



CADRE Benefits Program

Finally! Easy access to comprehensive Health & Dental Benefits

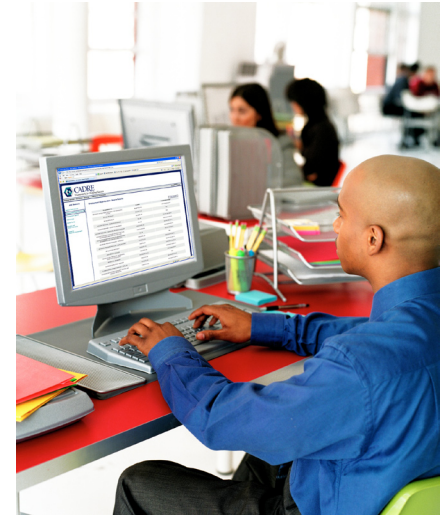
Until now, access to basic Health & Dental benefits has been all but impossible for many people. Recognizing the enormous need for **affordable Health & Dental protection**, we're pleased to make available a unique plan - the most flexible benefits program available in Canada today - **The CADRE Benefits Program**.

The Program offers a unique combination of the basic Health & Dental coverage you want - at a price

you'll appreciate - plus the flexibility of tailoring coverage with optional benefits that are normally only available in large group programs.

Your plan, your choice:

Different people have different needs. That's why **The CADRE Benefits Program** lets you choose the coverage that's right for you, offering three levels of protection: **Starter, Basic or Plus**, all available with Dental coverage.



Real-world, needs-related coverage options



Comprehensive, affordable coverage:

The **CADRE Benefits Program** is designed to give you the basic coverage you need, with the flexibility of customizing your coverage with Optional Benefits.

Available coverage includes:

- Extended Health Care with or without Dental Benefits
- Prescription Drugs
- Paramedical Services

- Ambulance & Hospital
- Private Nursing & Home Support
- Medical Equipment & Supplies
- Vision & Hearing Aids
- Prosthetics & Orthotics
- Out-of-Country Coverage
- Catastrophic Drug Coverage

Optional Benefits:

- Critical Illness Insurance
- Accidental Death & Dismemberment Insurance
- Disability Insurance

How To Apply for Coverage

Please review the details of the coverage available for Health & Dental and Optional Plans on the next page, and decide which **CADRE Benefits Program** is right for you. Premium rates for your Province and age group are included in the Application Form and are available on the website. If you require assistance or further information, please contact us or visit our website.

No Medical Examination required:

Coverage is subject to the Insurer's approval of a medical questionnaire. To participate, simply complete the Application Form and the Personal Health Declaration and mail with a VOID cheque to the Program Administrator at the address indicated. Faxed Applications are also acceptable.

MACLAGAN Inc.
 19 Peony Street
 Markham, Ontario
 L6B 1K9



Phone: (905) 554-0875
Cell: (416) 453-9430
Fax: (905) 294-2235
E-mail: esmaclagan@rogers.com



