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GROUP BENEFIT PLAN
Medical Questionnaire

To be completed by each family member. If your medical information will not fit on this questionnaire, please attach an additional sheet.

A. Applicant Information

First Name	Last Name	Initial

Physician Name	Physician Phone ( )

Specialist Name	Specialist Phone ( )

B. Medical Conditions

Have you ever suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following:

1. Cardiovascular/Heart ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s) below.*

❑ Arrythmia ❑ Chest Pain/Angina ❑ Congestive Heart Failure ❑ Other
❑ Atrial Fibrillation ❑ Heart Attack ❑ Arteriosclerosis/Angioplasty
❑ Heart Murmur ❑ Aneurysm ❑ Arterial Bypass

If other, please specify the condition. _____

What was the date of diagnosis for your cardiovascular/heart condition(s? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your cardiovascular/heart condition?

_____

2. Cerebrovascular/Stroke ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s) below.*

❑ Cerebrovascular Accident (CVA) ❑ Transient Ischemic Attack (TIA) ❑ Neurological Disorder ❑ Other

If other, please specify the condition. _____

What was the date of diagnosis for your cerebrovascular/stroke condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your cerebrovascular/stroke condition?

_____

3. Respiratory/Lung ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s)/treatment(s) below.*

❑ Chronic Obstructive Pulmonary Disease (COPD) ❑ Asthmatic Bronchitis/ Bronchial Asthma ❑ Emphysema ❑ Prednisone
❑ Home Oxygen ❑ Other
❑ Chronic Bronchitis

If other, please specify the condition. _____

What was the date of diagnosis for your respiratory/lung condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your respiratory/lung condition?

_____

4. Gastro-Intestinal/Liver/Kidney/Urinary ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s) below.*

❑ Kidney Disorder ❑ Liver Disease ❑ Diverticulitis
❑ Intestinal Bleeding ❑ Peptic Ulcer ❑ Spleen/Pancreas Disorder
❑ Stomach/Bowel Disorder ❑ Urinary Disorder ❑ Other

If other, please specify the condition. _____

What was the date of diagnosis for your gastro-intestinal/liver/kidney/urinary condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your gastro-intestinal/liver/kidney/urinary condition?

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Continued...

B. Medical Conditions *Continued...*

5. Cancer ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s)/treatment(s) below.*

❑ Cancer is Eliminated ❑ Radiation Treatment ❑ Chemotherapy ❑ No Treatment/Other Treatment

If other, please specify the condition. _____

What was the date of diagnosis for your cancer? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your cancer?

_____

6. Other ❑ **Yes** ❑ **No** *If "Yes", please indicate the condition(s) below.*

❑ Diabetes without Medication
❑ Diabetes with Medication
❑ High Cholesterol
❑ Alzheimer's Disease/Dementia
❑ Back Disorder
❑ Epilepsy
❑ Circulatory Disorder of Artery/Vein
❑ Epilepsy
❑ Muscle/Bone/Joint Disorder *(not arthritis)*
❑ High Blood Pressure/Hypertension
❑ Weight Loss Recommended by a Physician
❑ HIV/AIDS/AIDS Related Complex
❑ Blood Disorder
❑ Leukemia
❑ Prostate Disorder
❑ Arthritis
❑ Other

If other, please specify the condition. _____

What was the date of diagnosis for your "other" condition(s)? (DD/MM/YYYY) _____

When and what was the last symptom, treatment or medication change (in type, dosage or frequency) for your "other" condition?

_____

C. Medication Information

Please list any medication(s) you are currently taking or have taken in the past six months.

Condition	Name of Medication	Original Date Prescribed *(DD/MM/YYYY)*	Current Dosage & Frequency	Last Date Dosage Changed *(DD/MM/YYYY)*

D. Surgery or Hospitalization Information

Please list any surgery or hospitalization you have had in the past two years.

Condition	Surgery/Hospitalization	Date *(DD/MM/YYYY)*

E. Declaration

I declare the statements made herein are true and complete and shall form part of the application for coverage. I authorize Group Medical Services: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b) for the purposes of administering my Group Benefits Program; and (b) for the purposes of determining my eligibility for benefits under my Group Benefits Program, to obtain information from, or provide information to: the government health plan in my province of residence; the operator of any hospital, clinic or other health care facility; a physician or other health care provider; any insurance company; or any other service provider as may be required. I understand that any misrepresentation, incorrect information or failure to fully complete all sections of the application may void my coverage. I understand that this application for coverage is not considered to be accepted until written confirmation is received from Group Medical Services.

Signature	Date *(DD/MM/YYYY)*
X	