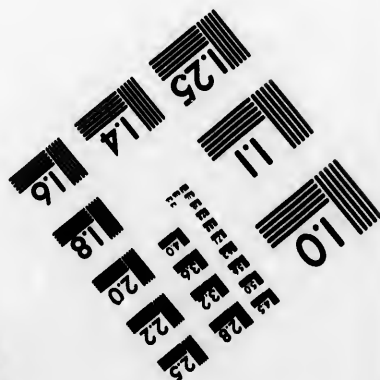
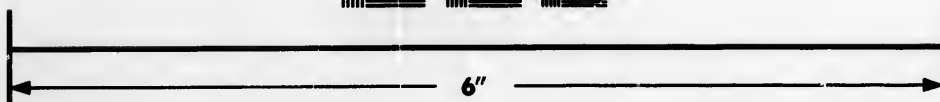
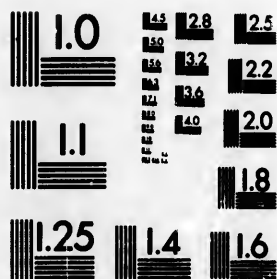
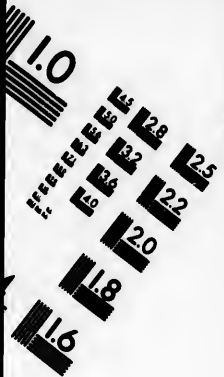


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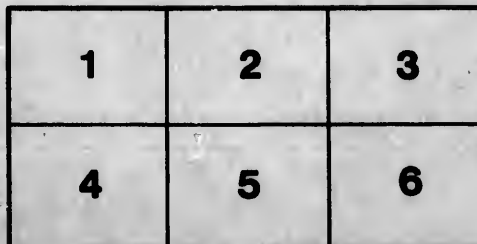
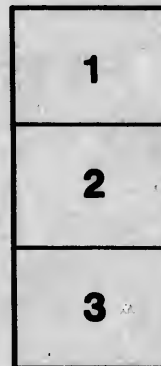
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30X



30X 32X

APPLICATION FOR ASSURANCE
 — IN THE —
FEDERAL LIFE ASSURANCE COMPANY,
 OF ONTARIO.
HEAD OFFICE IN HAMILTON.

1. Name of the Person whose Life is proposed to be Assured. OCCUPATION.
WRITE THE NAME IN FULL. (STATE DEFINITELY). RESIDENCE.

	P. O.	
	County	
	Province	

2. Where shall notices of Premiums be addressed? _____

3. How much assurance is desired? - (\$ _____) Dollars,

4. What kind of Policy is desired? _____ How { Yearly, half-yearly or quarterly } payable? {

5. Are you now assured in this Company, or have you been? Ans. (YES or No.) _____

6. What amounts are now assured on your life? _____
 In what Companies, and on what Plans? _____

7. A. Has any proposal or application to insure your life ever been made to any Company Society or Organization upon which a policy has not been issued of the form and amount for which you applied? If so, state to WHOM, WHEN and FOR WHAT CAUSE or CAUSES. }
 B. Has any opinion ever been sought from, or any consultation ever held with any Physician or Surgeon as to whether your life was safely insurable? }
 C. If so, was any decision or opinion given that you were, or that you were not safely insurable? }

8. Give the Date and Place of your Birth. DAY. MONTH. YEAR. PROVINCE OR COUNTRY

9. A. Age nearest Birthday? _____ B. Are you married? _____ How many children have you? _____
 Are they in good health? _____ How many dead? _____ Cause of death? _____

10. Name and residence of one or more intimate friends? _____

11. For whose benefit is the Assurance to be effected? RELATIONSHIP TO LIFE TO BE ASSURED. RESIDENCE. OCCUPATION.
(WRITE ALL NAMES IN FULL.)

	P. O.	
	County	
	Province	

11. IT IS HEREBY EXPRESSLY STIPULATED AND AGREED that this Application, of which the statements to the Medical Examiner shall form a part, and this Agreement, with the Policy issued thereon, shall form the contract between the above named persons and the said FEDERAL LIFE ASSURANCE COMPANY, and that if any misrepresentation or fraudulent or untrue answer be made; or if any fact which should be stated to the Company is suppressed therein; or if any violation of the covenants, conditions or restrictions of the Policy (should one be issued) shall occur; or if from any cause any payment be not made, as required by the conditions of the Policy; that then, in either event, the said Policy shall become and be null and void, and all moneys which shall have been paid thereon shall be forfeited to the Company for its sole use and benefit.

IT IS ALSO FURTHER AGREED that the continuance at the time of the delivery of the Policy, whether by mail or otherwise, of the applicant in the same state of health as when examined, is a condition of the Assurance taking effect, and the applicant agrees to accept the Policy when delivered, and hereby promises to pay the first premium thereon.

That if a cheque, draft, or other obligation be given for the first or any subsequent premium, or any part thereof, and if the same be not paid at maturity, it is expressly agreed that any insurance or policy made on this application shall thereupon become null and void, nevertheless the cheque, or obligation must be paid.

