

**CSI – CANADA INSURANCE PLAN**  
**STATEMENT of HEALTH**  
 Insured by Manulife Financial

**1. Note:** Use for late applicants (past 30 days of eligibility). Complete and send original to CSI with Enrolment Form.

**2. Member and Dependent Details (to be completed by the Member)**

All information received by Manulife Financial is treated as strictly confidential and is used for the sole purpose of determining your eligibility and administering the CSI Canada Insurance Plan.

**2.1 General information about the Member**

School Name			Contract Number <b>84168</b>	
Member's Name (First)	(Last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member ID
Member's Address (Street, City, Province, Postal Code)			Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Member's Home Telephone Number (    )		Member's Business Telephone Number (    )		

**2.2 General information about the Member's Dependents**

Spouse's Name (First)	(Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> Kg.
Child's Name (First)	(Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> Kg.
Child's Name (First)	(Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> Kg.
Child's Name (First)	(Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> Kg.
Child's Name (First)	(Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> Kg.

**2.3 Medical information**

If you answer yes to any questions, please provide further details on the next page. Include dates, treatment and medication.

	Member	Spouse	Child(ren)
1. Do you have a regular attending physician (if yes, provide name, address, date last consulted and reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have a yearly checkup? If yes, please specify (date of last check-up and results)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Within the past 12 months have you lost work due to illness or injury (if yes provide dates, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Within the last 3 years have you: a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than 5 consecutive days? b) Received disability benefits for 3 months or longer? c) Had an application for life or disability insurance declined or assessed at a higher than standard premium rate? (If yes, specify name of insurer, date, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you used any tobacco products within the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a physician?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you consume alcoholic beverages? • Specify date of last consumption, frequency of use • Have you ever been advised to stop drinking or to drink less?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Do you engage in any hazardous sport activity such as sky diving, scuba diving, vehicle or boat racing or aviation except as a passenger?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you have diabetes mellitus? a) Do you take insulin? b) Do you take oral medication? (please list medications used) List your last 3 blood sugar readings _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Are you presently under medical treatment by diet, medicine or other means (included names of all medications currently being used)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



**3. Declaration and authorization**

Please read and sign this Section.

The intentional falsification, misrepresentation or omission of information on or relating to this form constitutes fraud and coverage granted may be voided

I understand I may be refused group benefits if, in the opinion of Manulife Financial, I am not insurable.

I certify that all the statements in this application are true and complete. I am authorized to disclose information about my dependants, as applicable, for the purpose of determining their insurability under my benefit plan.

I authorize Manulife Financial, its agents and service providers and reinsurers to collect, use, disclose and exchange the personal information requested in this form for the purposes of underwriting, administrating and adjudicating claims under this benefit plan with any person or organization who has relevant information pertaining to this form including, but not limited to health professionals, institutions, insurers and reinsurers. I understand that information pertaining to any claim that may be made if this coverage is approved may be reviewed by CSI and its agents and service providers in the event that my benefit plan is audited.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage under my benefit plan. If my participation in this benefit plan and/or employment with a member school should end for any reason, this authorization will continue for the purposes of managing, administering, and arranging for benefits that may continue after my participation and/or employment terminates.

Signature of Member X	Date (d/m/y)
Signature of Spouse X	Date (d/m/y)

Manulife Financial must receive your completed Statement of Health within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Statement of Health.

**You may send the completed form to CSI in an envelope marked "Confidential". Please do not send the Enrolment and Change Form in a confidential envelope. Send both the Enrolment and Change Form and Statement of Health to CSI at:**

**CSI Canada Insurance Plan  
3350 East Paris Ave. SE  
Grand Rapids, MI 49512-3054**