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APPLICATION FOR MAJOR MEDICAL INSURANCE

**TO BE
 COMPLETED
 BY PROPOSED
 INSURED**

**PLEASE
 ANSWER ALL
 QUESTIONS**

Proposed Insured:	Citizenship:
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Address:

Date of Birth	Day/Month/Year	Height:	Weight:
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Profession or occupation:

Nature of duties:

Employer's name:

Employer's address:

Maximum sum insured \$

US or CDN dollars

Broker/Agent/Consultant

Contact name and telephone no.

Are you now, and have you been, in sound health for one year preceding this application?

yes	no/describe nature of impairment
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no	yes/state date, reason and name and address of Physician
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no	yes/describe in detail
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no	yes/state countries to be visited, length of stay, purpose
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Within the past ten years have you consulted a physician, or had treatment or surgery, or taken prescribed medication, for a sickness or injury arising from any of the following: If yes, please describe in detail including dates and prognosis.

no	yes
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**COVERAGE
 BEING
 APPLIED
 FOR:**

**BROKER
 INFORMATION**

Diabetes, cancer, tumor or disorder of the glands, bone, blood or skin?	no	yes
Disorder of the breasts, reproductive organs, kidneys or urinary system?	no	yes
Hernia, or disorder of the liver, gall bladder, stomach, intestines or rectum?	no	yes
Arthritis, rheumatism, or disorder of the limbs, back, neck or spine?	no	yes
Neuritis, sciatica, gout or any disorder of the muscles, bones or joints?	no	yes
Allergy, asthma, sinusitis, emphysema, or disorder of the lungs?	no	yes
Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, tuberculosis or chronic respiratory disorder?	no	yes
Disorder of the eyes, ears, nose or throat?	no	yes
Epilepsy, stroke, dizziness, or disorder of the brain or spinal cord?	no	yes
Emotional, mental or nervous disorder?	no	yes
Any change of weight in the past year?	no	yes
Have you ever had any disorder of menstruation, of pregnancy or of the female organs or breasts?	no	yes
To the best of your knowledge and belief are you now pregnant?	no	yes

**FEMALES
ONLY**

FAMILY HISTORY

Is there, in your family, any history of diabetes, cancer, high blood pressure, heart disease, or mental illness or suicide?	no	yes
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	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers & sisters No. living [] No. dead []			

**HAVE YOU EVER:
If yes, please describe in detail:**

Smoked any tobacco products in the past twelve months?	no	yes
Required treatment for the use of alcohol or drugs, or used either to excess?	no	yes
Used cocaine, narcotics, marijuana or any other habit forming drug?	no	yes
Have you ever had your drivers license revoked, for any period of time, for driving while under the influence of alcohol?	no	yes
To the best of your knowledge, have you ever been treated for, or told you had, AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?	no	yes
Do you have an amputation of any kind, or any physical deformity, impairment or handicap?	no	yes
During the past five years have you undergone any surgical operation(s)?	no	yes/state month/date/year, reason, physician's name and address
Have you any reason to think that you may need to undergo a surgical operation in the future?	no	yes/approximate date for surgery, reason for surgery
Do you have insurance similar for that now being applied for?	no	yes/name of insurer, policy benefit(s)
In the event of accident or illness would the applicant be eligible for reimbursement under any Canadian Provincial or Federal Government Health Plan?	no	yes/please state duration
Have you made any claim(s) against an insurer in respect of an accident or illness?	no	yes/date & nature of claim, amount of claim

Have you ever been declined, or accepted on special terms, for Life Insurance or Accident and Health Insurance?	no	yes
Has any Life, or Accident and Health Insurer, ever cancelled or declined to renew your coverage?	no	yes/month/year of action, reason for action
Have you an application pending for any other Accident or Sickness Insurance?	no	yes/date of application, name of Insurer, benefit(s) applied for
Do you sky dive or operate an aircraft, glider or balloon?	no	yes
Do you scuba dive, or race motorcycles or boats?	no	yes
Do you engage in other hazardous activities not shown above?	no	yes/nature of activity, extent and frequency or participation

If you use a motor vehicle in connection with your business or occupation, give your approximate annual mileage if this will exceed 18,000 miles/30,000 km (business and pleasure) _____

DECLARATION

I hereby warrant that the above statements are true and correct to the best of my knowledge and belief and, that I have not withheld any information which is calculated to influence the decision of the Insurer. I understand that non-disclosure or misrepresentation of a material fact will render this insurance null and void.

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 you should consult your agent, or WILLIAM J. SUTTON & CO. LTD.

I understand that signing this application does not bind me to complete the insurance but, I do agree that, should a Document of Insurance be concluded, this Application, and the statements made herein, shall form the basis of the Insurance. Further, that WILLIAM. J. SUTTON & CO. LTD. is hereby authorized as the sole representative for placement of this insurance.

Signature of Proposed Insured

Date

Applicant/Owner (corporation/partnership/trustee or individual other than Proposed Insured)

By (signature & title)

Witnessed, by Licensed resident agent

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 regarding me, or my health, to give WILLIAM J. SUTTON & CO. LTD. any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured

Date

Signed at