CADRE Benefits Program Summary

Health Care	Starter (no medical evidence required)	Basic (medical evidence required)	Plus (medical evidence required)
Medical Underwriting Requirements	Guaranteed Issue - No Medical Questions or Testing Required	Medical Questionnaire Required for Coverage Approval	Medical Questionnaire Required for Coverage Approval
EHC Benefits	Lifetime Benefit Maximum: \$100,000	Lifetime Benefit Maximum: \$250,000	Lifetime Benefit Maximum: \$250,000
Reimbursement	100% except prescription drugs	100% except prescription drugs	100% except prescription drugs
Pay-direct card	Yes	Yes	Yes
Prescription Drugs:			
Annual Maximum	\$350 per calendar year	\$3,500 per calendar year; generic drugs	\$4,500 / calendar year; brand name drugs
Reimbursement	70%	70% of 1st \$500; 100% of next \$3,000	80% of first \$500; 100% of next \$4,000
Dispensing Fee Cap	\$6.50	\$7.50 per prescription	N/A
Hospital:			
Room	not included	semi-private	semi-private or private
Maximums	not included	up to \$150 / day; \$4,500 / calendar year	up to \$200 /day; \$25,000 / calendar year
Vision Care: (after 6 month waiting period)			
Frames / Lenses	\$100 / 2 years	\$150 / 2 years	\$250 / 2 years
Eye Exams	\$30 / 2 years	\$100 / 2 years	\$100 / 2 years
Paramedicals: (Acupuncturist, Chiropractor, Chiroprapist, Physiotherapist, Osteopath, Podiatrist, Registered Massage Therapist, Naturopath)			
Per Practitioner Max.	combined max. for all practitioners: Yr 1: \$300, Yr 2: \$600, Yr 3: \$750, Yr 4: \$900	\$450 per calendar year	\$500 per calendar year
Per Visit Max.	\$20	\$50	\$50
Speech Therapist	N/A	maximum of \$60 first visit, \$40 subsequent	maximum of \$60 first visit, \$40 subsequent
Chiropractic X-Rays	\$35 per year	\$35 per year	\$35 per year
Psychologist	50% Co-insurance, max. \$75 first visit; \$60 thereafter; \$300 overall annual maximum	maximum of \$75 first visit and \$60 subsequent; limited to 15 visits per year	maximum of \$75 first visit and \$60 subsequent; limited to 15 visits per year
Medical Appliances & Support:			
Home Support, Durable Medical Equipment, Prosthetic Appliances, Orthotics	Combined calendar year Maximum for all services: Year 1: \$750 Year 2: \$1,000 Year 3: \$1,500 Orthotics: \$225 annual maximum	Calendar year maximums: Home Support: \$3,000 / year Equipment: \$3,000 / year Private Duty Nursing: \$3,000 / year Orthotics: \$225 / year Prosthetics \$3,000 / year	Combined calendar year maximum of \$7,500 for Home Support & Durable Medical Equipment, Private Duty Nursing and Prosthetic appliances; Custom Orthotics to \$225 per calendar year;
Ambulance	\$1,000 ground; \$4,000 air / calendar year	\$10,000 ground; \$4,000 air / calendar year	\$10,000 ground; \$4,000 air / calendar year
Hearing Aids	\$300 every 4 years	\$400 every 4 years	\$500 every 4 years
Accidental Dental	\$2,000 per year	\$2,500 per calendar year	\$3,000 per calendar year
Out-of-Country:	\$2 Million for unlimited trips up to 30 days	\$2 Million for unlimited trips up to 30 days	\$2 Million for unlimited trips up to 30 days
DENTAL	Starter (mandatory)	Basic (optional)	Plus (optional)
Preventative Services	70% reimbursement; 3 month waiting period; 6 units scaling per year; 9 month recall; Level 1 Services only	80% reimbursement; no waiting period; 8 units scaling; 9 month recall; Oral Surgery; Endodontics; Periodontics.	80% reimbursement; no waiting period; Exams, cleaning, scaling every 6 months; fillings, x-rays, fluoride, space maintainers, extractions, anesthesia, endodontics, periodontics, denture repairs..
Major Restorative	not included	not included	Crowns, bridges, dentures & orthodontics; Available Year 3+ at 60% reimbursement
Orthodontia	not included	not included	see above
Annual Maximums	\$350 per year	80% to \$500 year 1; 80% to \$750 year 2+	80% up to \$500 year 1; 80% to \$750 year 2; 80% to \$1,000 year 3 & 4; and \$1,250 year 5, including combined Perio/Endo max. of \$500/year; 80% Perio. reimbursement.

OPTIONAL BENEFITS: (available to all coverage levels)

Accidental Death & Dismemberment Insurance: 24 hours per day / 365 days per year individual or family coverage in units of \$50,000 to \$300,000.

Critical Illness Benefit: Lump sum benefit paid if you are diagnosed with one of TEN life threatening illnesses and survive for 30 days. Some conditions apply.

Disability Insurance Benefits: Available coverage includes Temporary Total Disability, Permanent Total Disability and Accidental Death & Dismemberment.

