Health Statement

Sun Life Financial

Important

- Incomplete forms will delay processing.
- Plan Administrator is to fill in Part 1 and then give form to Member for completion.
- Member to mail form directly to Sun Life Assurance Company of Canada.

Please PRINT clearly.

1 Plan Administrator information

This section is to be completed by the Plan Administrator.

Coverage is not in effect until you receive notice of approval from Sun Life Assurance Company of Canada.

Member's name (first)	(last)		
Contract number	Member ID	Billing group	Class
Occupation	Current salary $ ☐ Hrly. ☐ Wkly. ☐ Bi-Wkly. ☐ Mthly. ☐ Ann.		
Company name	Plan Administrator's name		
Company address (street, city, province, postal code)		Telephone number ( )	

Reason for Application

☐ New Enrolment – Effective date _____
☐ Increased Coverage
☐ Late Applicant (enrolled after 31 days)
☐ Re-application (previously declined)
☐ Annual Enrolment – Effective date _____

Benefits Requested (Please check off)	A. Existing Amount of Coverage (if applicable)	B. New Amount of Coverage Requested	C. Total Amount of Coverage (A + B)
☐ Basic Life - member	$	$	$
☐ Basic Life - spouse	$	$	$
☐ Basic Life - dependent	$	$	$
☐ Optional Life - member	$	$	$
☐ Optional Life - spouse	$	$	$
☐ Optional Life - dependent	$	$	$
☐ Long-term disability	$	$	$
☐ Short-term disability	$	$	$
☐ Other _____	$	$	$

☐ Extended Health - member*	New Benefit	Yes ☐	No ☐
☐ Extended Health - dependent*	New Benefit	Yes ☐	No ☐
☐ Dental - member*	New Benefit	Yes ☐	No ☐
☐ Dental - dependent*	New Benefit	Yes ☐	No ☐

* If applicable - Date of loss of comparable coverage _____

For Sun Life Financial Use Only

Health Statement

2 Member and Dependent details (to be completed by the Member)

All information received by Sun Life Assurance Company of Canada is treated as strictly confidential and is used for the sole purpose of determining your eligibility and administering the group plan to which you belong. Returning your forms and medical information to us in a confidential envelope ensures that only our medical underwriters will have access to them. Please fully complete the address.

2.1 General information about the Member

Member's Name (First) (Last)	Date of birth (d/m/y)	☐ Male ☐ Female	Contract Number
Member's street address (street number and name)		Apartment/suite number	
City	Province	Postal code	

Please provide a phone number where you can be reached for any additional information:

Member's home telephone number	Member's business telephone number
( ) ☐ Day ☐ Evening	( ) ☐ Day ☐ Evening

Complete this section only if applying for dependent coverage.

2.2 General information about the Member's Dependents

Spouse's name (first)	(last)	Date of birth (d/m/y)	☐ Male ☐ Female
Child's name (first)	(last)	Date of birth (d/m/y)	☐ Male ☐ Female
Child's name (first)	(last)	Date of birth (d/m/y)	☐ Male ☐ Female
Child's name (first)	(last)	Date of birth (d/m/y)	☐ Male ☐ Female
Child's name (first)	(last)	Date of birth (d/m/y)	☐ Male ☐ Female

Complete this section only for person(s) applying for insurance.

Complete section(s) 2.4 and/or 2.5, as applicable, with any additional comments to these questions.

2.3 Medical information

If you answer yes to any questions, please provide further details on the next page. Include dates, treatment and medications.

	Member	Spouse	Child(ren)
1. Do you have a regular attending doctor? (If yes, provide name, address, date last consulted and reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have a yearly check-up? (If yes, please specify date of last check-up and results)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Within the last 12 months have you lost work due to illness or injury? (If yes, provide dates and reasons)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Within the last three years have you:			
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than five consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Received disability benefits for three months or longer?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
c) Ever been declined for Life or Disability insurance? (If yes, specify name of insurer, date and reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
d) Ever been offered Life or Disability insurance at a higher than standard risk? (If yes, specify name of insurer, date and reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you used any tobacco products within the last 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Within the last 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a doctor?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you consume alcoholic beverages?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
a) Average number of drinks per week: Beer:			
Wine:			
Spirits:			
b) Have you ever been advised to stop drinking or to drink less?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Who _____
(e.g. spouse, friend, doctor, etc.)

