ACFO–ACAF

MERCER
MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

LONG TERM CARE INSURANCE APPLICATION FORM

PROPOSED INSURED (Please print answers to all questions in ink.)

☐ New Application ☐ Request for Reinstatement

☐ Mr. ☐ Mrs. ☐ Ms. Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ Province _____ Postal Code _____ Telephone _____ Best time of day to call ☐ AM ☐ PM

Birthdate (DD/MM/YYYY) _____ Gender ☐ Male ☐ Female Language Preference ☐ English ☐ French

Affiliation of Applicant : ACFO - ACAF E-mail _____

Is your spouse also applying for coverage? ☐No ☐Yes If "Yes", Name of Spouse : _____

Please submit two separate applications together.

OWNER - IF OTHER THAN PROPOSED INSURED

Last Name _____ First Name _____ Middle Initial _____ Relationship _____

Billing Address _____

City _____ Province _____ Postal Code _____ Telephone _____

HEALTH QUESTIONNAIRE

SECTION A *(If any questions in Section A are answered 'Yes', we will not be able to offer coverage.)*

1. Do you currently:
   a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift ☐No ☐Yes
   b. Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence ☐No ☐Yes
   c. Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation ☐No ☐Yes
2. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or been advised to be treated for:
   a. Cancer which has spread from the original site or organ, Lymphoma or Multiple Myeloma ☐No ☐Yes
   b. Scleroderma, Systemic Lupus Erythematosus, Sarcoidosis or Cystic Fibrosis ☐No ☐Yes
   c. Platelet disorder, Hemophilia or Hemochromatosis ☐No ☐Yes
   d. Amputation due to disease or medical condition or organ transplant ☐No ☐Yes
   e. Ataxia, Transverse Myelitis, Myasthenia Gravis or Post-Polio Syndrome ☐No ☐Yes
   f. Alzheimer's Disease, memory loss, senility, dementia or Organic Brain Syndrome ☐No ☐Yes
   g. More than one stroke or Transient Ischemic Attack (TIA), or one of each ☐No ☐Yes
   h. Parkinson's Disease, Muscular Dystrophy, Huntington's Chorea, or Motor Neuron Disease ☐No ☐Yes
   i. Lou Gehrig's Disease (ALS), Demyelinating Disease or Multiple Sclerosis ☐No ☐Yes
   j. Dialysis, Renal Failure, Hepatitis, Liver Disease or Cirrhosis ☐No ☐Yes
   k. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex, AIDS related conditions or tested positive for HIV ☐No ☐Yes

3. If you currently use, or have used at any time in the past 24 months, any form of tobacco products, please answer the following question. If not, please proceed to Section B.

Do you have a history of being diagnosed with, treated for, or advised to be treated for, any of the following:

a. Chronic Obstructive Pulmonary Disease, Asthma or Emphysema or Lung Cancer ☐ No ☐ Yes

b. Carotid Artery Disease, stroke, Transient Ischemic Attack (TIA) or mini-stroke ☐ No ☐ Yes

c. Diabetes, Glucose Intolerance, Hypoglycemia or Hyperglycemia ☐ No ☐ Yes

d. Congestive Heart Failure, Peripheral Vascular Disease or Raynaud's Syndrome ☐ No ☐ Yes

If any questions in Section A are answered 'Yes', we will not be able to offer coverage.

SECTION B

1. Within the past 5 years (60 months), have you been diagnosed with, consulted a medical professional for, been treated for or been advised to be treated for:

a. Rheumatoid or Osteoarthritis, Degenerative Bone or Joint Disease or Osteoporosis ☐ No ☐ Yes

b. Degenerative Disc Disease, back or neck condition or surgery ☐ No ☐ Yes

c. Hip, knee, shoulder or other bone or joint condition or surgery, amputation ☐ No ☐ Yes

d. Cancer (other than skin), Leukemia, Melanoma or tumour ☐ No ☐ Yes

e. Diabetes, Glucose Metabolism Disorder, thyroid or other glandular problem ☐ No ☐ Yes

