Paramedical Examination Report

P.O. Box 4241, Station A
Toronto, ON M5W 5R3

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 24, 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/Cannabinoids/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 have given 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).

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 ("Sources") to give *ivari*, its authorized representatives and its reinsurers any such information upon the request of *ivari*. I authorize *ivari*, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I further authorize *ivari* to release medical information to my personal physician(s).

ACKNOWLEDGEMENT

I acknowledge, understand and agree that:

i) the information collected from the Sources will be used by *ivari* for the following purposes: evaluating my insurance application, servicing my policy and investigation and claim analysis.

ii) 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 the managing general agencies, distributors and market intermediaries and their employees with which my advisor is associated 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)

Proposed Insured | **Examiner/Witness**

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

ivari™ P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • ivari.ca