That any person having or claiming any interest under such Policy, adopts as his or her own each and all the statements in said Application, and in this Agreement, whether written by him or her own hand or not, and declares the same to be full, complete and true as facts, and that such statements are the only statements upon which the Policy, should the insurance applied for be granted, will be founded.

AND THE SAID PERSON whose life is proposed for Assurance FURTHER DECLARES that he is not now afflicted with any Disease or Disorder, and that he does not now, and that he will not practice any pernicious habit that obviously tends to shorten life, and agrees to submit himself to the Company's Medical Examiner for the examination provided and required with this application.

Dated at the
 day of 189
 in presence of

*Signature of person or persons for whose benefit the insurance is to be effected. _____
[WRITE NAMES IN FULL.]

*In case of husband for wife, or parent for children, the former may sign the latter, thus Mary Smith
by John Smith

Signature of person on whom life insurance is applied for. _____
[WRITE NAME IN FULL.]

These blanks must be filled in by the Medical Examiner. Use ink and be careful to answer every question fully and plainly. The Examination should be made in private.

DECLARATIONS MADE TO THE MEDICAL EXAMINER

OF THE

FEDERAL LIFE ASSURANCE COMPANY

The Answers of the Applicant to the Medical Examiner form an essential part of the contract.

1. Name,		Occupation, (define clearly)	Former Occupation,	
2. Are you at present in good health?		Has your health been, as a rule, good?		When were you last vaccinated?
3. Have you recently gained or lost in weight?		If so, which?	How much?	In what time?
4. Are you, to the best of your knowledge and belief, free from any infirmity, disorder, weakness or habit tending to impair your constitution or shorten your life?			Which parent do you most resemble physically?	
5. Are you ruptured?	A. If so, what form, Single or Double?	B. How long duration?	C. Is a truss habitually worn?	E. Has the rupture ever given you any trouble?
6. Have you ever had inflammatory rheumatism?		A. How often?	B. Duration of each attack?	C. What years?
				D. Where there any complications?
7. Have you ever had any of the following complaints? (YES or NO to be answered to each.)				
Apoplexy?	Asthma?	Renal or Hepatic Colic?	Bronchitis?	Cancer?
Dropsy?	Disease of Brain?	Disease of Heart?	Disease of Kidneys?	Disease of Liver?
Disease of Lungs?	Disease of Urinary Organs?	Delirium Tremens?	Diabetes?	Discharge from Ear?
Dizziness or Vertigo?	Erysipelas?	Fistula?	Epilepsy?	Fits or Convulsions?
Gravel?	Gout?	General Debility?	Insanity?	Jaundice?
Palpitation?	Pneumonia or Inflammation of the Lungs?	Paralysis?	Piles?	Pleurisy?
Scrofula?	Smallpox?	Sunstrokes?	Skin Disease?	Spinal Disease?
Spitting or Raising Blood?	Syphilis?	Varicose Veins?	Stricture?	Swellings or Lumps in any part?
Chronic Ulcers?				
8. If you have had any of the above or any other ailment, give particulars, date, frequency, and duration, and attending physician.				
9. Have you had any severe accident or injury, or undergone any surgical operation?				
10. Are you subject to dyspepsia?		A. Constipation?	B. Diarrhoea?	C. Dysentery?
D. When were you last confined to the house by illness, for what?				
11. Do you drink wine, beer or spirits?		A. How often on an average each day?		B. Have you ever used them to excess, or been intemperate?
If so, when, and for what period?				
C. Are you engaged in any way in the sale or manufacture of intoxicating liquors?			D. Do you use opium, chloral or other narcotics?	E. Tobacco?
12. The Medical Examiner will please obtain from the applicant answers in full detail to the following queries, being particular to avoid all indefinite terms, such as "General Debility," "Change of Life," "Fever," "Dropsy," "Decline," "Confinement," "Exposure," "Accident," etc. If the word "Childbirth" is used, state how long after delivery death occurred, the previous state of health, whether there was any cough or any symptoms of disease of the lungs or other organs?				

Height.		Standard weight.
FT.	IN.	POUNDS.
5		115
5	1	120
5	2	125
5	3	130
5	4	135
5	5	140
5	6	143
5	7	145
5	8	148
5	9	155
5	10	160
6	0	170
6	1	175

(BE CAREFUL TO FILL IN EVERY BLANK.)

18.	Age (if living.)	Condition of Health.	Age at Death.	Cause of Death.	How Long Ill?	Previous Health.
Father,						
Mother,						
..... Brothers						
..... Sisters						
Father's Father,						

Note.—If any vague terms are used in the family history, explain fully here. In case of brother or sister dying of any hereditary disease, state which parent he or she resembled. If answer to "Condition of health" be given as "Fair" or "Poor," state fully the cause.

Answer to "Expectation of Health" given as "Fair" or "Poor," state fully the cause.

