Statement of Health (Optional Life Only)

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
☐ Increased Coverage
☐ 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)
☐ Optional Life - Member	$	$	$
☐ Optional Life - Spouse	$	$	$
☐ Optional Life - Dependent	$	$	$

For Sun Life Financial Use Only

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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 physician? (If yes, provide name, address, date last consulted and reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have a yearly checkup? (If yes, please specify: date of last check-up and results)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Within the past 12 months have you lost work due to illness or injury? (If yes, provide dates, reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Within the last 3 years have you:			
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than 5 consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Received disability benefits for 3 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, 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, reason)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you used any tobacco products within the past 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Within the past 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a physician?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you consume alcoholic beverages?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
a) Confirm usual weekly consumption: # of drinks :	_____	_____	_____
beer:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
wine:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
spirits:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Have you ever been advised to stop drinking or to drink less?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Who _____

Reason _____

Date _____

Continued on next page

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2 Member and Dependent details (continued)

		Member	Spouse	Child(ren)
8. Are you presently under medical treatment by diet, medicine or other means? (include 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.	☐ ____ ft./in.	☐ ____ ft./in.
		☐ ____ m/cm	☐ ____ m/cm	☐ ____ m/cm
b) Weight		☐ ____ lb.	☐ ____ lb.	☐ ____ lb.
		☐ ____ kg	☐ ____ kg	☐ ____ kg
11. Within the past 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) Cirulatory or illnesses of the heart?		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, 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?		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
l) Gastrointestinal disorder (including colon, esophageal, bowel disorders)?		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you ever tested positive for AIDS, ARC, 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

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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.

The intentional falsification, misrepresentation or omission of information on or relating to this form constitutes fraud and coverage granted may be voided.

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 application are true and complete.

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, or my spouse and/or dependents (if applicable), pertaining to this application, including any Third Party administrator retained by my plan sponsor to administer this group contract, health professionals, institutions, insurers and reinsurers.

If this application is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administrating and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada to disclose information about this application to me, for the purposes of assessing this application and managing my 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.

Signature of Member X	Date (d/m/y)
Signature of Spouse X	Date (d/m/y)
Signature of Dependent Child 14 years or older X	Date (d/m/y)
Signature of Dependent Child 14 years or older X	Date (d/m/y)

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

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.