Application for Critical • Choice • Care™ **Policy No.** ______________

Please answer all questions fully – it helps us to provide better service. Please print or type 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 and reason of your last medical consultation: ____________

    ____

    b) Was treatment prescribed? ☐ Yes ☐ No

    c) If "Yes", type of treatment ____________

    ____

    d) What were the results from treatment? ☐ Positive, "Declared in Good Health" ☐ Negative

    e) If "Negative", please provide details ____________

    ____

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, Suite 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.

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 any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5

2020 University Street, Suite 700, Montreal, Quebec H3A 2A5

645 - 7th Avenue SW, Suite 1400, Calgary, Alberta T2P 4G8