



GROUP HEALTH STATEMENT

For Employees and Dependants aged 15 or older.

A separate form must be completed by the Employee or Dependand.

Please answer all questions. Please give complete details of all "Yes" answers in questions 1-5, and 9-11.

Please give complete details if your answer is "No" to question 12. Please state diagnoses, results, dates, and names of all attending physicians and medical facilities in table on the next page. Any changes or corrections MUST be initialled.

| | | | |
|---|-----------------------|---------------------------------|--------------------------|
| Company Name / Stamp | | Group Policy No. | Certificate No. |
| Employee's Last Name | Employee's First Name | Maiden Name (if applicable) | Employee's Address |
| Name of Personal Physician or Doctor last visited | | Physician's Address | Physician's Office Phone |
| Date of Last Visit | Reason and Results | Treatment/Medication Prescribed | |

Complete this section if form is being completed on behalf of the Dependand

| | | | |
|-----------------------|------------------------|-----------------------------|--------------------------|
| Dependand's Last Name | Dependand's First Name | Maiden Name (if applicable) | Relationship to Employee |
|-----------------------|------------------------|-----------------------------|--------------------------|

Details of Employee or Dependand

| | | | | | | |
|------------------------------|---------------------------|-------------------------|--------|-----|---|----------------|
| Birth date DD / MM / YYYY | Birthplace Country | Height | Weight | | Weight Change in Past Year | |
| | | Cm. Ft. Ins | Kilos | Lbs | <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> None | Kilos Lbs |

1. Have you Yes No
 - (a) ever applied for or received benefits, compensation or pension because of sickness or injury?
 - (b) been absent from work because of sickness or injury during the last six months?
 - (c) undergone treatment for alcoholism or drug habit?
 - (d) any condition for which medical treatment or consultation is contemplated or has been advised?

2. Have you ever consulted a physician been treated for, or ever had any known indication of (underline illness if "Yes"):
 - (a) Disorder of Eyes, Ears, Nose or Throat?
 - (b) Dizziness, Fainting, Convulsions, Headaches, Speech Defect, Paralysis, Stroke or Transient Ischemic Attack (T.I.A), Epilepsy, Depression, Alzheimer's, Parkinson's, Tremor, Motor Neuron Disease, Multiple Sclerosis, Coma, Mental or Nervous Disorder?
 - (c) Shortness of Breath, Persistent Hoarseness or Cough, Blood Spitting, Bronchitis, Pleurisy, Asthma, Emphysema, Tuberculosis, Sleep Apnoea or Chronic Respiratory Disorder?
 - (d) Chest Pain, Palpitation, High Blood Pressure, Rheumatic Fever, Angina, Irregular Pulse, Elevated Cholesterol, Abnormal ECG, Heart Murmur, Heart Attack or Other Disorders of the Heart or Blood Vessels or Circulatory System?
 - (e) Jaundice, Intestinal Bleeding, Ulcer, Hernia, Appendicitis, Colitis, Diverticulitis, Haemorrhoids, Recurrent Indigestion, Intestinal Polyps, GERD, Crohn's, Diarrhoea or Other Disorders of the Stomach, Intestines, Liver or Gallbladder, Colon Polyps, Hepatitis?
 - (f) Sugar, Albumin, Blood or Pus in Urine, Sexually Transmitted Disease including Hepatitis B; Stone, Cysts or Other Disorders of the Kidney, Bladder, Prostate or Reproduction Organs?
 - (g) Diabetes; Thyroid, Pancreas, Glandular Disorder, or Other Endocrine Disorders?
 - (h) Neuritis, Sciatica, Rheumatism, Arthritis, Gout, Lupus, Fibromyalgia, Chronic Fatigue or Disorder of the Muscles or Bones, including the Spine, Back or Joints?
 - (i) Deformity, Physical Impairment, Lameness, Back or Limb disorder or Amputation?
 - (j) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or any immunological disorder, Positive HIV test?
 - (k) Sickle Cell Disease or Trait, Other Anaemia, Allergies or Other Blood Disorders?
 - (l) Cancer, Tumour, Cyst, Polyp, Lump, Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, Unusual Skin Lesions, Discharge, Unexplained Infections, or any Other Malignancy?
 - (m) Any Breast Disorder, including Swelling, Cysts, Unusual Changes, Lesions, Discharge or Abnormal Mammogram or Ultrasound?
 - (n) Do you have any Tattoos or Multiple Body Piercings?

3. Have you ever used or dealt in Barbiturates, Narcotics or other Drugs, Excitants or Hallucinogens, Marijuana, except as Medication prescribed by a Physician? (*If "Yes", kindly complete a Drug Usage Questionnaire*)

4. Are you now under observation or taking treatment including alternative therapy, herbal or special diet?

5. Other than the above, have you within the past 5 years
 - (a) Had any Mental or Physical Disorder not listed above?
 - (b) Had a Check-up, Consultation, Illness, Injury, Operation or Same Day Surgery?
 - (c) Been a patient in a Hospital, Clinic, Sanatorium or other Medical Facility?
 - (d) Had an ECG, Xray, Colonoscopy, Ultrasound, PSA or other Diagnostic Tests?
 - (e) Been advised to have any Diagnostic Test, Hospitalization or Surgery which was NOT completed?

6. Have you ever used alcoholic beverages? (*If yes, please give details in the table below*)

| | Stout/Beer (# of bottles) | Wine (# of glasses) | Liquor (# of drinks) |
|---------|---------------------------|---------------------|----------------------|
| Daily | | | |
| Weekly | | | |
| Monthly | | | |

7. Within the last 12 months, have you used any product containing tobacco, cigar, pipe, nicotine, including tobacco cessation products? (*If "Yes", kindly complete a Smoking Questionnaire*)