The Starter Plan includes mandatory Health & Dental Coverage. The Basic and Plus Plans allow an individual to select one of two options: Health Only or Health & Dental.

CADRE Health & Dental Benefit Programs: Starter, Basic and Plus Plans

Welcome to the CADRE Health & Dental Benefits Program!

We know that filling out insurance applications can sometimes be confusing and complicated, so we've made every effort to make enrolling in these plans as quick and simple as possible. Please use the checklist below to guide you through the application process - it will help you to complete the application accurately and allow us to process your information as quickly as possible.

Which Application kits do you need?

There are two separate sets of documents used to apply for coverage. You may need only one, or both. One (this kit) covers your **Health & Dental Plan** choices, and includes a description of the three available plans (**Starter, Basic or Plus**), an **Application Form** and a **Personal Health Declaration**.

A second Application kit is used for the **Disability / Income Protection Program**.

How to Complete the Health & Dental Application:

1. First, read the Health & Dental Plan brochure and refer to the Plan Summary on page 2 to decide which of the three plans (Starter, Basic or Plus) is right for you.
2. Proceed to Section 1 of the Application for Insurance and provide the requested General Information (ie Name, Address, Employment information, etc.)
3. In Section 2, you need to **indicate your Coverage Selection (ie Single, Couple, Family)** and **your Plan Choice (Starter, Basic or Plus, with or without Optional Benefits)** and **whether you want only Extended Health Care, or Extended Health Care PLUS Dental Coverage**.
4. **Section 3 requires you to provide name and birthdate information for your Spouse and Dependent Children.** If your Spouse also has health or dental coverage through his/her workplace, please provide information about their plan.
5. **In Section 4, please Sign and Date the Application Form.**
6. **For the STARTER Plan:** In Section 6, on page 2, find the Base rate (Single or Couple) for your Age band. Then, if applicable, add the Per Child amount for any children based on their age.
7. **For the BASIC or PLUS Plans:** Also in Section 6, on page 2, you'll find all of the possible monthly rates for the Basic and Plus Programs. The amount of numbers here can appear confusing, but don't worry, you only have to find the one number that applies to your Age Group and your chosen coverage. Start by locating the section that applies to you: Single or Couple, Two-Parent Family or Single-Parent Family. Next, look for the coverage you've chosen (EHC Only or EHC + Dental), and find the column that matches your Program choice (Basic or Plus). Finally, find the monthly rate in that column that corresponds to your Age Group, and copy that number to Box (1) in the lower right.
8. **Section 7: Optional Benefits** - You can supplement your coverage with Optional Critical Illness Benefits and Optional Accidental Death & Dismemberment Insurance (Optional Disability / Income Protection Insurance is also available but requires a separate application form). **For the Optional Critical Illness Benefits**, choose a benefit of \$10,000, \$25,000 or \$50,000 for you and/or your spouse, and copy the amount for your age band and smoker/non-smoker status to the line at right. **For the Optional AD&D Insurance**, circle the amount of coverage you require and then select either the Single Plan or Family Plan. You must also complete the Beneficiary Designation section.
9. **Section 8: Calculate your Monthly Cost** - Add the amounts from Boxes (1), (2), (3) and (4) and write the total in the box at right. This amount represents the monthly cost of your Health & Dental Benefits, and is the amount that will be withdrawn from your financial institution on a monthly basis. **IMPORTANT: To enable these monthly withdrawals YOU MUST ATTACH A CHEQUE MARKED "VOID" TO YOUR APPLICATION.**
10. **Finally, you must complete in full the Personal Health Declaration in order to be approved for coverage.** Provide the Applicant and Dependent information requested, and answer all questions in the Health Declaration accurately, including the name and address of your regular doctor or medical clinic. **It is particularly important that you complete Section 3, providing details for any questions for which you have answered "YES" in Section 2. An incomplete Personal Health Declaration will be returned, and this will delay the processing of your application.**

If you require assistance, please contact us at one of the numbers below:

In Toronto: (905) 629-1252 Toll-free: 1-866-636-8359

Please remember to complete in detail both the Application and the required Personal Health Declaration(s) and attach a cheque marked "VOID" to enable monthly premium withdrawals.

