Declaration of Insurability

ALBERTA RETIRED TEACHERS' ASSOCIATION

Allianz Global Assistance

Travel insurance is underwritten by CUMIS General Insurance Company, a member of the Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc.

How to complete this form

Please complete a separate form for **each** person that has been requested to complete and submit a detailed medical questionnaire:

- Answer all questions in all sections of this form. If you are unsure of any details pertaining to any medical questions, please discuss with your **physician** before completing this form.
- Applicant, legal guardian or power of attorney must sign and date the form.
- If you have any questions about this form, please contact Allianz Global Assistance's Underwriting Department by email at urgent.uw@allianz-assistance.ca Please allow 48 business hours for a response. Alternatively call 1-800-670-4467 x61107 to speak with the Underwriting Department between the hours of 8:30am -4:30pm EST from Monday to Friday.
- If your application is incomplete, missing information, or not signed and dated on page 3, it may cause delays in processing your application.

General information

Name of Plan sponsor: **Alberta Retired Teachers' Association** Group Plan #: **FC310040**

Name of member:

Member's address

City: Province: Postal Code:

Home telephone: Mobile telephone:

Best to Contact ☐ Home ☐ Mobile ☐ a.m. ☐ p.m. ☐ evening

Email Address:

Name of applicant: ☐ Member ☐ Spouse ☐ Child

Date of Birth Day: Month: Year:

Height: ft in or cm Weight: lb kg

Name and address of your family physician or medical facility

City: Province: Postal Code:

Date and reason for last consultation:

Describe the symptoms that motivated this consultation:

Result:

Tests ordered:

Future tests recommended? ☐ Yes ☐ No Treatment or medication prescribed? ☐ Yes ☐ No

1. Indicate whether you ever had symptoms, been told you have symptoms, sought medical attention or received treatment for any of the following:

a)	Eye, ear, nose or throat disorders;	☐ Yes ☐ No
b)	Dizziness, fainting, convulsions, epilepsy, headaches, paralysis, paresthesia, numbness, neurological condition, meningitis, motor neuron disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Alzheimer's disease, Parkinson's disease, degenerative disease;	☐ Yes ☐ No
c)	Shortness of breath, persistent hoarseness or cough, coughing up blood, chronic bronchitis, pleurisy, asthma, emphysema, sleep apnea or other respiratory disorders;	☐ Yes ☐ No

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d)	Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, angina, cardiomyopathy, heart enlargement, pulmonary hypertension, abnormal ECG, stroke (CVA), transient ischemic attack (TIA), cardiac arrhythmia, peripheral vascular disease, ankle swelling, phlebitis or any other disorders of the heart or blood vessels;	☐ Yes ☐ No
e)	Hepatitis, carrier of hepatitis, cirrhosis, jaundice, intestinal bleeding, ulcer, colitis, ulcerative colitis, Crohn's disease, ileitis, diverticulitis, or other disorders of the esophagus, stomach, intestine, liver or pancreas;	☐ Yes ☐ No
f)	Sugar, blood, pus or protein in urine, stones or other disorders of the kidneys, bladder, prostate, testicles or reproductive organs, sexually transmitted disease, breast disorder including lumps, cysts, other physical changes or abnormal mammogram findings or biopsy;	☐ Yes ☐ No
g)	Diabetes, thyroid, high cholesterol or other endocrine disorders;	☐ Yes ☐ No
h)	Anxiety, depression, burnout or other psychiatric, psychological or nervous disorders, chronic fatigue syndrome, fibromyalgia, insomnia, mental retardation or other mental disorders;	☐ Yes ☐ No
i)	Lupus, scleroderma, muscular dystrophy, neuritis, arthritis, rheumatism, gout or other disorders of the bones or muscles, including the spine, back, neck and joints;	☐ Yes ☐ No
j)	Physical deformity, amputation, lameness or disability;	☐ Yes ☐ No
k)	Cancer or tumor, cyst, polyp, mole, mass or growth, lump, skin or lymph gland disorders;	☐ Yes ☐ No
l)	AIDS, positive HIV screening test or AIDS-related complex (ARC), positive result for a hepatitis B or C sceening test, anemia, immunodeficiency or other blood disorders;	☐ Yes ☐ No
m)	Any mental or physical disorder not mentioned above.	☐ Yes ☐ No

