Critical Illness Insurance – Claimant statement

Sun Life Financial

Policy number

Do not tell us about genetic testing or genetic testing results.

1 Personal information

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Gender ☐ Male ☐ Female

Provincial health insurance plan number	Date of birth (dd-mm-yyyy)

Address (street number and name)	Apartment	City

Province	Postal code	Daytime telephone number

2 Claim details

Describe the nature and extend of your critical illness.

Date your condition was diagnosed (dd-mm-yyyy)	Date surgery was performed, if applicable (dd-mm-yyyy)	Date the symptoms of your illness first appeared (dd-mm-yyyy)	Date you first consulted a physician for your illness (dd-mm-yyyy)

Last name of the physician consulted	First name

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number

Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No
If '**yes**' provide details including dates.

Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No
If '**yes**', provide details including dates.

3 Medical consultations

Last name of your physician	First name

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number

3 Medical consultations (continued)

Provide details of any other physicians or specialists who have been consulted in connection with your illness.

Physician's last name	First name	Dates seen (dd-mm-yyyy) to	
Address			Telephone number
Physician's last name	First name	Dates seen (dd-mm-yyyy) to	
Address			Telephone number
Physician's last name	First name	Dates seen (dd-mm-yyyy) to	
Address			Telephone number

If you have been treated at a hospital or health facility, provide the following information.

Name of hospital/facility	Dates admitted (dd-mm-yyyy)
Address	Dates discharged (dd-mm-yyyy)
Name of hospital/facility	Dates admitted (dd-mm-yyyy)
Address	Dates discharged (dd-mm-yyyy)

4 General information

Has your father, mother or any of your brothers or sisters **ever** suffered from a similar or related condition? ☐ Yes ☐ No

If '**yes**', provide details below.

Relationship	Name of condition	Year diagnosed	Age at diagnosis

Are you insured for critical illness benefits under any other Sun Life Financial policy or with another company? ☐ Yes ☐ No

If '**yes**', provide details below.

Name of insurer	Policy number	Amount of benefits insured	Has a claim been submitted?
		$	☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No

If '**yes**', indicate amount per day. ☐ How long have you used tobacco? ☐

If '**no**', did you previously use tobacco products? ☐ Yes ☐ No If '**yes**', to the best of your knowledge, in what year did you quit? ☐

5 Authorization

I authorize Sun Life Assurance Company of Canada, it's agents and service providers to collect, use and exchange information about the insured person or this claim (including medical history, autopsy results, toxicological or pathological findings), needed for underwriting, administration and adjudicating this claim, form and with any person or organization, including, health professionals, hospitals, medically-related facilities, government agencies, provincial health care plans, institutions, the MIB, Inc., investigative agencies, law enforcement agencies, insurers and reinsurers.

I uderstand this authorization continues to have effect beyond the duration of this claim.

Signature of insured X		Date (dd-mm-yyyy)
Name of claimant/benefit payee		Relationship to insured
Date (dd-mm-yyyy)	Signature of claimant/benefit payee X	

A copy of this authorization is as valid as the original.

Sun Life Assurance Company of Canada, by providing this form for the claimant's convenience, doesn't admit any liability to pay or waive any of its rights.

Please send the completed original form to:

Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5

You can fax this form to fax number 1-866-487-4745. If you do, please keep a copy for your future reference and ensure the original form is sent to the address above.

Policy number

Important information you should know

Important: Ensure you leave this page with the claimant.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.