

Statement of Health

SunAdvantage



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.

Company Name	Contract Number	Billing Group	Class
Company Address (Street, City, Province, Postal Code)			
Plan Administrator's Name		Telephone Number ()	
Member's Name (First)	(Last)	Member ID	
Occupation	Current Salary \$ <input type="checkbox"/> Hrly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Bi-Wkly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Ann.		

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

Does the member currently have coverage for the benefits being requested for dependent(s)? Yes No

Reason for submitting health status

Excess/Increased Coverage Late Applicant Re-application (previously declined)

If your plan has optional life and the member is applying for this benefit, please indicate optional life benefit type below and amount of coverage requested:

Benefits Requested (Please check off)	Amount of Coverage (Being Requested)
<input type="checkbox"/> Optional Life - Member	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - Spouse	\$ <input type="text"/>

Plan Administrator's signature X	Date (d/m/y)
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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.

2.1 General information about the Member

Company Name			Contract Number		
Member's Name (First) (Last)		Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member ID	
Member's Address (Street, City, Province, Postal Code)			Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg	
Member's Home Telephone Number ()		Member's Business Telephone Number ()			

2.2 General information about the Member's Dependents

Spouse's Name (First) (Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Child's Name (First) (Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Child's Name (First) (Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Child's Name (First) (Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Child's Name (First) (Last)	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in. <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have a yearly checkup? If yes, please specify (date of last check-up and results)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Within the past 12 months have you lost work due to illness or injury (if yes provide dates, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Received disability benefits for 3 months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Had an application for life or disability insurance declined or assessed at a higher than standard premium rate? (If yes, specify name of insurer, date, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you used any tobacco products within the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a physician?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you consume alcoholic beverages?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Specify date of last consumption, frequency of use			
• Have you ever been advised to stop drinking or to drink less?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you have diabetes mellitus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
a) Do you take insulin?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Do you take oral medication? (please list medications used)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) List your last 3 blood sugar readings _____			
10. Are you presently under medical treatment by diet, medicine or other means (include names of all medications currently being used)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Cancer, malignancy, leukemia or enlarged lymph nodes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Heart problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Liver disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Kidney disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Lung disorder (including asthma)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Neurological disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Psychiatric or psychological problems (including anxiety, depression, panic disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Chronic fatigue syndrome?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) Arthritis joint or bone problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
l) Back or neck problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
m) High blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
n) Gastrointestinal disorder (including colon, esophageal, bowel disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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”.

Sun Life Assurance Company of Canada
SunAdvantage Department
Private and Confidential
PO Box 11010 Stn CV
Montréal QC H3C 4T9

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