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A- IDENTIFICATION

 PARTICIPANT'S NAME: _____ FIRST NAME: _____ GROUP NO.: _____
 (Maiden name if applicable)
 ADDRESS: _____ EMPLOYER NO.: _____
 No. Street Apt. City Postal code
 CURRENT POSITION (employment): _____ IDENTIFICATION No.: _____ DAYTIME PHONE NO.: () -

B-	Surname (Maiden name if applicable)	Given name	Date of birth			Height	Current weight	Weight one year ago
			Year	Month	day	Ft. in./cm	Lbs/kilo	Lbs/kilo
PARTICIPANT:	_____	_____	_____	_____	_____	_____	_____	_____
DEPENDENT'S PARTICIPATION (FAMILY OR SINGLE PARENT COVERAGE)								
SPOUSE:	_____	_____	_____	_____	_____	_____	_____	_____
CHILD:	_____	_____	_____	_____	_____	_____	_____	_____
CHILD:	_____	_____	_____	_____	_____	_____	_____	_____
CHILD:	_____	_____	_____	_____	_____	_____	_____	_____

C- MEDICAL QUESTIONNAIRE
IMPORTANT: ANSWER ALL QUESTIONS AND PROVIDE DETAILS REQUESTED UNDER SECTION "D" ON REVERSE SIDE, IF NECESSARY.

HAVE ANY OF THE PERSONS TO BE INSURED	PARTICIPANT		SPOUSE		CHILDREN		FIRST NAME
	YES	NO	YES	NO	YES	NO	
1) CURRENTLY BEEN ABSENT FROM THEIR ORDINARY OCCUPATIONS OWING TO CONVALESCENCE, ILLNESS OR INJURIES, OR HAVE BEEN OVER THE LAST THREE YEARS? DATE: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) BEEN REFUSED, HAD AN INSURANCE APPLICATION MODIFIED OR ACCEPTED WITH AN EXTRA INSURANCE PREMIUM? DATE: _____ CO.: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) PRACTISED OR INTEND ON PRACTISING A PROFESSIONAL SPORT OR A LEISURE ACTIVITY PRESENTING A RISK? PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) BEEN TAKING MEDICATION OR HOMEOPATHIC MEDECINES? NAME: _____ OTY/DAY: _____ REASON: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) BEEN TAKING OR HAVE ALREADY TAKEN DRUGS OR NARCOTICS? TYPE: _____ DATE OF MOST RECENT CONSUMPTION: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) BEEN SHOWING SIGNS OF PHYSICAL ABNORMALITIES OR MENTAL ILLNESSES OR ACCIDENT AFTERMATHS? PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) BEEN SUFFERING OR HAVE ALREADY SUFFERED FROM AN ILLNESS OR SHOWN SIGNS OF A HEALTH PROBLEM? DATE: _____ PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8) BEEN CONSULTING OR PLANNING ON CONSULTING A <i>PHYSICIAN</i> OR UNDERGOING AN OPERATOR OR HAVE BEEN NOTIFIED TO SUCH EFFECT? PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9) BEEN CONSULTING OR ARE PLANNING ON CONSULTING SOME <i>OTHER HEALTH CARE PROFESSIONAL OR A THERAPIST</i> , INCLUDING IN ALTERNATE MEDECINES? PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) OVER THE PAST 5 YEARS CONSULTED A PHYSICIAN, THERAPIST OR OTHER HEALTH PROFESSIONAL, INCLUDING IN ALTERNATE MEDECINES, OR BEEN ADMITTED TO A HOSPITAL OR OTHER HEALTH CARE INSTITUTION? IF SO, REFER UNDER SECTION "D".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11) UNDERGONE OR BEEN ADVISED TO TAKE A TEST FOR DETECTING AIDS? DATE: _____ REASON: _____ RESULT: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