Reason _____

Date _____

Continued on next page

Health Statement

2 Member and Dependent details (continued)

		Member	Spouse	Child(ren)
8.	Are you presently under medical treatment by diet, medicine or other means? (provide details including names of all medications and reason(s) why you are using them)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9.	Do you have diabetes or impaired sugar levels?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	a) What is your current treatment for diabetes? insulin:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	oral medication:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	diet only:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b) List your last 3 blood sugar readings	_____ _____ _____	_____ _____ _____	_____ _____ _____
10.	a) Height	☐ ____ ft./in. ☐ ____ m/cm	☐ ____ ft./in. ☐ ____ m/cm	☐ ____ ft./in. ☐ ____ m/cm
	b) Weight	☐ ____ lb. ☐ ____ kg	☐ ____ lb. ☐ ____ kg	☐ ____ lb. ☐ ____ kg
11.	Within the last three years have you received treatment for, consulted a doctor or other health practitioner for, or been diagnosed as having any one of the following:			
	a) Cancer, malignancy, leukemia or enlarged lymph nodes?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	b) Illnesses of the heart or circulatory system?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	c) Liver disorder or hepatitis?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	d) Kidney disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	e) Lung or respiratory disorder (including asthma)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	f) Neurological disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	g) Psychiatric or psychological problems (including anxiety, depression or panic disorders)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	h) Chronic fatigue syndrome or fibromyalgia?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	i) Musculoskeletal, joint or bone disorder (including arthritis)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	j) Back or neck problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	k) High blood pressure or high cholesterol? (If yes, please list your last three readings below)	Yes ☐ No ☐ _____ _____	Yes ☐ No ☐ _____ _____	Yes ☐ No ☐ _____ _____
	l) Gastrointestinal disorder (including esophageal, colon or bowel disorders)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12.	Have you ever tested positive for AIDS, ARC or HIV?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
13.	Have you ever suffered a heart attack or myocardial infarction?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
14.	Have you ever had a stroke?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
15.	Have you ever had an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If you answered yes to any questions in the previous section, please provide further details.

Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

2.4 Additional medical details - Member

Question	Further details

Health Statement

2 Member and Dependent details (continued)

Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

2.5 Additional medical details - Dependent Spouse/Children

Question	Dependent Name	Further details

3 Declaration and authorization

Please read and sign this section.

In this declaration and authorization, "I" applies to each of the member, the spouse and the child(ren) age 18 and older signing below.

I understand I may be refused those group benefits or any benefit amounts for which proof of good health is required if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. I certify that all the statements in this form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Health Statement, will cause the insurance to be void.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administrating and adjudicating claims under this Plan with any person or organization who has relevant information about me and/or my dependents under age 18 (if applicable), pertaining to this Health Statement. This includes any health professionals, institutions, investigative agencies, insurers, reinsurers and any Third Party administrator retained by the plan sponsor to administer this group contract.

If I am a spouse or dependent age 18 and older, I also authorize Sun Life Assurance Company of Canada to disclose information about this application to the member, for the purposes of assessing this application and managing the group benefits plan.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage under this group contract, unless withdrawn in writing.

Signature of Member	Date (d/m/y)
X	
Signature of Spouse	Date (d/m/y)
X	
Signature of Dependent Child 18 years or older	Date (d/m/y)
X	
Signature of Dependent Child 18 years or older	Date (d/m/y)
X	

Sun Life Assurance Company of Canada must receive your completed Health Statement within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Health Statement.

Send the completed form to the following address in an envelope marked "Confidential" and retain a copy for your records.

If your head office is located in Ottawa, Québec or an Eastern Province:
Fax: (514) 954-1081
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 11010 Stn CV
Montréal QC H3C 4T9

If your head office is in another location:
Fax: (519) 888-3477
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 578 STN Waterloo
Waterloo ON N2J 4B8

Toll free number 1-866-882-0884

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.