Health Statement

Sun Life Financial

Important

- Incomplete forms will delay processing.
- Part 1 is to be completed by the Plan Administrator or the member with information provided by the Plan Administrator.
- Member to mail form directly to Sun Life Assurance Company of Canada.

Please PRINT clearly.

Clear

1 Plan Administrator information (to be completed by the Plan Administrator or the Member)

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

Member's last name	Member's first name		Contract number
Occupation	Class	Billing group	Member ID
Current salary ☐ Hrly. ☐ Wkly. ☐ Bi-Wkly. ☐ Mthly. ☐ Ann. $	Company name	Plan Administrator's name	
Company street address	City	Province	Postal code	Telephone number

Reason for application

☐ New enrolment – effective date (dd-mm-yyyy) _ _

☐ Increased coverage

☐ Late applicant (enrolled after 31 days)

☐ Re-application (previously declined)

☐ Annual enrolment – effective date (dd-mm-yyyy) _ _

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	$	$	$
☐ Critical Illness – member	$	$	$
☐ Critical Illness – spouse	$	$	$
☐ Critical Illness – 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 (dd-mm-yyyy) _ _

For Sun Life Financial Use Only

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

2.1 General information about the member

Member's last name	Member's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female
		— —	

Member's street address (street number and name)	Apartment or suite	City	Province	Postal code

Please provide all applicable contact information where you can be reached for additional information:

Home phone number:	Business phone number:	Email address:
☐ Day ☐ Evening — —	☐ Day ☐ Evening — —	

Height	Weight	Change in weight in the last 12 months	Reason for weight change
ft. in. m cm	☐ lbs. ☐ kg	☐ No change ☐ Gain _____ ☐ Loss _____ ☐ lbs. ☐ kg	

Date and reason for your last consultation with attending doctor (if no attending doctor, please state none)

Name of doctor, diagnosis, treatment given, results, medication prescribed

If the doctor named above does not have the most complete records of your medical history, please provide full name and address of the doctor who does have them

2.2 General information about the member's dependents (complete this section only if applying for dependent coverage)

Spouse's last name	Spouse's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female
		— —	

Height	Weight	Change in weight in the last 12 months	Reason for weight change
ft. in. m cm	☐ lbs. ☐ kg	☐ No change ☐ Gain _____ ☐ Loss _____ ☐ lbs. ☐ kg	

Date, reason and results for your last consultation with attending doctor (if no attending doctor, please state none)

Name of doctor, diagnosis, treatment given, results, medication prescribed

If the doctor named above does not have the most complete records of your medical history, please provide full name and address of the doctor who does have them

Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Height	Weight
		— —		ft. in. m cm	☐ lbs. ☐ kg
		— —		ft. in. m cm	☐ lbs. ☐ kg
		— —		ft. in. m cm	☐ lbs. ☐ kg

2.3 Family history information

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had heart disease, heart attack, high blood pressure, polycystic kidney disease, familial polyposis of the bowel, stroke, diabetes, cancer (specify type below), multiple sclerosis, Huntington's Chorea, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis) or any hereditary disease?	**Member**	**Spouse**
	☐ Yes ☐ No	☐ Yes ☐ No

If **yes**, complete chart below.

Member's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Spouse's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

2 Member and dependent details (continued)

2.4 Medical information (complete this section only for person(s) applying for insurance)

Complete section(s) 2.4, 2.5 and/or 2.6, as applicable, with any additional comments to these questions.

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

	Member		Spouse		Child(ren)	
1. Have you ever:						
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) Been declined or offered Life, Disability or Critical Illness insurance at a higher than standard risk? (If yes, specify name of insurer, date and reason)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
2. Have you used any tobacco products within the last 12 months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
3. Within the last 10 years, have you used cocaine, hashish, heroin, narcotics, marijuana, LSD, hallucinogens, amphetamines, except as prescribed by a doctor, or sought or received advice or treatment for the use of drugs (over-the-counter, prescribed or non-prescribed)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
4. Do you consume alcoholic beverages?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
a) Average number of drinks per week						
b) Have you ever been advised to stop drinking, to drink less or received treatment for the use of alcohol?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Who _____ (e.g. spouse, friend, doctor, etc.)						
Reason _____ Date (dd-mm-yyyy) ____-____-____						
5. 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
6. Have you ever had diabetes, impaired sugar levels or ever had sugar, blood or protein in your urine?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
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
7. Have you ever had or 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, enlarged lymph nodes, lymph gland disorder, tumours, polyps or other growths including moles, breast lumps or cysts, had a biopsy for any reason or had an abnormal cancer screening test?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b) Illnesses of the heart or circulatory system, including chest pain, abnormal electrocardiogram (ECG), irregular pulse, heart murmur?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c) Liver disorder or any type of hepatitis or blood disorders?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
d) Disease or disorder of the kidneys, urinary tract, bladder, prostate or reproductive organs?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
e) Chronic lung or respiratory disorder (including asthma and sleep apnea), disease or disorder of the eyes, ears, nose or throat?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
f) Transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
g) Psychiatric or psychological problems (including anxiety, depression, panic attacks, eating disorders, any other emotional disorders) or been counselled for such?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
h) Chronic fatigue syndrome, fibromyalgia, rheumatic/arthritic disease or lupus?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
i) Musculoskeletal, joint or bone disorders, paralysis or numbness?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
j) Back and neck problems?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
k) High blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
l) High cholesterol?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
m) Gastrointestinal disorder (including esophageal, stomach, colon, colitis or bowel/intestinal disorders)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. Have you ever tested positive for AIDS, ARC or HIV?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. Have you ever suffered a heart attack or myocardial infarction?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
10. Have you ever had a stroke?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
11. Have you ever had an organ transplant?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
12. Have you ever had any other illness, disease or disorder, condition, injury, diagnostic testing or surgical procedure not listed above?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
13. Have you ever used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker, artificial limb or hearing aid?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
14. Do you require assistance of any kind to perform any daily activities, such as bathing, continence, dressing, eating, using the toilet or transferring (for example: bed to chair)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
15. Have you ever had any health symptoms or complaints for which a doctor has not been consulted or been advised to have further examinations or tests which have not been completed yet?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

2 Member and dependent details (continued)

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.

2.5 Additional medical details – Member

Question	Further details

2.6 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 collect, use and disclose 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 and reinsurers.

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 X	Date (dd-mm-yyyy) – –
Signature of Spouse X	Date (dd-mm-yyyy) – –
Signature of Dependent Child 18 years or older X	Date (dd-mm-yyyy) – –
Signature of Dependent Child 18 years or older X	Date (dd-mm-yyyy) – –

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.

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.

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

Toll-free fax number: 1-877-897-5519
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 11691 Stn CV
Montreal QC H3C 3J9

Another location

Toll-free fax number: 1-877-897-6605
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.