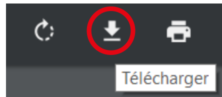
Steps to complete the form

1

Click on the download button for save the form on your computer.



2

Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE

HEALTH STATEMENT FOR DEPENDENTS

GROUP INSURANCE

EMPLOYER		GROUP	DIVISION	CERTIFICATE N^O
NAME	MAIDEN NAME		GIVEN NAME	

SPOUSE

SPOUSE'S NAME (MAIDEN NAME)		DATE OF BIRTH D M Y	PLACE OF BIRTH	SOCIAL INSURANCE N^O
HEIGHT ______ FT.IN. OR ______ CM	ACTUAL WEIGHT ______ LBS. OR ______ KG	WEIGHT ONE YEAR AGO ______ LBS. OR ______ KG	REASON FOR WEIGHT VARIATION	

CHILDREN

GIVEN NAME	DATE OF BIRTH D M Y	HEIGHT	ACTUAL WEIGHT
GIVEN NAME	DATE OF BIRTH D M Y	______ FT.IN. OR ______ CM	______ LBS. OR ______ KG
GIVEN NAME	DATE OF BIRTH D M Y	______ FT.IN. OR ______ CM	______ LBS. OR ______ KG
GIVEN NAME	DATE OF BIRTH D M Y	______ FT.IN. OR ______ CM	______ LBS. OR ______ KG
GIVEN NAME	DATE OF BIRTH D M Y	______ FT.IN. OR ______ CM	______ LBS. OR ______ KG

REASON FOR DEPENDENT COVERAGE

☐ MARRIAGE ☐ COHABITATION ☐ LOSS OF EMPLOYMENT SPECIFY DATE : DAY ______ MONTH ______ YEAR ______

☐ OTHER, SPECIFY : ______

INFORMATION CONCERNING YOUR SPOUSE AND CHILDREN

		SPOUSE YES	SPOUSE NO	CHILDREN YES	CHILDREN NO	GIVEN NAME
1.	DOES YOUR SPOUSE HAVE ANY FAMILY MEMBERS (PARENTS, GRANDPARENTS, UNCLES, AUNTS) WITH DIABETES, CANCER, TUBERCULOSIS, HIGH BLOOD PRESSURE, HEART DISEASE OR MENTAL DISORDERS ?	☐	☐	☐	☐	______
2.	DOES YOUR SPOUSE OR ANY OF YOUR CHILDREN SUFFER FROM OR HAVE SUFFERED FROM ANY ILLNESS, INJURY OR PHYSICAL OR MENTAL DISABILITY ?	☐	☐	☐	☐	______
3.	IN THE LAST FIVE YEARS, HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN BEEN EXAMINED, CONSULTED OR TREATED BY A PHYSICIAN OR ANY OTHER PRACTITIONER ?	☐	☐	☐	☐	______
4.	HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER RECEIVE ANY TREATMENT IN THE HOSPITAL, CLINIC, IN A SANITARIUM, ETC ?	☐	☐	☐	☐	______
5.	DOES YOUR SPOUSE OR ANY OF YOUR CHILDREN PRESENTLY RECEIVE ANY TREATMENT FROM A PHYSICIAN OR TAKE ANY MEDICATION ?	☐	☐	☐	☐	______
6.	HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER BEEN TREATED FOR ALCOHOL OR DRUG ADDICTION ?	☐	☐	☐	☐	______
7.	HAS YOUR SPOUSE OR ANY OF YOUR CHILDREN EVER RECEIVE OR REQUEST A PENSION OR INDEMNITY FOR BODILY INJURY OR DISABILITY ?	☐	☐	☐	☐	______

8. IS YOUR SPOUSE PREGNANT? YES ☐ NO ☐ IF YES, SPECIFY DELIVERY DATE DAY ______ MONTH ______ YEAR ______

IF YOU HAVE ANSWERED YES FOR ANY OF THE PRECEEDING QUESTIONS, GIVE DETAILS IN THE EXPLANATIONS SECTION BELOW

EXPLANATIONS

QUESTION NUMBER	GIVEN NAME OF THE CONCERNED PERSON	DATE	TERM		ILLNESS, SURGERY, EXAMS, TESTS, CONSULTATIONS, TREATMENTS, MEDICATION, RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL
			HOSPITAL	ILLNESS		

I CERTIFY THAT ALL THE INFORMATION GIVEN IN THIS HEALTH DECLARATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND ARE PART OF MY REQUEST FOR INSURANCE.

