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.

   ____

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   ____

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.

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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. ______________________________

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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

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