.....Brothers					
.....Sisters					
Father's Father					
Father's Mother					
Mother's Father					
Mother's Mother					

14. A. Has either of your parents, brothers, sisters, grandparents, uncles or aunts now, or ever had, Rheumatism? Consumption? Cancer?
 Gout? Diabetes? Epilepsy? Insanity? or other hereditary disease?
 B. If so, give full the particulars of each case.
15. If married, is your wife healthy and free from disease of lungs or throat? Have any of your children been so affected?

I HEREBY FURTHER DECLARE that I have read or heard read and understand all the above questions put to me by the Medical Examiner, and the answers thereto are warranted by me to be correct and true, and that I am the person described above.

Witness, M. D. Person Examined.

If the applicant is a woman make a Special Report for which a form is provided on the back hereof in addition to the following

MEDICAL EXAMINATION.

1. How long have you known the applicant? | 2. Does his occupation affect the risk? | 3. Does applicant look older or younger than age given?
- | | | | | |
|-----------------|---------|---------------------|-------------------------------|--|
| 4. Weight? lbs. | Race? | General appearance? | Color of Hair? | Any deformities?
Deaf, Dumb, Blind or Lame?
Size of bones? |
| Height? ft. in. | Figure? | Temperament? | Color of Eyes?
Complexion? | |
5. If under or over weight, is it a family or individual characteristic?
6. Chest on inspiration? inches. | Chest on expiration? inches. | Girth of waist? inches.
7. (The chest must be bared.) On inspection, is the chest symmetrical and well developed? Does it expand equally well under each clavicle?
 Is the percussion note over both lungs normal? Is the respiratory murmur clear and distinct over every part of both lungs?
 Do you discover any indication of disease of the organs of respiration? What are the number of respirations per minute (standing)?
8. Are the sounds and rhythm of the heart regular and normal? Do you discover any indication of disease of the heart or blood vessels?
9. Pulse per minute? (Sitting) , (Standing) Does it intermit or become irregular?
 (If above 98 or below 54, examine at another time.) Is the apex beat in the normal position?
10. Condition of tongue? | Condition of teeth? | Has he any scar or mark of identification?
11. What is YOUR OPINION as to the extent of his use of intoxicating liquors or narcotics either now or in the past?
12. Is urine normal in quantity and appearance? Does he have to rise at night to pass it? (Urine to be examined in all cases.)
- | | | | | | | |
|------------|-----------|-------------------|----------|--------|-----------|--|
| 13. Color. | Reaction. | Specific Gravity. | Albumen. | Sugar. | Deposits. | If found alkaline or neutral, give reason. |
|------------|-----------|-------------------|----------|--------|-----------|--|
14. Do you find the applicant in perfect health and safely insurable?
15. Do you consider the applicant a **FIRST-CLASS** risk—a **GOOD** risk—or only a **FAIR** risk?
16. Do you think he will survive the "Expectation" as shown by the table in the margin?

If you have any hesitation in deciding, give the Company the benefit of the doubt and answer, "No," and write confidentially to the Medical Director at the Head Office, giving full particulars.

Examined at the day of 189... By Medical Examiner, P. O.

Present Age.	Expectation of Life.
30 41-66	(Healthy Male Life)
31 42-67	
32 43-68	
33 44-69	
34 45-70	
35 46-71	
36 47-72	
37 48-73	
38 49-74	
39 50-75	
40 51-76	
41 52-77	
42 53-78	
43 54-79	
44 55-80	
45 56-81	
46 57-82	
47 58-83	
48 59-84	
49 60-85	
50 61-86	
51 62-87	
52 63-88	
53 64-89	
54 65-90	
55 66-91	
56 67-92	
57 68-93	
58 69-94	
59 70-95	
60 71-96	
61 72-97	
62 73-98	
63 74-99	
64 75-100	
65 76-101	

REMARKS

General Agent,
Local Agent,
P. O. Address,
Policy to be sent to,
Commission, per cent. to

The blank spaces below are to be filled up only at the Head Office.

Policy No.

FEDERAL LIFE ASSURANCE CO.

Date of Policy, day of 189.....

Sum Assured, \$.....

Life of.....

Residence,.....

Occupation,.....

Born,..... day of..... 18.....

Age,.....

Benefit of.....

Relationship,.....

Annual Premium, \$.....

REMARKS:

Expectation years.

APPROVED

**ADDITIONAL STATEMENTS TO THE MEDICAL EXAMINER
WHEN THE APPLICANT IS A WOMAN.**

Have you passed the change of life?
If married, how long?
Were labors difficult?
Have you ever been treated for womb disease?
If so, when, and by whom?
Have you any disease of the breast?
Husband's occupation?

If not, are the uterine functions regular in all respects?
How many children? How long since birth of last child?
How often miscarried? Are you now pregnant?
His state of health?

The foregoing statements are true to the best of my knowledge and belief.

Applicant.

I have carefully examined the applicant and believe her statements and the answers given above to be correct and true.

M. D.