f. Emphysema, Chronic Bronchitis, Chronic Obstructive Pulmonary Disease ☐ No ☐ Yes

g. Asthma or any other lung or breathing condition ☐ No ☐ Yes

h. Epilepsy, seizures, convulsions, fainting or falls ☐ No ☐ Yes

i. Chronic fatigue, Chronic Fatigue Syndrome, Epstein-Barr Virus or Fibromyalgia ☐ No ☐ Yes

j. Heart attack, heart surgery, chest pain, Angina, Coronary Artery Disease or bypass surgery ☐ No ☐ Yes

k. Arrhythmia, palpitations or irregular heart beat ☐ No ☐ Yes

l. Circulatory or vascular disease or surgery, aneurysm, Carotid Artery Disease or surgery ☐ No ☐ Yes

m. Single episode of stroke, mini-stroke or Transient Ischemic Attack (TIA) ☐ No ☐ Yes

n. Paralysis, blindness, numbness, tremors, imbalance or condition causing limited motion ☐ No ☐ Yes

o. Mental or nervous disorders, psychosis, depression, anxiety or attempted suicide ☐ No ☐ Yes

p. Alcohol or drug overuse or abuse, Bulimia, Anorexia or other eating disorder ☐ No ☐ Yes

q. Any other condition not listed above ☐ No ☐ Yes

Please provide details of all "Yes" answers below. *(If additional space is required, please use a separate sheet of paper with your signature and date.)*

Condition	Date of diagnosis DD/MM/YYYY	Date of last symptom DD/MM/YYYY	Treating Physician	Treatment

SECTION C

1. What is your height: _____ ☐ cm ☐ ft/in

2. What is your weight: _____ ☐ kg ☐ lbs

3. Please provide the name, address and phone number of your primary care physician or the doctor who will have the most complete, up to date health history.

Doctor's Name	Address	Telephone

Date of last visit (DD/MM/YYYY)	Reason for last visit

4. Please provide the name, address and phone number of the doctor you have most recently consulted.

Doctor's Name	Address	Telephone

Date of last visit (DD/MM/YYYY)	Reason for last visit

5. Have you used any tobacco products including smoking cessation therapy in the past 24 months? ☐ No ☐ Yes

6. Do you consume alcoholic beverages? ☐ No ☐ Yes
   If "Yes," What type and how often?: _____

7. Have you ever been advised to limit or reduce your alcohol intake? ☐ No ☐ Yes
   If "Yes," When and why?: _____

8. Have you ever used cocaine, barbiturates, marijuana or any narcotic or habit forming drugs? ☐ No ☐ Yes
   If "Yes," When and for how long?: _____

9. Have you ever consulted a medical professional regarding or been advised to receive treatment for the use of any habit forming drugs, prescribed or non-prescribed? ☐ No ☐ Yes
   If "Yes," When and for how long?: _____

10. Other than the information provided previously, have you ever had any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment? ☐ No ☐ Yes

11. In the past 24 months, have you?:
    a. Received treatment in a nursing home, assisted living, rehabilitation or convalescent facility? ☐ No ☐ Yes
    b. Received any home health care, physiotherapy or adult day care services? ☐ No ☐ Yes
    c. Been advised to seek care in a hospital, nursing home, psychiatric facility, assisted living, rehabilitation or convalescent facility or any other health care facility? ☐ No ☐ Yes

    If "Yes," When and why?: _____

    _____

12. Please list all medications prescribed and/or taken in the past 24 months and provide the appropriate details as requested below.

Name of medication	Dose and frequency	Prescribing Doctor	Reason for taking	Date started (DD/MM/YYYY)	Date stopped (DD/MM/YYYY)

13. Have any of your natural parents, brothers, sisters, either living or dead, ever suffered from any of the following conditions: Polycystic Kidney Disease, Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Huntington's Chorea, Motor Neuron Disease, Muscular Dystrophy, Alzheimer's, dementia or any other form of inherited disease? ☐ No ☐ Yes
    If "Yes," please provide details as requested below.