DATE	X EMPLOYEE'S SIGNATURE	X SPOUSE'S SIGNATURE
	X SIGNATURE OF CHILDREN AGES 14 YEARS AND MORE	X WITNESS

NOTICE TO INSURED

ALL INSURANCE COMPANIES INCLUDING **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS MAY AT TIMES REQUEST AN INVESTIGATIONREPORT WITH RESPECT TO THEIR STANDARDS IN PROCESSING AN APPLICATION.
THE INFORMATION CONCERNING YOUR INSURABILITY WILL BE TREATED CONFIDENTIALLY. HOWEVER **UL MUTUAL** AND ITS REINSURERS MAY COMMUNICATE A SUMMARY TO THE MEDICAL INFORMATION BUREAU, THE BUREAU IS A NON-PROFIT ORGANISATION FOR THE EXCLUSIVE USE OF ITS MEMBER LIFE INSURANCE COMPANIES WHOSE PURPOSE IS TO ALLOW ITS MEMBERS THE EXCHANGE OF INFORMATION. IF YOU HAVE MADE AN APPLICATION FOR LIFE OR HEALTH INSURANCE, OR SUBMITTED A DISABILITY CLAIM TO ONE OF THE MEMBER COMPANIES, THE BUREAU WILL PROVIDE, UPON REQUEST, THE INFORMATION CONTAINED IN THEIR FILES.
UPON REQUEST THE BUREAU WILL TRANSMIT ALL INFORMATION IT HAS ON YOU. SHOULD YOU CHALLENGE THE ACCURACY OF THE INFORMATION, YOU MAY REQUEST TO RECTIFY IT BY SENDING A REQUEST TO THE MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, TORONTO, ONTARIO M5G 1R7. TELEPHONE (416) 597-0590.
UL MUTUAL AND ITS REINSURERS MAY COMMUNICATE ALL INFORMATION THEY HAVE TO ANOTHER INSURANCE COMPANY THAT HAS RECEIVED AN APPLICATION FOR LIFE OR MEDICAL INSURANCE OR A DISABILITY CLAIM FROM YOU.

AUTHORIZATION

I HEREBY AUTHORIZE ANY HEALTH CARE PROFESSIONAL, HOSPITAL, CLINIC, PUBLIC OR PRIVATE HEALTH OR SOCIAL SERVICE ORGANISATION, OR ANY OTHER MEDICAL OR MEDICALLY RELATED FACILITY, THE MEDICAL INFORMATION BUREAU, FINANCIAL INSTITUTION, OTHER ORGANIZATION, INSTITUTE OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF ME, TO GIVE **UL MUTUAL (THE UNION LIFE MUTUAL ASSURANCE COMPANY)** AND ITS REINSURERS ANY SUCH INFORMATION.
I FURTHER AUTHORIZE **UL MUTUAL**, OR THIRD PARTY INVESTIGATION AGENCIES OR ORGANIZATIONS HIRED **UL MUTUAL** TO ACQUIRE INFORMATION ABOUT ME.
I CONSENT TO **UL MUTUAL** RELEASING THE RESULTS OF ANY TESTS, REPORTS AND PERSONAL INFORMATION GATHERED ABOUT ME TO ITS REINSURERS, IF INVOLVED IN THE UNDERWRITING, TO MY ATTENDING PHYSICIAN, TO THE MEDICAL INFORMATION BUREAU AND OTHER AUTHORIZED INSURERS, AND TO INQUIRE TO THEM FOR THE APPRAISAL OF THE RISK OR THE EVALUATION OF A CLAIM.
A REPRODUCTION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

DATE	X EMPLOYEE'S SIGNATURE	X SPOUSE'S SIGNATURE
	X SIGNATURE OF CHILDREN AGES 14 YEARS AND MORE	X SIGNATURE OF WITNESS

RETURN THE ORIGINAL AND CONSERVE THE COPY

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