Application for Critical • Choice • Care™

Policy No. 9227624

Saint Mary's University

Please answer all questions fully – it helps us to provide better service. Please print all your answers.

1. Name of Applicant _____ Sex: ☐ Male ☐ Female

   Name of Employee _____

2. Address _____
   Number & Street City Province Postal Code

3. Telephone ( ) _____ 4. Date of Birth D M Y _____

5. Amount of Insurance $ _____ 6. Occupation _____

7. a) Are you currently insured for Critical Illness Insurance? ☐ Yes ☐ No

   b) If "Yes", are you insured by AXA Assurances Inc.? ☐ Yes ☐ No

   i) If "Yes", is this application for ☐ a new policy ☐ an increase in coverage ☐ a decrease in coverage

   Existing Policy No. _____ Amount of coverage $ _____

   ii) If "No", please provide the name of current Insurer

   _____ Amount of coverage $ _____

8. Have you ever applied for life, critical illness or health insurance, which was declined, rated or modified in any way?

   ☐ Yes ☐ No If "Yes", please provide details: _____

9. Have you ever consulted a physician for symptoms of, or been diagnosed with or treated for:

   a) Chest pain, heart attack, high blood pressure, abnormal ECG, elevated cholesterol, stroke, paralysis, transient ischemic attack (TIA), or other disorders of the heart, blood vessels or circulatory system ☐ Yes ☐ No

   b) Cancer, polyp or other growth, mole, blood disorder or any form of malignant disease ☐ Yes ☐ No

   c) Diabetes, kidney, bladder, prostate or breast disorder (including lumps, cysts, unusual discharge or abnormal mammogram findings) ☐ Yes ☐ No

   d) Hepatitis, colitis or other disorder of the liver, intestines or colon ☐ Yes ☐ No

   e) Alzheimer's, Parkinson's, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, tremor or other neurological symptoms or disorder ☐ Yes ☐ No

   f) Permanent loss of speech, ear or eye disorder (excluding near or far sightedness) ☐ Yes ☐ No

   g) Chronic lung or respiratory disease ☐ Yes ☐ No

   h) Any immune system abnormality including AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, enlargement of lymph glands, skin lesions or unexplained infections ☐ Yes ☐ No

   If yes, please provide details. Include dates, reasons for consultations, results of tests and treatments or medications prescribed:

10. Have any of your natural parents, brothers or sisters ever suffered or been diagnosed with any of the following: heart condition, stroke, polycystic kidney disease, cancer or tumors of the breast or colon, diabetes, Multiple Sclerosis, Alzheimer's, Parkinson's, Amyotrophic Lateral Sclerosis (ALS) or any hereditary disease? ☐ Yes ☐ No

If yes, please provide details below:

	Condition	Age at Onset		Condition	Age at Onset
Mother:			Brother:		
Father:			Sister:		

11. Have you smoked any cigarettes, cigarillos, cigars, marijuana, used pipes or chewing tobacco or any nicotine products (patch, gum, etc.) within the past 12 months? ☐ Yes ☐ No
If yes, please provide details:

12. Are you aware of any symptoms for which a doctor has not yet been consulted or have you any condition for which hospitalization, further testing, investigation or surgery has been advised but not yet completed?
☐ Yes ☐ No
If yes, please provide details:

13. Are you taking any prescribed medication? ☐ Yes ☐ No

If yes, please provide details:

14.
Height (cms) (ft/ins) Weight (kgs) (lbs)
Have you lost 20 lbs or more within the last year? ☐ Yes ☐ No If yes, how much?

Reason and details if "Yes"

15. a) Date, reason and results of your last medical consultation:

Date: D M Y Reason:

Results: ☐ Positive, Declared in good health ☐ Negative

b) If negative, please provide details

c) Was any treatment prescribed as a result of your last medical consultation? ☐ Yes ☐ No
d) If yes, please provide details of the treatment

16. Name and address of physician

Number & Street City Province Postal Code

I hereby certify that to the best of my knowledge, the statements made above are complete and true.

Dated D M Y Signature of Applicant

Please return completed application with the "Consent to collect, use and disclose personal information" form.

Consent to collect, use and disclose personal information

Critical • Choice • Care™

I authorize AXA Assurances Inc. and its authorized representatives to collect, use, and disclose personal information about me as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for AXA Assurances Inc.;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by AXA Assurances Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at AXA Assurances Inc.'s offices. Within AXA Assurances Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer
AXA Assurances Inc.
2020, University Street, Bureau 700
Montréal, Québec H3A 2A5

This consent shall be valid for the length of time necessary for AXA Assurances Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving AXA Assurances Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in AXA Assurances Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

		9227624
Signature of Insured	Print Name	Policy Number

Date D M Y Telephone ( )

Address
Street & Number City Province Postal Code

The completed authorization can be returned to AXA Assurances Inc. at the following address:

239 Brownlow Ave.
Suite 101
Dartmouth, N. S. B3B 2B2