Tel: (519) 742 – 7979 Fax: (519) 742 - 0004

SCHWABEN CLUB

1668 King Street East
Kitchener, Ont. N2G 2P1

SCHWABEN CLUB SICK BENEFIT FUND APPLICATION FORM

PERSONAL INFORMATION **(PLEASE PRINT CLEARLY, IN INK)**

APPLICANT'S NAME: _____
LAST NAME FIRST NAME

APPLICANT'S ADDRESS: _____
HOUSE # STREET APT #

_____
CITY PROVINCE POSTAL CODE

APPLICANT'S TELEPHONE: _____
(AREA CODE)

APPLICANT'S EMAIL: _____

DATE OF BIRTH: _____
MONTH DAY YEAR

APPLICANT'S GENDER: **MALE ☐** **FEMALE ☐**

APPLICANT'S OCCUPATION: _____

DATE THAT APPLICANT JOINED THE SCHWABEN CLUB: _____
MONTH / DAY / YEAR

MEDICAL INFORMATION **(PLEASE PRINT CLEARLY, IN INK)**

HEIGHT: _____ **CM** **WEIGHT:** _____ **KG**

HAVE YOU LOST WEIGHT IN THE PAST TWO (2) YEARS? **YES ☐** **NO ☐**

IF YES, HOW MANY KILOGRAMS? _____

HAVE YOU EXPERIENCES AN ILLNESS IN THE PAST 5 YEARS THAT HAS CAUSED YOU TO MISS WORK FOR A PERIOD OF TIME OR BEEN DIAGNOSED WITH ANY SIGNIFICANT AILMENT (CANCER, ETC)? **YES ☐** **NO ☐**

IF YES, PLEASE DESCRIBE EACH ILLNESS/DIAGNOSIS AND HOW LONG IT LASTED:

1ST ILLNESS: _____

2ND ILLNESS: _____

3RD ILLNESS: _____

OTHER: _____

_____

DID YOU COLLECT SICK BENEFITS IN THE PAST FIVE (5) YEARS? **YES ☐** **NO ☐**

IF YES, WHAT WAS THE TOTAL AMOUNT RECEIVED: $ _____

TO BE COMPLETED BY PHYSICIAN **(PLEASE PRINT CLEARLY, IN INK)**

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

_____

PHYSICIAN'S TELEPHONE: _____

PHYSICIAN'S FAX NUMBER: _____

PHYSICIAN'S EMAIL: _____

PHYSICIAN'S SPECIALTY: _____

1. Does oscillation and percussion of the chest indicate that the heart and lungs are in a healthy condition?

_____

2. Is there any heart murmur or defects?

_____

3. Do organs or Respiratory System have any known defects or disease? If so state particulars:

_____

4. Are there any indications of cardiac disease or condition? If so state particulars:

_____

5. Are there any other health conditions known or diagnosed? If so state particulars:

_____

6. Do you recommend that the applicant be enrolled in the "Canadian Schwaben Sick Benefit Association?

_____

PHYSICIAN'S SIGNATURE _____

DATE _____

I, _____ AGREE THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE CASE SAID ANSWERS ARE FOUND TO BE UNTRUE OR MISLEADING, I AGREE TO HEREBY FORFEIT ALL CLAIMS UPON THE SCHWABEN CLUB FOR AND SICK FUND BENEFITS. I ALSO AGREE TO COMPLY WITH THE LAWS AND REGULATIONS GOVERNING THE SICK BENEFIT FUND AS OUTLINED IN THE CONSTITUTION AND ANY CONSTITUTIONAL AMENDMENTS, NOW IF FORCE OR THAT MAY BE ENACTED HEREAFTER.

APPLICANT'S SIGNATURE _____

WITNESS NAME: _____ **SIGNATURE**_____

PLEASE PRINT

DATE SIGNED: _____

DAY **MONTH** **YEAR**