Application for Insurance - CADRE Starter, Basic & Enhanced Programs

Please submit this Application and the Personal Health Declaration with a cheque marked "VOID". For more information or assistance in completing this application, or to request additional applications & health statements, please contact the Program Administrator toll-free at **1-866-636-8359** or visit our website at **www.menuflex.com**

Section 1: General Information

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> OTHER _____		
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH		PRIMARY OCCUPATION	
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE		WORKPLACE TELEPHONE		FAX	
EMAIL ADDRESS			YOUR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> INCORPORATED		
YOUR COMPANY NAME		YOUR BUSINESS ADDRESS		CITY	PROVINCE
YOUR AGENT / BROKER'S NAME (IF APPLICABLE) Scott Maclagan, Maclagan Inc.		AGENT / BROKER'S TELEPHONE: 416-453-9430		AGENT / BROKER'S E-MAIL ADDRESS: esmaclagan@rogers.com	
AGENT / BROKER'S ADDRESS: 19 Peony Street		CITY Markham		PROVINCE Ontario	POSTAL CODE L6B 1K9

Section 2: Coverage Selection & Plan Choice

1. Please indicate your level of coverage:

Single Two Parent Family with _____ Child / Children
 Couple Single Parent Family with _____ Child / Children

2. Please choose your Benefits Program: Starter Basic Plus | Optional Critical Illness Optional AD&D

3. Please choose Extended Health Care ONLY or Extended Health Care + Dental: EHC ONLY EHC + DENTAL

Section 3: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 21
Spouse:				
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED

If a Child is over age 21, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
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Section 4: Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

I authorize the Plan Administrator, Alternative Benefit Solutions Inc., to withdraw from my financial institution the required insurance premiums, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary date of August 1st each year.

Signed at: _____ this _____ day of _____, _____ Applicant's Signature _____
CITY / TOWN PROVINCE DATE MONTH YEAR

Section 5: Privacy & Confidentiality

We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to Alternative Benefit Solutions Customer Service, the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Mail or Fax your completed application to:

Alternative Benefit Solutions Inc.
5045 Orbitor Drive, Unit 10
Suite 300
Mississauga, Ontario L4W 4Y4



Phone: (905) 629-1252
Toll-free: 1-866-636-8359
Fax: (905) 602-7983
E-mail: apps@alternativebenefits.ca

Section 6: Monthly Premium Rates - NEWFOUNDLAND (choose Starter, Basic or Plus coverage, and any Optional Benefits)

Starter Plan Monthly Rates (includes mandatory Dental Coverage)

	Age 44 and under	Age 45 - 54	Age 55 - 59	Age 60 - 64	Age 65 - 69
Single	\$74.69	\$93.41	\$96.55	\$102.09	\$84.12
Couple	\$128.43	\$163.46	\$169.75	\$179.92	\$144.60

Per Child Rate (1 or 2 Children)		Per Child Rate (3 or more Children)	
0 - 4 years old	\$31.43	0 - 4 years old	\$28.29
5 - 20 years old	\$38.77	5 - 20 years old	\$34.74

- Your Base Rate (Single or Couple) for your age band: = \$ _____
- Plus (if applicable) _____ child(ren) 0 - 4 years old X \$ _____ per child = \$ _____ +
- Plus (if applicable) _____ child(ren) 5 - 20 years old X \$ _____ per child = \$ _____ +
- Total Monthly Rate for Starter Plan: = \$ _____ (taxes do not apply)

Starter Plan Monthly Cost: \$ _____ (1)

Basic or Plus Program Rates (choose EHC ONLY or EHC + DENTAL coverage)

