Paramedical Examination Report

500-5000 Yonge Street
Toronto, ON M2N 7J8

For Policy no. / Application no. ____________________

Instructions: When answering the health questions on this form, DO NOT provide information about any genetic tests you have taken or plan to take. A genetic test is a type of medical test which analyses DNA, RNA or chromosomes. You must however, provide information about all other types of medical tests.

1 Proposed insured

PLEASE PRINT IN BLOCK LETTERS

Mr. Mrs. Ms Miss Other ____________________

First name: ____________________ Last name: ____________________

Address: ____________________

Date of birth: ____________________ (DD/MM/YYYY) Sex at birth: Male Female Current smoking status: Smoker Non-smoker

2

Name of advisor or distributor requesting examination: ____________________

3

Family doctor/clinic (if no family doctor, please provide details regarding last doctor seen).

Do you have a family doctor or clinic that you use regularly?

yes no If ***"yes",*** give the name of the doctor and the name of the clinic.

Name of doctor/clinic: ____________________

Address: ____________________

Phone: ____________________ Date of last visit: (DD/MM/YYYY) ____________________

Reason for visit: ____________________

Results: ____________________

Treatment/Prescribed Medication: ____________________

Have you used any non-prescribed drugs or narcotics? yes no

Follow-up needed or scheduled (other than routine check-up): yes no If ***"yes",*** give details:

____

____

4

FOR QUESTIONS 4 TO 25, IF ANSWER IS "YES", PROVIDE ADDITIONAL INFORMATION

Has any family member listed below (whether living or deceased) ever suffered from, or is any family member listed below suffering from, high blood pressure, heart disease, stroke, cancer (specify type), diabetes, polycystic kidney disease, mental illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), motor neuron disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease or any other hereditary disease?

yes no If ***"yes",*** provide details:

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

5

In the last 5 years, have you consulted any medical advisors other than as identified above?

yes no If ***"yes",*** provide details:

____

____

____

6 a) Are you being treated or followed by any medical advisor not mentioned on the previous page?
yes no If ***"yes",*** provide details:

b) Are you taking herbal, holistic or prescribed medication not mentioned on the previous page?
yes no If ***"yes",*** provide name, dosage and reason:

7 Have you ever had, or ever been told you had, or received treatment or advice for:

a) **Heart and circulatory system:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Heart	Blood vessels	Chest pain	Shortness of breath	Palpitations	Irregular pulse
Angina	High blood pressure	Heart attack	Stroke	Transient Ischemic Attack (TIA)	Rheumatic Fever
Murmur	Poor circulation	Abnormal ECG	Bypass	Angioplasty	High cholesterol levels
Aneurysm	Arteriosclerosis	Peripheral vascular disease	Blood clot	Congenital heart disorder	Any other disease or disorder

b) **Eyes, ears, nose, throat, lungs, respiratory system:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Lungs	Nose	Throat	Shortness of breath	Persistent cough	Hoarseness	Blood spitting
Chronic bronchitis	Emphysema	Asthma	Tuberculosis	Chronic obstructive pulmonary disease	Sleep apnea	Sarcoidosis
Blindness	Optic neuritis	Other visual disturbance	Deafness	Persistent fever	Any other disease or disorder	

c) **Gastrointestinal system:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Digestive organs	Ulcer	Bleeding	Recurrent indigestion	Celiac disease
Ulcerative colitis	Colitis	Crohn's disease	Hepatitis	Hepatitis carrier
Jaundice	Cirrhosis of the liver	Gastrointestinal problem	Persistent or chronic diarrhea	Inflammatory bowel disease
Any other disease or disorder				

d) **Kidney, bladder and reproductive organs:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Kidney	Bladder	Prostate	Genital organs	Urinary organs
Nephritis	Abnormal pap	Sexually transmitted disease	Abnormal sugar level	Abnormal protein levels
Blood in the urine	Abnormality in the urine	Elevated Prostate Specific Antigen (PSA)	Any other disease or disorder	

e) **Nervous system and brain:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Chronic headaches	Epilepsy	Dizziness	Chronic fatigue	Motor neuron disease	Muscular dystrophy
Memory loss	Alzheimer disease	Paralysis	Loss of sensation	Loss of balance	Hereditary disorder
Weakness of the extremities	Numbness or tingling	Neuritis	Neuropathy	Multiple sclerosis	Any congenital abnormality
Parkinson's disease	Meningitis	Coma	Cerebral palsy	Down syndrome	Any other disease or disorder
Head or brain injuries	Loss of consciousness	Loss of speech	Seizure	Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)	

