Declaration of Health

ASSOCIATION OF MANITOBA MUNICIPALITIES

Administrative Information

Name of Employee **Name of Municipality**

Participant Statement – Information on Persons Applying for Coverage

Complete for all persons applying for coverage.

☐ **EMPLOYEE** Height Weight ☐ lbs. ☐ kg Gender ☐ M ☐ F

Occupation

Home Address No. Street City Postal Code

Phone Number Date of Birth

Name of Attending Physician (first, initial, last)

Address pf Attending Physician No. Street City Postal Code

☐ **SPOUSE** Height Weight ☐ lbs. ☐ kg Gender ☐ M ☐ F

Surname (1)

Given Name

Date of Birth

Name of Attending Physician (first, initial, last) Phone Number

Address pf Attending Physician No. Street City Postal Code

☐ **CHILDREN**

Surname (2) Given Name Date of Birth

Height Weight ☐ lbs. ☐ kg Relationship to Employee Gender ☐ M ☐ F

Surname (3) Given Name Date of Birth

Height Weight ☐ lbs. ☐ kg Relationship to Employee Gender ☐ M ☐ F

Surname (4) Given Name Date of Birth

Height Weight ☐ lbs. ☐ kg Relationship to Employee Gender ☐ M ☐ F

Surname (5) Given Name Date of Birth

Height Weight ☐ lbs. ☐ kg Relationship to Employee Gender ☐ M ☐ F

Name of Attending Physician (first, initial, last) Phone Number

Address pf Attending Physician No. Street City Postal Code

Participant Statement – Medical Questionnaire

All questions should be fully completed to avoid delays in the assessment. For questions with bold print answered 'Yes', please complete appropriate questionnaire in the following section. For all other questions answered 'Yes', use the details section to explain.

If 'Yes' to any questions for a dependent, please provide dependent number.

	Employee	Dependents
1. Have you ever been tested for, or told you had:		
a) **abnormal blood pressure, chest pain, heart attack, phlebitis, or any other disease or disorder of the heart or blood vessels?**	☐ Y ☐ N	☐ Y ☐ N
b) ulcers, jaundice, chronic diarrhea, gallbladder, hepatitis or liver disease, or any other disease of the stomach, intestines, or rectum?	☐ Y ☐ N	☐ Y ☐ N
c) asthma, bronchitis, emphysema, tuberculosis or any other respiratory disease?	☐ Y ☐ N	☐ Y ☐ N
d) abnormal urine, venereal disease, or any disease of the kidneys, bladder, prostate or reproductive organs?	☐ Y ☐ N	☐ Y ☐ N
e) **arthritis, ruptured disc, back or neck pain, knee problems, whiplash, amputation or any other disease, injury, or deformity of the spine, joints, bones, or muscles?**	☐ Y ☐ N	☐ Y ☐ N
f) epilepsy, paralysis, stroke, recurrent headaches, or any other disease or disorder of the brain or nervous system?	☐ Y ☐ N	☐ Y ☐ N
g) **anxiety, depression or any other mental illness?**	☐ Y ☐ N	☐ Y ☐ N
h) **diabetes, thyroid or any other glandular disease?**	☐ Y ☐ N	☐ Y ☐ N
i) cancer, cyst, tumor, or skin disease?	☐ Y ☐ N	☐ Y ☐ N
j) anemia, leukemia, or any other disease of the blood or lymph glands?	☐ Y ☐ N	☐ Y ☐ N
k) any disease or disorder of the eyes, ears, nose or throat?	☐ Y ☐ N	☐ Y ☐ N