SINGLE & COUPLE RATES										
Age Group	EHC ONLY				Age Group	EHC + DENTAL				
	Single		Couple			Single		Couple		
	Basic	PLUS	Basic	PLUS		Basic	PLUS	Basic	PLUS	
21-44	\$44.70	\$62.42	\$79.66	\$105.36	21-44	\$79.58	\$111.80	\$143.14	\$189.88	
45-54	\$51.86	\$77.70	\$92.55	\$131.36	45-54	\$92.61	\$139.59	\$166.58	\$237.15	
55-59	\$60.53	\$83.22	\$108.14	\$140.73	55-59	\$108.36	\$149.63	\$194.94	\$254.19	
60-64	\$68.21	\$92.78	\$121.97	\$156.98	60-64	\$122.33	\$167.01	\$220.08	\$283.74	

FAMILY RATES (TWO PARENTS with Dependent Children)													
Age Group	EHC ONLY						Age Group	EHC + DENTAL					
	with 1 Child		with 2 or 3 Children		with 4 + Children			with 1 Child		with 2 or 3 Children		with 4 + Children	
	Basic	PLUS	Basic	PLUS	Basic	PLUS		Basic	PLUS	Basic	PLUS	Basic	PLUS
21-44	\$101.37	\$135.81	\$126.46	\$174.16	\$161.62	\$227.28	21-44	\$182.62	\$245.25	\$228.24	\$314.96	\$292.16	\$411.55
45-54	\$112.83	\$158.75	\$136.84	\$195.26	\$171.15	\$246.85	45-54	\$203.46	\$286.95	\$247.11	\$353.34	\$309.49	\$447.13
55-59	\$126.69	\$167.02	\$149.40	\$202.87	\$182.66	\$253.91	55-59	\$228.66	\$301.99	\$269.96	\$367.17	\$330.43	\$459.97
60-64	\$138.98	\$181.36	\$160.54	\$216.06	\$192.88	\$266.14	60-64	\$251.01	\$328.05	\$290.21	\$391.15	\$349.01	\$482.21

SINGLE PARENT FAMILY RATES (ONE PARENT with Dependent Children)													
Age Group	EHC ONLY						Age Group	EHC + DENTAL					
	with 1 Child		with 2 or 3 Children		with 4 + Children			with 1 Child		with 2 or 3 Children		with 4 + Children	
	Basic	PLUS	Basic	PLUS	Basic	PLUS		Basic	PLUS	Basic	PLUS	Basic	PLUS
21-44	\$63.73	\$90.89	\$87.52	\$126.49	\$121.77	\$177.79	21-44	\$114.19	\$163.58	\$157.45	\$228.30	\$219.71	\$321.57
45-54	\$70.89	\$106.18	\$94.68	\$141.78	\$128.93	\$193.08	45-54	\$127.21	\$191.38	\$170.46	\$256.10	\$232.72	\$349.37
55-59	\$79.56	\$111.70	\$103.35	\$147.30	\$137.59	\$198.60	55-59	\$142.96	\$201.40	\$186.22	\$266.13	\$248.48	\$359.40
60-64	\$87.24	\$121.26	\$111.03	\$156.86	\$145.27	\$208.16	60-64	\$156.93	\$218.78	\$200.19	\$283.51	\$262.45	\$376.78

Instructions:
To determine your monthly rate for **Basic** or **Plus** coverage, copy the amount for your chosen Program, age band and level of coverage to box (2) below.

Notes: Rates for other Provinces and age groups are available upon request.

Basic or Plus Health Benefits Monthly Cost: \$ _____ (2)

Section 7: Optional Benefits Optional Benefits can be selected to enhance your overall protection or address specific personal needs.

Optional Critical Illness Benefits Monthly Rates: Applicant: Non-Smoker Smoker Spouse: Non-Smoker Smoker

Unit of \$10,000	Attained Age	Non-Smoker		Smoker	
		Male	Female	Male	Female
		18-24	\$1.17	\$1.52	\$1.54
25-34	\$2.18	\$3.12	\$3.16	\$4.06	
35-44	\$4.22	\$5.38	\$9.65	\$10.58	
45-54	\$10.93	\$9.96	\$31.47	\$26.10	
55-64	\$26.17	\$19.09	\$80.00	\$55.66	