7 *Continued*

f) **Blood, glandular and endocrine system:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Anemia | Enlarged glands | Diabetes | Abnormal blood sugar | Hormone disorders
Thyroid | Adrenal disorder | Pituitary gland disorder | Tumour | Breast disorder
Abnormal mammogram | Abnormal ultrasound | Biopsy of the breast | Persistent anemia | Hemophilia
Disorder of the endocrine system | Any other disease or disorder

g) **Nervous, mental or mood disorder:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Anxiety | Stress | Burnout | Depression | Bipolar disorder
Schizophrenia | Suicide attempt | Suicide ideation disorder | Behavioural disorder | Eating disorder
Emotional disorder | Cognitive impairment | Developmental handicap | Attention deficit disorder (ADD) | Autism
Any other disease or disorder

h) **Back, muscles and bones:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Arthritis | Paralysis | Deformity | Fibromyalgia | Osteoarthritis
Rheumatoid arthritis | Repetitive strain injury | Other conditions causing limited motion | Any other disease or disorder

i) **Immune system:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

An immune deficiency syndrome | AIDS | Test results indicating exposure to the virus causing AIDS (HIV)
Lupus | Scleroderma | Any other disease or disorder

j) **Tumours or growths:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Cancer | Cyst | Tumour | Melanoma | Lymphoma
Leukemia | Polyp | Any other disease or disorder

k) **Skin disorders:** yes no If ***"yes",*** select appropriate box(es) and provide details below.

Psoriasis | Skin sores | Ulcer | Mole | Dysplastic nevus syndrome | Any other disease or disorder

8 a) Are you or have you experienced any symptoms, complaints or persistent undiagnosed pain, for which you have not yet sought treatment or consultation? yes no If ***"yes",*** provide details.

b) Have you been advised to have treatment, consultation, or medical testing which has not yet been completed or for which you have not yet received the results? yes no If ***"yes",*** provide details.

9 In the last 5 years, have you ever had or been recommended to have any of the following tests:
yes no If ***"yes",*** select appropriate box(es) and provide details below.

Computer Tomography Scan (CT Scan) Coronary calcium scan Magnetic Resonance Imaging (MRI) Electrocardiogram X-ray Any other diagnostic test

10 Have you ever applied for or received a pension, disability benefit or any compensation because of an illness, injury or surgery not yet completed? yes no If ***"yes",*** provide details.

11 Have you been absent from work? *(Select and complete appropriate box(es) and provide details below.)*

For more than 7 days in the last 6 months because of sickness or injury? yes no If ***"yes",*** provide details.

For more than 2 weeks due to disability in the last 24 months? yes no If ***"yes",*** provide details.

12 In the past 10 years have you used any sedative, tranquilizer, heroin, morphine, cocaine, barbiturates, amphetamines, LSD, marijuana or any depressants, ecstasy, stimulants or hallucinogenic, narcotic or any other habit-forming or illicit drug(s)?
yes no If ***"yes",*** complete the table below.

TYPE	QUANTITY	FREQUENCY	DATE OF LAST USE (DD/MM/YYYY)
		day week month year single use	
		day week month year single use	
		day week month year single use	
		day week month year single use	

13 Do you drink alcohol? yes no If ***"yes",*** complete the table below.

TYPE	NUMBER/AMOUNT		FREQUENCY PER
Beer		Bottles per	day week month year occasionally/socially
Wine		Glasses per	day week month year occasionally/socially
Liquor		oz ml per	day week month year occasionally/socially

14 Have you ever decided to or been advised to decrease consumption of alcohol or drugs, or ever received, or been advised to receive, counselling or treatment for drug dependency or the use/abuse of alcohol or chemicals?
yes no If ***"yes",*** provide details and ***Date of last use***: (DD/MM/YYYY) ____________________

15 Have you smoked or used any of the products listed in the table below? yes no If ***"yes,"*** complete the table below.
in the last 12 months? in the last 24 months?

