

Application For Engineers Canada Extended Health Care & Dental Insurance



engineerscanada

Engineers Canada is the business name
of the Canadian Council of Professional Engineers



YES! I would like to apply for coverage.

MEMBER INFORMATION New Client Existing Client Policy/Certificate # _____ (if existing client)

Name of Member (PLEASE PRINT)

Last _____ First _____

Address _____ City _____ Province _____ Postal Code _____

E-mail _____ Tel. Res: () _____ Bus: () _____

Birthplace: City _____ Country _____

Applicant is a/an: Engineer Engineering Student Technician/Technologist Limited Licensee
 Geologist/Geoscientist Architect Permanent full-time employee of Association Member in Training
 Provisional Licensee Name of Prov./Terr. Assoc. _____ Membership No. _____

PLAN CHOICES (Please choose one of Extended Health Care and Dental)

Extended Health Care: Member Only Member and Spouse Member and Children Member, Spouse and Children

Dental Care: Member Only Member and Spouse Member and Children Member, Spouse and Children

FAMILY INFORMATION (List all family members being covered.)

FIRST AND LAST NAME	GENDER	BIRTH DATE			IF SMOKER, # of cigarettes smoked daily	HEIGHT	WEIGHT	WEIGHT CHANGE IN LAST YEAR		REASON
		DD	MM	YYYY				Gain	Loss	

Member's name _____ Phone number _____

UNDERWRITING QUESTIONNAIRE

For prompt and accurate processing of your application, please complete all questions on behalf of all proposed Insureds. Provide full details below or attach a separate signed and dated sheet.

A *Member's Doctor*

Name

Address

Telephone

Date last seen (DD/MM/YYYY)

Reason for last visit

Tests, Treatment, Medication prescribed

Results and current status

Spouse's Doctor

Name

Address

Telephone

Date last seen (DD/MM/YYYY)

Reason for last visit

Tests, Treatment, Medication prescribed

Results and current status

Dependent Child(ren)'s Doctor

Name

Address

Telephone

Date last seen (DD/MM/YYYY)

Reason for last visit

Tests, Treatment, Medication prescribed

Results and current status

Dependent Child(ren)'s Doctor

Name

Address

Telephone

Date last seen (DD/MM/YYYY)

Reason for last visit

Tests, Treatment, Medication prescribed

Results and current status

Québec residents may detach this section and the Underwriting Questionnaire, and send directly to the insurance company.

Member's name _____ Phone number _____

B Has any individual proposed for coverage (member, spouse or child(ren)):

	Member		Spouse		Child(ren)	
	YES	NO	YES	NO	YES	NO
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including name of applicant, date, name of company and reason: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 5 years, had their driver's license suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), Driver's License # and Licensing province: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the next 12 months, have any intention of traveling or residing outside North America? If "yes", give details including name of applicant, where, when, why and for how long. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If yes, give details including name of applicant, drug or alcohol type(s) and date(s) last used: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc), arthritis, paralysis or weakness, fibromyalgia or chronic pain, had x-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu etc), been advised to undergo further investigation, see another doctor or have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to Questions 6 through 9 above, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Name of Applicant	Nature of Disorder	Date and Duration	Treatment and Current Status	Attending Physician or Hospital

10. Is any individual applying for coverage currently taking medication or undergoing treatment or therapy or expect to do so within the next 3 months? If yes, give details below:	Member		Spouse		Child(ren)	
	YES	NO	YES	NO	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name of Applicant	Name of drug or medication or type of treatment or therapy	Condition being treated	Dosage and Frequency	Monthly Cost	Date treatment started
					(DD/MM/YYYY)
					(DD/MM/YYYY)
					(DD/MM/YYYY)
					(DD/MM/YYYY)

11. Adult female applicants only:		Member		Spouse		Child(ren)	
1. Are you currently pregnant? If yes, give due date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a miscarriage, pre-eclampsia, caesarean section or other complication of pregnancy? If yes, give date and details: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: The Insurer may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate health department if required by law.