2. Within the past 5 years, have you:

a)	consulted a chiropractor, physiotherapist, psychologist, acupuncturist, audiologist, speech therapist, osteopath, podiatrist or any other health care professionnal?	☐ Yes ☐ No
b)	had an electrocardiogram (resting or stress), echocardiogram, X-Ray, MRI, blood test, biopsy or any other test?	☐ Yes ☐ No
c)	been a patient in a hospital or a clinic?	☐ Yes ☐ No

3. Are you currently taking any medications, receiving any treatment(s) or following a special diet? ☐ Yes ☐ No

4. Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done, which was not completed?
☐ Yes ☐ No

5. Do you have any signs or symptoms for which you have not sought treatment or consulted a doctor? ☐ Yes ☐ No

Please provide details for any question answered "YES" in questions 1 to 5. If additional space is required, please attach a separate sheet duly dated and signed.

Question #	Nature of disorder	Date of first occurrence	Frequency of episodes	Medication / Treatment	Date of recovery or current status

6. Within the past 12 months, have you used tobacco products such as cigarette, cigar, cigarillo or pipe or smoked drugs? ☐ Yes ☐ No

7. Within the past 5 years, have you practiced a high-risk activity such as mountain climbing, parachuting, motor vehicle racing, hang-gliding, scuba diving, flying in an ultra-light or privately owned aircraft or other? ☐ Yes ☐ No

If yes, which activity: _____

Date of most recent participation: Day: _____ Month: _____ Year: _____

Do you still intend to participate in this activity? ☐ Yes ☐ No

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8. Has any application for insurance filled by you been refused or been modified or accepted with an extra premium or exclusion? ☐ Yes ☐ No

If yes, date: Day: Month: Year:

Reason:

Insurer:

Personal information protection

To safeguard the confidentiality of your personal information, Allianz Global Assistance opens an insurance file to hold information about your application for insurance and any claims you make.

Access to your file is restricted to those employees and agents of Allianz Global Assistance who must consult your file for underwriting, claims adjudication and claims audit purposes, and any other person you may authorize.

Your file is kept at Allianz Global Assistance offices. You may consult the personal information contained in your file, and have any errors or inaccuracies rectified, by making a request in writing to the Privacy Officer at privacy@allianz-assistance.ca.

Allianz Global Assistance will retain the personal information collected for a specified period of time and in a storage method appropriate with legal and our internal corporate requirements. Personal information will be securely destroyed following the expiration of the appropriate retention period. Individuals have a right to request to access or correct personal information we have on file by contacting the Privacy Officer at privacy@allianz-assistance.ca or by writing to:

Privacy Officer
Allianz Global Assistance
4273 King Street East
Kitchener, Ontario N2P 2E9

For a complete copy of Our Privacy Policy please visit www.allianz-assistance.ca.

Declaration

You declare that:

- The information you've provided in this questionnaire is truthful, complete and accurate.

You understand that:

- This questionnaire and the answers you provided are part of the insurance contract.
- If your medical status or any of your answers changes between the date you complete this questionnaire and effective date of your enrollment into the Plan, you must contact Allianz Global Assistance. Failure to do so may limit the amount of your claim payment or result in your claim being denied.
- Allianz Global Assistance will collect, use and/or disclose your personal information only to provide you with the insurance products and services you've requested, for other uses authorized by you, or as required by law.

You acknowledge that:

- If you misrepresent your medical status in this questionnaire, or if you don't disclose material information about your medical status, or if any of your answers are found to be incorrect or untrue, your coverage will be null and void, your claims won't be paid and your premium will be refunded, even if the material non-disclosure or inaccuracy is not related to the claim reported, and you will be solely responsible for all expenses related to your claim.
- This coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable.

Authorization

You authorize: Any organization or person that has records or knowledge of your health to give any and all information[1] regarding your health, medical history and treatment to CUMIS General Insurance Company, Allianz Global Assistance or their authorized representatives for the purpose of processing your file.

You understand and agree that:

- If you refuse or withdraw this authorization review of your application cannot be completed.
- A copy of this authorization and declaration is as valid as the original.

I HAVE READ AND UNDERSTOOD THE IMPORTANT INFORMATION IN THE DECLARATION & AUTHORIZATION STATEMENTS ABOVE ☐ Yes ☐ No

You must sign and date this questionnaire or it will be returned to you.

Signature of aplicant (Parent or guardian if for a child under age 18) Date

[1] IMPORTANT: Information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.