Family Member	Condition	Age at Onset	Age (if living)	Age at Death	Cause of Death
Mother					
Father					
Sister(s)					
Brother(s)					

14. Do you now have (or have a pending application for) any other long term care/home care insurance coverage? ☐ No ☐ Yes
    If "Yes", please complete the following information:

    Company: _____ Policy Number: _____ Maximum Daily Benefit: $_____

PLAN SELECTION

Please choose ONE of the following lifetime maximum coverage options: ☐ $50,000 ☐ $100,000

PREMIUM PAYMENT OPTIONS

☐ Option 1: PRE-AUTHORIZED DEBIT (PAD) *(Attach a void cheque)* ☐ I have attached a void cheque.

I authorize ACE INA Life Insurance and the financial institution designated to begin deduction of premium for the Long Term Care Insurance Plan in the amount of $ _____ (Your monthly premium) to be charged on or about the first business day of each month to the account shown on the attached void cheque.

Signature: _____ Date: _____

Signature: _____ Date: _____

Secondary signature required on joint account.

I have waived the right to pre-notification at least 10 days before my first PAD; however ACE INA Life Insurance will send me written notice identifying the new amount at least 10 days before each and any change in the amount of my PAD, with the exception of a reduction in tax rate. I may revoke my authorization at any time in writing or by phone, subject to a 30 day notice. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any PAD does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

☐ Option 2: CREDIT CARD

I authorize premiums for the Long Term Care Insurance Plan to be charged to the following account: (Check one) ☐ VISA ☐ MASTERCARD

Account #: _____ Expiry Date: _____

Signature: _____ Date: _____

AUTHORIZATION OF DESIGNEE (OPTIONAL)

I designate the following Authorized Designee, other than myself to receive notice of lapse or termination of this long term care coverage for non-payment of premium. I understand that this notice will not be given until 10 days after a premium is due and unpaid.

Last Name _____ First Name _____ Middle Initial _____ Relationship _____

Mailing Address _____

City _____ Province _____ Postal Code _____ Telephone _____

DECLARATION AND AUTHORIZATION TO OBTAIN & RELEASE INFORMATION

USES OF YOUR PERSONAL INFORMATION: When you apply for coverage under the Long Term Care Insurance Plan ("Plan"), underwritten by ACE INA Life Insurance ("ACE"), the information in ACE's existing insurance files and the information requested in connection with your application is required by ACE, its reinsurers and authorized agents to process your application, and if approved, administer your insurance policy, assess coverage and claims. ACE will create a file with your information, and in the event of a claim, with such information as ACE obtains from you and other sources, for the purpose of considering your claim and administering benefits under the Plan. Access to this file will be restricted to those ACE employees, authorized agents and reinsurers who require access to administer the Plan and process claims and other persons where authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer; ACE INA Life Insurance, The Exchange Tower, 130 King Street West, 12th Floor, Toronto, ON M5X 1A6. From time to time there may be additional or enhanced ACE products or services available to you. The use of your personal information for the purposes of offering you such additional or enhanced products or services is entirely optional. If you do not wish your personal information to be used by ACE for this optional purpose, please tick here: ☐

YOUR DECLARATION: I hereby declare that the above answers and statements are complete and true and I understand that concealment, misrepresentation or false declaration concerning this application will cause any policy to be void. I understand and agree that any coverage issued as a result of this application shall not take effect until this application is approved by ACE INA Life Insurance.

YOUR AUTHORIZATION: I, the undersigned, authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance or reinsurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Life Insurance, or representatives thereof, all personal health information about me, or any other information or records about me, in connection with my application to ACE INA Life Insurance for insurance.

I agree that a photocopy or electronic copy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____ 20 _____

Applicant's Signature _____

Applicant's Name (Please Print) _____

MAILING ADDRESS: ACE Life Long Term Care, 14-50 Galaxy Blvd., PO Box 56368 STN B, Toronto, ON, M7Y9C1