Medical information and functional ability questionnaire for long term care insurance

Sun Life Financial

Before completing this questionnaire, please first review the General eligibility questions in section 1 to determine if an application should be submitted.

Proposed insured's first name	Middle initial	Last name	Evidence number (For H.O. use only)
			E#

1 General eligibility

It's important you provide complete and true information for us to assess your application. If you're not sure whether some information is relevant, provide it anyway. If you fail to provide all relevant information that you know about, future claims could be denied and any policy we've issued declared void. Do not tell us about genetic testing or genetic test results.

Note: If more space is required for any question in section 1, provide additional details in section 4.

1. Height: ☐ cm ☐ ft & in Weight: ☐ kg ☐ lb

2. In the **last 12 months**, have you lost/gained more than 10 lbs or 4.5 kgs? ..... ☐ Yes ☐ No
   If '**yes**', provide details including how much weight has been lost/gained and the reason for weight change.

3. Have you **ever** been diagnosed with, treated for, or consulted with a medical or health care professional for any of the following:

		Yes	No
a)	acquired immune deficiency syndrome (AIDS) or HIV positive, or AIDS related complex (ARC)	☐	☐
b)	Alzheimer's disease	☐	☐
c)	amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)	☐	☐
d)	chronic congestive heart failure	☐	☐
e)	cirrhosis of the liver	☐	☐
f)	current use of narcotic pain medication more than once per week	☐	☐
g)	cystic fibrosis	☐	☐
h)	Huntington's disease	☐	☐
i)	Marfan's syndrome	☐	☐
j)	memory loss, senility, dementia, confusion or organic brain syndrome	☐	☐
k)	multiple myeloma	☐	☐
l)	multiple sclerosis or demyelinating disease	☐	☐
m)	muscular dystrophy	☐	☐
n)	neurogenic bladder or renal/kidney failure	☐	☐
o)	paraplegia, hemiplegia, quadriplegia	☐	☐
p)	Parkinson's disease	☐	☐
q)	post polio syndrome	☐	☐
r)	schizophrenia	☐	☐
s)	sickle cell anemia	☐	☐
t)	systemic lupus erythematosus	☐	☐
u)	two or more (individually or in combination): mini-stroke, transient ischemic attack (TIA), stroke, or cerebrovascular accident (CVA)	☐	☐

4. Do you use a medical appliance or therapeutic medical equipment such as chronic nebulizer (mask), dialysis, feeding tube, hospital bed, Hoyer lift, motorized cart, multi-pronged cane, oxygen equipment, respirator, stair-lift, walker or wheelchair? ..... ☐ Yes ☐ No

5. Has it been recommended that you have any medical tests, investigations or health care consultations that are not yet completed or for which the results are not yet known (**exclude routine preventative testing**)? ..... ☐ Yes ☐ No

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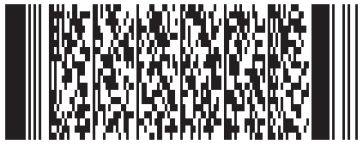

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1 General eligibility (continued)

6. Do you need the assistance or supervision of another person for bathing, dressing, toileting, transferring (such as moving to or from a bed or chair), continence or feeding? ..... ☐ Yes ☐ No

7. Do you need the assistance or supervision of another person for **more than one** of the following: using the telephone, managing finances, taking transportation, shopping, laundry, housework, preparing meals/cooking or taking medications? ..... ☐ Yes ☐ No

If you answered 'yes' to question 3, 4, 5, 6, or 7, you are ineligible for long term care insurance with us. Please do not proceed with this application.

8. a) Have any of your biological parents, brothers or sisters been diagnosed **before age 65** with heart disease, stroke/TIA, cancer (including leukemia, lymphoma and Hodgkin's disease), diabetes or Parkinson's disease?..... ☐ Yes ☐ No

   b) Have any of your biological parents, brothers or sisters, **ever** been diagnosed with Huntington's disease, polycystic kidney disease (PKD), multiple sclerosis (MS), muscular dystrophy, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease), retinitis pigmentosa, or any other hereditary disease or disorder? ..... ☐ Yes ☐ No

   If '**yes**' to a) or b), complete the following chart. **Do not tell us about genetic testing or genetic test results.**

Relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

9. i) In the **last 12 months**, have you smoked or used cigarettes, cigarillos, small or large cigars, pipes, marijuana or hashish, betelnut, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ..... ☐ Yes ☐ No

   If '**yes**', specify which type and date last smoked or used.

