Statement of Health

Sun Life Financial

Please PRINT clearly

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.

1 Plan Administrator information

This section is to be completed by the Plan Administrator.

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 ( )	

Is the member actively at work and physically able to complete every duty of his/her employment? Yes ☐ No ☐

Reason for submitting health status

☐ New Enrolment ☐ Increased Coverage ☐ Late Applicant (greater than 31 days)
☐ Re-application (previously declined) ☐ Annual Enrolment

Benefits Requested (Please check off)	Current Amount of Coverage (in force)	Additional Amount of Coverage (Being Requested)
☐ 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	$	$
☐ 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 ☐

For Sun Life Financial Use Only

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.

2.1 General information about the Member

Member's Name (First) (Last)	Date of birth (d/m/y)	☐ Male ☐ Female	
Member's Address (Street, City, Province, Postal Code)		Height ☐ ft./in. ☐ m/cm	Weight (lbs.)
Please provide a phone number where you can be reached for any additional information:			
Member's Home Telephone Number ( ) ☐ Day ☐ Evening		Member's Business Telephone Number ( ) ☐ Day ☐ Evening	

2.2 General information about the Member's Dependents

Spouse's Name (First) (Last)	Date of birth (d/m/y)	Height ☐ ft./in ☐ m/cm	Weight ☐ lb. ☐ kg
Child's Name (First) (Last)	Date of birth (d/m/y)		
Child's Name (First) (Last)	Date of birth (d/m/y)		
Child's Name (First) (Last)	Date of birth (d/m/y)		
Child's Name (First) (Last)	Date of birth (d/m/y)		

Please 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? a) Confirm usual weekly consumption: # of drinks _____ beer _____ wine _____ 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 ☐
8. Do you engage in any of the following activities: sky diving, scuba diving, vehicle or boat racing or aviation except as a passenger?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. 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 ☐
10. Do you have diabetes mellitus?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
a) What is your current treatment? insulin _____ oral medication _____ diet only _____			
b) List your last 3 blood sugar readings _____ _____ _____			

Continued on next page

2 Member and Dependent Details (Continued)

		Member	Spouse	Child(ren)
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)	Acquired Immune Deficiency Syndrome (A.I.D.S.) or A.I.D.S. related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b)	Cancer, malignancy, leukemia or enlarged lymph nodes?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
c)	Heart problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
d)	Liver disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
e)	Kidney disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
f)	Lung disorder (including asthma)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
g)	Neurological disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
h)	Stroke?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
i)	Psychiatric or psychological problems (including anxiety, depression, panic disorders)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
j)	Chronic fatigue syndrome?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
k)	Arthritis joint or bone problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
l)	Back or neck problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
m)	High blood pressure?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
n)	Gastrointestinal disorder (including colon, esophageal, bowel disorders)?	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

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 group benefits 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, administration and adjudicating claims under this group contract with any person or organization who has relevant information about me in connection with this Application, including any third party administrator retained by my plan sponsor to administer this group contract, health professionals, institutions, insurers and reinsurers.

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 (for Québec residents only) X	Date (d/m/y)
Signature of Dependent Child 14 years or older (for Québec residents only) 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".

If your head office is located in Ottawa, Québec or an Eastern Province:

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:

Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 578 STN Waterloo
Waterloo ON N2J 4B8