ContinYou™

JG25-CY

EVIDENCE OF INSURABILITY

General Information

Covered Individual's Name _____ Date of Birth _____ YYYY/MM/DD

Home Address _____ ❑ Female ❑ Male

City _____ Province _____ Postal Code _____ Phone (_____) _____

Applying for coverage for ❑ Myself ❑ Myself AND my spouse ❑ Myself AND my dependents ❑ Myself AND my spouse AND my dependents

Spouse Information (Completed by the Spouse, if applying for coverage)

Last Name _____ Date of Birth _____ YYYY/MM/DD

Given Name(s) _____ ❑ Female ❑ Male

Dependent Coverage (Completed when applying for dependent coverage)

Last Name _____ Date of Birth _____ YYYY/MM/DD

Given Name(s) _____ ❑ Female ❑ Male

Last Name _____ Date of Birth _____ YYYY/MM/DD

Given Name(s) _____ ❑ Female ❑ Male

Last Name _____ Date of Birth _____ YYYY/MM/DD

Given Name(s) _____ ❑ Female ❑ Male

Health Declaration (All questions must be completed)

Please check box if any person for whom application is being made (including yourself, spouse and dependents) has been advised, counseled, tested, diagnosed, treated, hospitalized, or recommended for treatment within the last 5 years for the following: (If you answer "YES" to any question, please circle the condition to which you are referring.)

MYSELF

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

SPOUSE

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

CHILD

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

		MYSELF	SPOUSE	CHILD
1.	Do you or any of your dependents have any physical defect or infirmity?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2.	Have you or any of your dependents suffered from any recurring illness or injury, whether or not medical attention was sought?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3.	Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4.	Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

PLEASE COMPLETE THE INFORMATION ON NEXT PAGE

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EVIDENCE OF INSURABILITY (CONTINUED)

Details to Health History (Give details on each item checked "Yes" above)

Question Number	Person Affected	Condition/ Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates From / To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Johnston Group Inc. and The Co-operators to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/ persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.johnstongroup.ca.

A photocopy of this authorization is as valid as the original.

Employee's Signature _____ Date _____

NATIONAL SERVICE CENTRE, 1051 King Edward Street, Winnipeg, MB R3H 0R4
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