

Health Statement



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 \$	<input type="checkbox"/> Hrly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Bi-Wkly. <input type="checkbox"/> Mthly. <input type="checkbox"/> 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)
<input type="checkbox"/> Basic Life - member	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Basic Life - spouse	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Basic Life - dependent	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - member	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - spouse	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - dependent	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Long-term disability	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Short-term disability	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Other _____	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Extended Health - member*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Extended Health - dependent*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Dental - member*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Dental - dependent*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	

* 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.

Complete this section only if applying for dependent coverage.

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.

2.1 General information about the Member

Member's Name (First) (Last)		Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> 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 ()		<input type="checkbox"/> Day <input type="checkbox"/> Evening	Member's business telephone number () <input type="checkbox"/> Day <input type="checkbox"/> Evening	

2.2 General information about the Member's Dependents

Spouse's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female

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 <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 check-up? (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 last 12 months have you lost work due to illness or injury? (If yes, provide dates and reasons)	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 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 <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 three 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) Ever been declined for Life or Disability insurance? (If yes, specify name of insurer, date 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"/>
d) Ever been offered Life or Disability insurance at a higher than standard risk? (If yes, specify name of insurer, date 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"/>
5. Have you used any tobacco products within the last 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 last 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a doctor?	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"/>
a) Average number of drinks per week:	Beer: _____ Wine: _____ Spirits: _____	_____	_____
b) 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"/>

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 <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 or impaired sugar levels?	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) What is your current treatment for diabetes?	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"/>
	oral medication: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	diet only: 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) List your last 3 blood sugar readings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
10. a) Height	<input type="checkbox"/> _____ ft./in. <input type="checkbox"/> _____ m/cm	<input type="checkbox"/> _____ ft./in. <input type="checkbox"/> _____ m/cm	<input type="checkbox"/> _____ ft./in. <input type="checkbox"/> _____ m/cm
b) Weight	<input type="checkbox"/> _____ lb. <input type="checkbox"/> _____ kg	<input type="checkbox"/> _____ lb. <input type="checkbox"/> _____ kg	<input type="checkbox"/> _____ lb. <input type="checkbox"/> _____ 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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Illnesses of the heart or circulatory system?	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) Liver disorder or hepatitis?	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) 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"/>
e) Lung or respiratory 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"/>
f) 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"/>
g) Psychiatric or psychological problems (including anxiety, depression or 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"/>
h) Chronic fatigue syndrome or fibromyalgia?	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) Musculoskeletal, joint or bone disorder (including arthritis)?	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) 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"/>
k) High blood pressure or high cholesterol? (If yes, please list your last three readings below)	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) Gastrointestinal disorder (including esophageal, colon or 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"/>
12. Have you ever tested positive for AIDS, ARC or HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you ever suffered a heart attack or myocardial infarction?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you ever had a 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"/>
15. Have you ever had an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Do you have any other relevant comments you feel will be helpful as we assess your medical and lifestyle history?			

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

Question	Further details

