RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, ON N3B 3B1
Fax: 519-669-1923

Group Health Evidence Form
Employee Application

Group/Div # ____________________

Certificate # ____________________

Insurer(s) ____________________

TO BE COMPLETED BY EMPLOYEE **Entire Application to be completed in ink. PLEASE PRINT**

Name of Employee				Phone Number:
Address of Employee No. & Street / City / Prov. / Postal Code				Work ( ) Home ( )
Name of policyholder/employer		Occupation		Are you Actively at Work? ○ Yes ○ No If No, why?
Date of Birth Day Month Year	Height		Weight	○ Male ○ Female

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?
   ○ No ○ Yes, If Yes, specify:

2. Have any of your parents, brothers or sisters had any hereditary disorder (e.g. Huntington's chorea, polycystic kidney disease, etc.)?
   ○ No ○ Yes, If Yes, specify:

	Yes	No
3. Have you ever consulted a physician or alternative healthcare provider (including herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which):		
a) Disorder of eyes, ears, nose, or throat?	○	○
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of the brain or nervous system?	○	○
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?	○	○
d) High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels?	○	○
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	○	○
f) Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system?	○	○
g) Hepatitis A, B, C, or "type unknown"?	○	○
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	○	○
i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome?	○	○
j) Leukemia, anemia, hemophilia, or any other disorder/abnormality of the blood?	○	○
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of pituitary, adrenals or other glands or unexplained infections?	○	○
l) Thyroid or other endocrine disorders?	○	○
m) Venereal disease or any other sexually transmitted disease or disorder of prostate or reproductive organs?	○	○
n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above?	○	○

Details of "Yes" answers:

Identify question number, circle applicable items.
Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

(CONTINUED OVER....)

	Yes	No	Details of "Yes" answers:
4. In the past ten years have you: a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions? b) Received advice or treatment in connection with any of the categories mentioned in 4.a)? c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	O O O	O O O	Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
5. Has an application for insurance on your life/health ever been declined, rated, or modified in any way?	O	O	When? Why? Company?
6. Do you currently have an individual life policy that has been issued within the last two years?	O	O	Issued by which insurance company?
7. Have you ever applied for or received a pension or Worker's Compensation or disability benefits because of illness or injury?	O	O	When? Why?
8. Have you lost any time from work during the last 12 months because of illness or injury?	O	O	When? Amount of time? Why?
9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated?	O	O	Give details and dates:
10. Are you receiving any other treatment/medication from any physician or alternative healthcare provider as previously not defined?	O	O	State type and frequency:
11. Female Applicant: a) Have you ever had any disease of the breasts, ovaries, cervix or uterus? b) Have any pregnancies or labours been abnormal? c) Are you pregnant? If "Yes" give expected delivery date.	O O O	O O O	
12. Do you now or have you ever used alcohol? If "Yes", complete the following: a) Frequency of use (daily, weekly, monthly) ______ b) Amount consumed on each occasion ______ c) Date last used ______	O	O	
13. Over the past three years have you ever had your driver's license suspended or revoked for any medical reason, or for driving under the influence of drugs or alcohol?	O	O	Reason:
14. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	O	O	
15. Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? If "Yes", complete the following: a) Type of drug ______ b) Frequency of use (daily, weekly, monthly) ______ c) Date last used ______	O	O	
16. Have you ever used any form of tobacco, nicotine products or substitutes (including nicotine patch and gum)?	O	O	For how long and how often? How long have you been smoking?

17. Who is your regular family physician? (If none, name Walk In Clinic used) ______

Address ______

Approximate date last seen ______ Reason/Outcome ______

RWAM Privacy Statement
RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.

Applicant Employee's Declaration and Authorization:

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this application and I declare that all such information and the information provided in this application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void my coverage. This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Employee Signature ______ **Date** ______

This form must be received at RWAM's office within 60 days of the date signed above. Otherwise a new form must be submitted.

