

Health Questionnaire Dependent – Odyssey Expatriate Benefits

Name of Employer/Sponsor	Billing Group	Applicant ID	Date Eligible (dd./mm/yy)
Name of Applicant Surname: _____ First Name: _____ Middle Initial: ____	Telephone ()		Occupation
Address of Applicant (number, street) Street _____ Apt. _____ City/town _____ Province _____ Postal Code _____			Date of Birth (dd./mm/yy)
Reason for Application: <input type="checkbox"/> New enrolment; <input type="checkbox"/> Other: _____			
Dependent Benefits being applied for: <input type="checkbox"/> Medical; <input type="checkbox"/> Optional Life \$ _____; <input type="checkbox"/> Optional AD&D: \$ _____; <input type="checkbox"/> Dental; <input type="checkbox"/> Maternity			

Name of Dependent (Last Name / First Name)	Relationship	Date of Birth	Height	Weight

INCOMPLETE FORMS WILL BE RETURNED

To be completed and signed by the Dependent – Statement of Health – Answer Every Question – Give Details

1. Height _____ m _____ ft b) Weight _____ kg _____ lbs.

2. Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:

- | | | No | Yes |
|--|--------------------------|--------------------------|--------------------------|
| a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) asthma, chronic cough, shortness of breath, or convulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) cancer, tumor, leukemia, enlarged glands or lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) diabetes, sugar in urine or thyroid disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) urine, kidney or bladder disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) anemia, bleeding or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) difficulty with eyes or ears? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) a positive HIV (Human Immune Deficiency Syndrome) test? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | No | Yes |
|---|--------------------------|--------------------------|--------------------------|
| 5. Do you have an annual checkup
If “Yes” provide results: _____
If “No” provide date and results of last check up.
Date: _____ Results: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

In the past 5 years have you:

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 6. a) except for an annual check up, consulted a Doctor or other health practitioner, submitted to an ECG, blood tests, X – rays or other tests, had surgery or been treated in a hospital? | | No | Yes |
| b) received or applied for disability benefits for 3 months or longer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) had a urinary tract infection or any sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Within the past 12 months, have:

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 7. a) your duties been modified due to health reasons? | | No | Yes |
| b) you been off work for more than 5 consecutive days due to illness or injury? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) you used tobacco products?
If “Yes”, indicate the number per day _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. a) Indicate your average weekly consumption of alcohol
Beer _____ oz. Wine _____ oz. Liquor _____ oz.
- b) Have you ever been advised to stop drinking alcohol or to drink less?
4. a) Have you ever been refused life or health insurance or been offered it on special terms?
- b) If you have recently applied for another insurance Policy, please provide:
Date: _____ Policy No. _____
Name of Insurance Company: _____

8. Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, except as prescribed by a physician?
9. Are you presently under medical treatment by diet, Medicine, or other means?
10. Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger?
11. a) For women: are you pregnant?
- b) Have you ever had any complications of pregnancy?

Odyssey Expatriate Benefits Program – Dependent Health Questionnaire - Page Two

Name of Applicant: _____

Name of Dependent: _____

For each “Yes” answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

Authorization

I certify that the above statements and those on any attached sheet are true and complete. I authorize The Norfolk Group and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for The Norfolk Group, to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy of this authorization is as valid as the original.

Date: _____ Signature of Dependent _____

(Required in all instances)

You should keep a copy of this Health Questionnaire for your records.