Catholic Principals' Council of Ontario
Statement of Health

Return completed form to: **Johnson Inc.**
Program Administrator
#700, 1595 16th Avenue
Richmond Hill,
ON L4B 3S5

Reason for Statement of Health Being Completed

Long Term Disability	Policy Number
❑ Not currently covered for LTD or Late Applicant (after 90 day open enrolment) ❑ Wanting to change LTD Options Please indicate 1. Current Option ______ and 2. Desired Option _____	

Life Insurance		Policy Number
Member	❑ New Applicant (applying after 90 day open enrolment or applying for coverage over $100,000) ❑ Increasing Life Coverage 1. Current Coverage _________ and 2. Desired Coverage ________	
Spouse	❑ New Applicant (applying after 90 day open enrolment or applying for coverage over $100,000) ❑ Increasing Life Coverage 1. Current Coverage _________ and 2. Desired Coverage _______	
Dependant	❑ New Applicant (applying after 90 day open enrolment) ❑ Increasing Life Coverage 1. Current Coverage _________ and 2. Desired Coverage _______	

Member Questionnaire		
Name in full (first, last)		
School Board		Annual Salary
Birthdate (MM/DD/YYYY)	Height	Weight
Full Name and Address of personal physician		
Date of last consultation	Reason for consultation	

Have you ever been treated or had any indication of:	
1. Chest pain, high blood pressure, mental or emotional disorder, arthritis, gout, cancer, tumour, or fainting spells?	❑ Yes ❑ No
2. Disease or disorder of the heart or circulatory systems, lungs, kidneys, bladder, genital or reproductive organs, brain or nervous system, skin, eyes, ears or speech?	❑ Yes ❑ No
3. Disease or disorder of the stomach or intestines, liver, thyroid, bones, muscles, joints, back or neck?	❑ Yes ❑ No
4. In the past five years, have you had any medical advice or operation, physical exam, treatment, illness, abnormality or injury not listed above?	❑ Yes ❑ No
5. Are you currently receiving any medical advice, treatment or medication?	❑ Yes ❑ No
6. Have you ever used stimulants, hallucinogens, narcotics or any controlled substance other than prescribed by a physician or been counseled or treated for excess use of alcohol or drugs?	❑ Yes ❑ No
7. Have you ever been diagnosed or told by a physician that you have AIDS or ARC?	❑ Yes ❑ No

Give details below to any yes answers

Question No.	Symptoms	Diagnosis	Treatment	Date and Duration of each occurrence	Time Lost from Work	Name and Address of Doctors & Medical Facilities

Female Applicants only	
	Have you ever had a miscarriage, preeclampsia, caesarian section or other complication of pregnancy?
	Are you pregnant? ❑ Yes ❑ No If yes, give Due Date

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS STATEMENT

I hereby declare that all answers on this form are true and complete and that any misstatements or failure to report information may be used as the basis of rescission of insurance for me and my dependents (if any). I further understand that if the insurance applied for becomes effective, I will be subject to all the terms of the policy.

I hereby authorize any 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 to RBC Life Insurance Company any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease, ailment or condition. A photocopy of this authorization shall be as valid as the original.

Signature of Applicant	Signature of Witness	Date
____________________	____________________	__________

Spousal Life and/or Dependent Life Questionnaire

Complete this section only if you are applying for Spousal Life and/or Dependent Group Life Insurance

Please list the name of your spouse and/or any dependent children proposed for coverage under this plan.

	Name (first, last)	Sex	Relationship	Date of Birth MM/DD/YYYY	Height	Weight
1.						
2.						
3.						
4.						

To the best of your knowledge are you aware of or have any of the above dependents been treated for or been given indication of having any of the following: heart trouble, disease or disorders, high blood pressure, diabetes, cancer or tumours, kidney trouble, disease or disorders, ulcer, or disorders of the back, nervous or respiratory systems, Acquired Immune Deficiency Syndrome (AIDS), alcoholism, drug addiction, or any other physical or mental disorders?

No ❑ Yes ❑,
If Yes, please explain: ____
____
____
____

I hereby declare that the above answers and statements are, to the best of my knowledge and belief, full complete, and true as of this date, it being understood that they are material to the risk and form part of the application and consideration for the insurance applied for.

Date ____________________ Signature of Member ________________________________

PRIVACY STATEMENT:

Beginning January 1, 2004, the Personal Information Protection and Electronic Documents Act (PIPEDA) will apply to personal information held by the insurance companies. In order to ensure the confidentiality of the personal information held concerning you, Johnson Inc. and/or RBC Life Insurance Company will establish an insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claims. Only employees or authorized organizations who will be responsible for underwriting, administration, investigation and claims, or any other person you authorize, will have access to this file, and if applicable, to have it rectified by submitting a written request to the address below.

PLEASE NOTE:
YOUR APPLICATION CANNOT BE PROCESSED IF ALL APPROPRIATE QUESTIONS ARE NOT ANSWERED.