RWAM Insurance Administrators Inc.
49 Industrial Drive,
Elmira, ON N3B 3B1
Fax: 519-669-1923

Group Health Evidence Form
Application for Dependents

Group/Div # ____________________

Certificate # ____________________

Insurer(s) ____________________

NAME OF EMPLOYEE ____

Entire Application to be completed in ink. PLEASE PRINT

Proposed Dependents To Be Insured	Date of Birth			Height	Weight
	Day	Month	Year		
Spouse:					
Child:					
Child:					
Child:					

	Yes	No	Details of "Yes" answers:
1. Is the employee Actively at Work? If "No", why? ______________________	O	O	Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
2. Do all the dependents named above reside with the employee? If "No", give details and identify each dependent.	O	O	
3. Was any child born prematurely?	O	O	Identify child: Premature by how many months? Birth weight?
4. Is any child less than one year old?	O	O	Identify child: Birth weight?
5. Has any dependent ever consulted a physician or alternative healthcare provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc) for, or ever had any condition of (please specify which):			
a) Disorder of eyes, ears, nose, or throat?	O	O	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of the brain or nervous system?	O	O	
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?	O	O	
d) High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels?	O	O	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	O	O	
f) Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system?	O	O	
g) Hepatitis A, B, C, or "type unknown"?	O	O	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	O	O	
i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome?	O	O	
j) Leukemia, anemia, hemophilia, or any other disorder/abnormality of the blood?	O	O	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, disorder of pituitary, adrenals or other glands or unexplained infections?	O	O	
l) Thyroid or other endocrine disorders?	O	O	
m) Venereal disease or any other sexually transmitted disease or disorder of prostate or reproductive organs?	O	O	
n) Any other conditions, illnesses, diseases, injuries or operations not mentioned above?	O	O	

(CONTINUED OVER....)

	Yes	No	Details of "Yes" answers:
6. Female Dependents: a) Has any dependent ever had any disease of the breasts, ovaries, cervix or uterus? b) Have any pregnancies or labours been abnormal? c) Is any dependent pregnant? If "Yes" give expected delivery date.	O O O	O O O	Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
7. Does any dependent have any condition for which hospitalization or surgery has been advised or is contemplated?	O	O	Give details and dates:
8. Has any dependent ever had an application for insurance on their life/health declined, rated, or modified in any way?	O	O	When? Why? Company?
9. In the past ten years has any dependent: a) Had or been told they had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related conditions? b) Received advice or treatment in connection with any of the categories mentioned in 9.a)? c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	O O O	O O O	

10. Spouse's regular family physician (If none, name Walk In Clinic used): ______________________

Address ______________________

Approximate date last seen ______________________ Reason/Outcome ______________________

11. Name of Child: ______________________

Child's regular family physician (If none, name Walk In Clinic used): ______________________

Address ______________________

Approximate date last seen ______________________ Reason/Outcome ______________________

12. Name of Child: ______________________

Child's regular family physician (If none, name Walk In Clinic used): ______________________

Address ______________________

Approximate date last seen ______________________ Reason/Outcome ______________________

13. Name of Child: ______________________

Child's regular family physician (If none, name Walk In Clinic used): ______________________

Address ______________________

Approximate date last seen ______________________ Reason/Outcome ______________________

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Applicant Declaration and Authorization:

I declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me or my dependent(s), to release to and exchange with RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite this application for group insurance coverage, evaluate the eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I confirm that I am authorized to act on behalf of my dependent(s).

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request me or my dependent(s) to undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this application and I declare that all such information and the information provided in this application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the coverage. This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Date ______________________ **Employee Signature** ______________________

Date ______________________ **Spouse's Signature** ______________________

Date ______________________ **Child's Signature** (If age 16 or more) ______________________

Date ______________________ **Child's Signature** (If age 16 or more) ______________________

Date ______________________ **Child's Signature** (If age 16 or more) ______________________

Any expense incurred in providing this or additional information is the responsibility of the employee.

This form must be received at RWAM's office within 60 days of the date signed above. Otherwise a new form must be submitted.