Unit of \$25,000	Attained Age	Non-Smoker		Smoker	
		Male	Female	Male	Female
		18-24	\$2.82	\$3.66	\$3.75
25-34	\$5.29	\$7.55	\$7.67	\$9.59	
35-44	\$10.24	\$13.07	\$23.43	\$25.69	
45-54	\$26.54	\$24.17	\$76.42	\$63.39	
55-64	\$63.55	\$46.34	\$195.54	\$138.67	

Unit of \$50,000	Attained Age	Non-Smoker		Smoker	
		Male	Female	Male	Female
		18-24	\$5.59	\$7.26	\$7.41
25-34	\$10.45	\$14.95	\$15.18	\$19.53	
35-44	\$20.29	\$25.88	\$46.39	\$50.88	
45-54	\$52.55	\$47.87	\$151.33	\$125.52	
55-64	\$125.85	\$91.77	\$385.27	\$267.68	

Applicant Benefit Amount: \$ _____

Monthly Premium: \$ _____ (a)

Spouse's Benefit Amount: \$ _____

Monthly Premium: \$ _____ (b)

Notes: Rates increase as an insured person moves from one age band to the next.

Optional Critical Illness Monthly Cost: \$ _____ (a) + (b) (3)

* Critical Illness coverage requires you to complete the attached ACE INA Critical Illness Evidence of Insurability Form

Optional Accidental Death & Dismemberment Insurance (AD&D) Monthly Rates:

Coverage Amount	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000
Applicant Only	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00	\$12.00
Applicant & Family*	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00	\$18.00

Instructions: Indicate the amount of coverage that you require in multiples of \$50,000, then choose the Single Plan at \$2.00 per \$50,000 per month or the Family Plan at \$3.00 per \$50,000 per month. *If Spouse only, spouse insured for 60% of Applicant's coverage. If Spouse + Children, Spouse coverage 50% each child 15%. If only dependent children, 20% each.

Beneficiary Designation: The beneficiary of the Applicant's AD&D benefits is revocable unless prohibited by law. The Applicant is the beneficiary of all other benefits payable under this plan.

Beneficiary Last Name	First Name & Initial	Relationship	Amount
			%
			%
Note: If beneficiary is under 18 years of age, name of Trustee is required. Trustee: _____			Total: 100%

Optional AD&D
Monthly Cost: \$ _____ (4)

Disability Insurance: Requires separate Application Form. Please complete the **Menuflex Income Protection Program Application**.

Section 8: Calculate your Monthly Cost:

Total the amounts from boxes (1) (2) (3) and (4) to determine your monthly benefits cost. This is the amount that will be withdrawn from your financial institution each month. Please attach a cheque marked "VOID" to enable these monthly withdrawals.

Your Total
Monthly
Benefits Cost: \$ _____

Notes:

- Basic & Plus levels of coverage require you to complete the attached **Personal Health Declaration** in order to be approved for coverage. You do not need to complete the Personal Health Declaration if applying for the Starter Plan.
- Optional Critical Illness coverage requires you to also complete the attached ACE INA Critical Illness Evidence of Insurability form.
- Coverage commences only after the Plan Administrator confirms your acceptance in writing. Coverage may be amended or surcharged based on the information provided in the Personal Health Declaration and any pre-existing conditions.
- Please remember to attach a cheque marked "VOID" to enable monthly premium payments.**

If you have any questions, or require assistance in completing the application, please call Maclagan Inc. at 416-453-9430.

Mail or Fax your completed application to:

Alternative Benefit Solutions Inc.
5045 Orbitor Drive, Unit 10
Suite 300
Mississauga, Ontario L4W 4Y4



Phone: (905) 629-1252
Toll-free: 1-866-636-8359
Fax: (905) 602-7983
E-mail: apps@alternativebenefits.ca



Personal Health Declaration



Please complete in full this Personal Health Declaration **ONLY IF APPLYING FOR "BASIC" OR "ENHANCED" COVERAGE. If you answer "YES" to any of the medical questions below, please provide details on reverse.** If you have questions or need further assistance, please call us toll-free at **1-866-636-8359**.