PRODUCTS	QUANTITY	FREQUENCY
Cigarettes		day week month year single use
Cigarillos		day week month year single use
Electronic cigarette		day week month year single use
Pipe		day week month year single use
Shisha/Hookah (water pipe/spiritual pipe)		day week month year single use
Traditional large cigars/small cigars		day week month year single use
Chewing tobacco		day week month year single use
Betel nuts		day week month year single use
Snuff		day week month year single use
Nicotine patch		day week month year single use
Nicorette chewing gum		day week month year single use
Marijuana/Hashish (joints/consumption)		day week month year single use
Any other smoking cessation products, or used tobacco in any other form		day week month year single use

16 Height (without shoes) ___________ ft. __________ins. __________ cms Did you measure? yes no
Weight (house clothing) ___________ lbs. ________ kgs Did you weigh? yes no

17 Weight change other than as identified above in past 12 months: yes no If ***"yes,"*** provide additional information below:
Gain ___________ lbs. ___________ kgs Loss ___________ lbs. ___________ kgs
Reason: ______________________________

18 Girth of bared chest (males only) Full inspiration: ____________ Girth of abdomen at umbilicus Full expiration: ____________

19 Blood pressure (sitting without exercise). Repeat at end of examination if over 140/90.

READINGS	FIRST	SECOND	FINAL
Systolic	mm	mm	mm
Diastolic (at cessation of sound)	mm	mm	mm

20

PULSE	RATE	IRREGULARITIES
a) At rest		
b) Recheck 5 minutes later if: i) initial rate is 90 or higher; or ii) there are irregularities		

21 If female, is proposed insured menstruating? yes no

22 Tests performed and/or specimens sent under separate cover:

Resting ECG	Urine specimen **DYNACARE** bar code:
Stress ECG	Blood specimen **DYNACARE** bar code:

23 Was a third party, such as a translator, present during the examination?
yes no If ***"yes,"*** please indicate why and relationship to the proposed insured.

____

____

24 Has the identity of the person to be examined been verified? yes no If ***"yes,"*** provide details below.
Please refer to an original identification with photo I.D of a non-expired passport, driver's licence, Canadian citizenship, age of majority or Canadian Armed Forces.

IDENTIFICATION DOCUMENT	IDENTIFICATION DOCUMENT NUMBER	ISSUING JURISDICTION	EXPIRY DATE (MM/YYYY)

Examiner/Health Practitioner information

Paramedical Order no.

Name (please print first name, last name)

Signature | Designation

Address:

City | Province | Postal code

Name of service provider

NOTICE: Please make sure that you have read your insurance application along with its Notice of Disclosure page carefully and that you fully understand all of it. Once we receive your insurance application, we will assess your eligibility as a Proposed Insured. We base this eligibility on the information you provide to us in your insurance application as well as information from other sources which may include, but is not limited to, medical history, physical condition, occupation, lifestyle and financial situation. Once we have determined the degree of risk, we will let you know if the insurance you applied for can be issued.

DECLARATION

I, the Proposed Insured, declare the above answers and statements that I gave in connection with this Paramedical Exam Report from *ivari* are full, complete and true and shall form part of the evidence of insurability in respect to my insurance application (or for reinstatement of, or change in my present insurance) with *ivari*.

PERSONAL INFORMATION AUTHORIZATION

I authorize a representative of *ivari* to perform such tests, examinations, x-rays, electrocardiograms, blood or urine tests as may be required by *ivari*. I understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus, the presence of medications, drugs, nicotine or their metabolites. *ivari* may release the results of these tests and all examinations to my personal physician(s).

For the purposes of risk assessment, investigation and loss analysis, I, the Proposed Insured, hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the MIB, Inc. or any other organization, institution, association or person that now has or may in future have any records or knowledge concerning me or my health to give *ivari*, its authorized representatives and its reinsurers any such information upon the request of *ivari*. I further authorize *ivari* to release medical information to my usual medical advisor.

ACKNOWLEDGEMENT

I acknowledge that the information collected from the above sources is to be used for the following purposes: evaluating, assessing and investigating my insurance application and your insurance risks; evaluating my insurance; administering and servicing the insurance and/or financial products you provide to me.

I understand and agree that this document forms part of my insurance application and that my personal information may be shared with the entities and persons identified above for the purposes of obtaining the information required, and it may otherwise be shared with or disclosed to managing general agencies, distributors and market intermediaries and their employees and agents and your independent advisors for purposes identified above.

If necessary, my personal information may also be shared with my beneficiaries in relation to a claim.

CONSENT

I hereby consent to the disclosure of my personal information as authorized and acknowledged above.

A photocopy of this Authorization shall be as valid as the original.

Signed at (city) ______________ in the province of ______________ on ______________ (DD/MM/YYYY)

Sign here ______________ **Proposed Insured**

Sign here ______________ **Examiner/Witness**

IF PROPOSED INSURED IS A MINOR THE SIGNATURE OF A PARENT OR LEGAL GUARDIAN IS REQUIRED

500-5000 Yonge Street, Toronto, ON M2N 7J8 • ivari.ca

™ ivari and the ivari logos are trademarks of ivari Holdings ULC. ivari is licensed to use such marks.