	Employee	Dependents
a) Have you ever had or been diagnosed or told you had AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus), ARC (AIDS Related Complex) or any other immunological disease or disorder?	☐ Y ☐ N	☐ Y ☐ N
b) consulted a physician or received advice or treatment for any of the above in 2 a)?	☐ Y ☐ N	☐ Y ☐ N
c) had a positive test for exposure to the AIDS virus including the HTLV III/LAV/HIV Antibody?	☐ Y ☐ N	☐ Y ☐ N
3. Have you any impairment or condition for which medical treatment, hospitalization or surgery has been advised within the next year?	☐ Y ☐ N	☐ Y ☐ N
4. Have you ever had an application for insurance declined, postponed, or rated? If 'Yes', state insurance company and reason.	☐ Y ☐ N	☐ Y ☐ N
5. If female, are you currently pregnant? If 'Yes', indicate expected date of confinement.	☐ Y ☐ N	☐ Y ☐ N
6. Have you or any dependent taken medication or been treated for or told that you had any physical impairment, condition, disease or disorder not stated in this questionnaire?	☐ Y ☐ N	☐ Y ☐ N
7. Have any persons applying for coverage lost or gained more than 10 lbs during the last 12 months? What was the amount of weight change? ☐ lbs ☐ kg Reason:	☐ Y ☐ N	☐ Y ☐ N

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group's commitment to privacy and security refer to our web site: www.westernfg.ca

Please complete reverse side.

Participant Statement – Questionnaires

If you have answered "yes" to any of the following conditions, please complete the corresponding questionnaire(s) below.

Blood Pressure

Name and Relationship (employee/dependent)

Date first advised blood pressure elevated (yy/mm/dd)

Treatment
☐ Diet ☐ Medicine ☐ Other
If Medicine, please list names, dosages, frequency:

How long on treatment?

Are you still under treatment?
☐ Yes ☐ No

In the past 2 years have special tests been done?
☐ No ☐ Yes. indicate the type of test, date(s) and results:

Are you aware of any recent readings?
☐ No ☐ Yes, give readings:

Diabetes

Name and Relationship (employee/dependent)

Type of Diabetes

Age of Diagnosis

Is diagnosis related to any other physical condition? ☐ Yes ☐ No
If yes, please provide details:

Treatment
☐ Diet
☐ Oral Medicine, given name(s), dosages, frequency:
☐ Insulin, specific type & dosage:

Have you experienced any of the following?
☐ Heart Trouble ☐ Trouble with Blood Vessels
☐ High Blood Pressure ☐ Diabetic Coma
☐ Kidney Trouble ☐ Hypoglycemic Shock

Arthritis

Name and Relationship (employee/dependent)

Name and Relationship (employee/dependent)
☐ Rheumatoid ☐ Osteoarthritis ☐ Other, specify:

What joints were involved?

Is there swelling or deformity?
☐ No ☐ Yes, give details:

Date problem began (yy/mm/dd)

In the past 2 years how frequent was the pain?

Duration

Treatment
☐ Medicine, given name(s), dosages, frequency:
☐ Other, specify:

Are you still under treatment?
☐ Yes ☐ No, give date treatment last received:

Anxiety or Depression

Name and Relationship (employee/dependent)

Type
☐ Anxiety ☐ Depression

Date problem began (yy/mm/dd)

Date(s) of further occurrence(s)

Treatment
☐ Hospitalization ☐ Psychiatrist consulted
☐ Medicine, given name(s), dosages, frequency
☐ Other, specify

Is the condition still present?
☐ Yes ☐ No

Are you still under treatment?
☐ Yes ☐ No

Participant Statement – Details

Please use this section to fully explain all questions answered 'Yes' in the Medical Questionnaire which has not been covered in the section above.
Please list all current medications – specify names, dosages, frequency and duration of medication.

Question Number	Name and Relationship (employee/dependents)	Health Details	Date (yy/mm/dd)	Attending Physician's Name and Address

Authorization to Provide Information

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

I HEREBY AUTHORIZE any physician, practitioner, hospital, medical or paramedical clinic, insurance company, or any other organization, institution or person having any information about me or my children concerning our health or our insurability, to provide such information in order to evaluate my eligibility and insurability or that of my spouse and my dependents, if any, under this plan. I agree that an investigation report regarding myself, my spouse and my children may be requested.

Participant Signature (if to be insured) **Spouse's Signature** (if to be insured) **Signature of Children over 18** **Date** (yy/mm/dd)

Western FINANCIAL GROUP
Canada's Insurance Broker

Complete and send to:
Western Financial Group
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Fax: 204-943-5531