certify that I have read the above Notice Regarding the MIB, Inc.

I understand and agree that the insurance applied for shall not take effect unless in writing;
a) your application for insurance is approved by Equitable Life; and
b) your first premium payment is received by Equitable Life.

Privacy

The personal information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of underwriting, claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes.

Applicant's Signature:_____ Date: _____

Please note: Equitable Life cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.265.4556.