Section 1: Applicant Information

APPLICANT NAME		DATE OF BIRTH (DAY / MONTH / YEAR)	
SPOUSE'S NAME (IF APPLICABLE)		DATE OF BIRTH (DAY / MONTH / YEAR)	
NAME OF APPLICANT'S EMPLOYER	DATE EMPLOYED (DAY / MONTH / YEAR)	CERTIFICATE OR PAYROLL NUMBER (OFFICE USE ONLY)	
OCCUPATION	NORMAL NUMBER OF HOURS WORKED PER WEEK	DIVISION / CLASS (OFFICE USE ONLY)	
APPLICANT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	APPLICANT'S HEIGHT _____ <input type="checkbox"/> ft/in or <input type="checkbox"/> cm	APPLICANT'S WEIGHT _____ <input type="checkbox"/> lbs or <input type="checkbox"/> kg	
SPOUSE'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPOUSE'S HEIGHT _____ <input type="checkbox"/> ft/in or <input type="checkbox"/> cm	SPOUSE'S WEIGHT _____ <input type="checkbox"/> lbs or <input type="checkbox"/> kg	
DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)		DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)	
DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)		DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)	

Section 2: Health Declaration

Have you or any of your dependents ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on reverse.

	APPLICANT	SPOUSE	DEPENDENTS
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you currently taking or have you been prescribed any prescription medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing, piloting aircraft, or bungee jumping?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Full name and address of your regular attending physician: If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. **If the answer is "none", state "none".**

NAME OF APPLICANT'S PHYSICIAN		ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT	
NAME OF SPOUSE'S PHYSICIAN		ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT	



ace life

ACE INA Life Insurance
130 King Street West
12th Floor
Toronto, Ontario
M5X 1A6

Critical Illness Insurance – Evidence of Insurability

Full Name (Please Print)

The following questions must be answered by each applicant - member, and spouse, if spouse is also applying for coverage:

1. Have you EVER had any known indication of, been diagnosed with, sought medical attention or been treated for:

- Cancer or any malignant growth
- Heart Attack, heart disease or circulatory problems, Angina, Arteriosclerosis
- A positive HIV test, Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex
- Uncorrectable loss of sight or hearing
- A blood disorder (excluding controlled high blood pressure)
- OR any disease or disorder of the kidneys, liver or lungs?
- Stroke, mini-stroke (TIA)
- Excessive use of alcohol or drugs
- Paralysis,
- Multiple Sclerosis,
- Diabetes that needs to be controlled by insulin,

Yes No

2. Within the past two (2) years, have you seen a doctor for a condition or illness, the diagnoses of which you have not been made aware of, or for which further tests are still required?

Yes No

3. Are you currently under treatment or observation for any medical condition or do you currently suffer from any condition that prevents you from performing all normal daily activities?

Yes No

4. Have two (2) or more of your direct family members (parents, brothers or sisters) died from or ever suffered from Cancer, Heart Disease, Stroke, Kidney disease, or any hereditary disease prior to their reaching age 70?

Yes No

If ANY of the above four (4) questions are answered "YES", Critical Illness Protection is NOT available. If a "YES" answer appears for any of the four (4) questions above, please DO NOT submit this application.

5. Have you used any form of Tobacco or nicotine product (including the nicotine patch) in the past 12 months?

Yes No If yes, indicate type and amount per week

Type of Product	Amount per week
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6. Sex Male Female Marital Status Single Married Divorced

Height	Weight	Date of Birth (dd/mm/yy)
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I acknowledge that no benefit is payable for an insured condition if during the first 24 months of coverage I am diagnosed with a symptom or medical problem for which I received treatment in the 24 month period prior to the Effective Date of my Policy.

I hereby attest that the answers to the above questions are true and complete to the best of my knowledge. I understand coverage commences only after the Plan Administrator confirms acceptance in writing. I hereby authorize the use of my Social Insurance Number in the administration of this Benefit Program.

Signature	Date (dd/mm/yy)	
Name and Address of Family Doctor		
Date of Last Visit (dd/mm/yy)	Reason	Result