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd-mm-yyyy)

   ii) Have you **ever** consulted a medical or health care professional, or been treated for or had any symptoms or indication of:

	Yes	No
a) aneurysm	☐	☐
b) arteritis	☐	☐
c) carotid artery disease	☐	☐
d) coronary artery disease (CAD)	☐	☐
e) cardiomyopathy	☐	☐
f) congestive heart failure (CHF)	☐	☐
g) diabetes	☐	☐
h) lung, throat or mouth cancer	☐	☐
i) neuropathy	☐	☐
j) peripheral vascular disease (PVD)	☐	☐
k) stroke	☐	☐

If you have answered 'yes' to question 9 i) and 'yes' to any of the conditions in 9 ii), you are ineligible for long term care insurance with us. Please do not proceed with this application.

   iii) Have you **ever** consulted a medical or health care professional, or been treated for or had any symptoms or indication of:

	Yes	No
a) asthma (**exclude childhood asthma**)	☐	☐
b) chronic bronchitis	☐	☐
c) chronic obstructive pulmonary disease (COPD)	☐	☐
d) emphysema	☐	☐
e) pulmonary fibrosis	☐	☐
f) shortness of breath, sleep apnea or other lung problems or breathing conditions **(excluding colds and flus)**	☐	☐

Excluding the use of betelnut, chewing tobacco, nicotine gum or patches in the last 12 months, if you have answered 'yes' to 9 i) and 'yes' to any of the conditions in 9 iii), you are ineligible for long term care insurance with us. Please do not proceed with this application.

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2 Personal information for the proposed insured

Note: If more space is required for any question in section 2, provide additional details in section 4.

1. Have you **resided** in Canada for the **last 12 months**? ☐ Yes ☐ No

   If '**no**', provide details.

2. Citizenship

   ☐ Canadian citizen ☐ Permanent resident status ☐ Other If other:

Specify citizenship	Country of birth	Date arrived in Canada (dd-mm-yyyy)
Current status in Canada	Intention for residency	

3. In the **last 12 months**, have you **travelled** outside of Canada or do you intend to do so within the **next 12 months**? **(Exclude travel of less than 6 months in the United States.)** ☐ Yes ☐ No

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

4. a) Occupation

   b) If unemployed or retired, is this for health reasons? ☐ Yes ☐ No

   If '**yes**', provide details including why you are unemployed, how long you have been unemployed, what your previous occupation was and when/if you plan to gain employment.

   c) If you are a student, provide details including field of study and expected graduation date.

5. Do you have any long term care insurance in force with any company, including the Sun Life Assurance Company of Canada? ☐ Yes ☐ No

   If '**yes**', complete the following chart.

Insurance company	**Insurance date (mm-yyyy)**	**Weekly benefit amount**	**Being replaced**
			☐ Yes ☐ No
			☐ Yes ☐ No

6. Do you have any applications for life, disability, critical illness or long term care insurance currently pending or contemplated? ☐ Yes ☐ No

   If '**yes**', provide details indicating all company names, plan types, amounts applied for and total amount of new insurance to be put into effect.

7. Have you **ever** had any applications for life, disability, critical illness or long term care insurance declined, rated or modified in any way? ☐ Yes ☐ No

   If '**yes**', provide details including all application dates, decisions, reasons and company names.

8. What is your annual earned income, including salary, commissions and bonuses? $

9. What is your annual unearned income from other sources, including pensions, dividends, interest and income from real estate? $

   Source of income

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2 Personal information for the proposed insured (continued)

10. What is your personal Canadian net worth? $

11. What is the total annual earned and unearned income for your spouse/partner (if applicable)? $

12. In the **last 5 years**, have you declared or been petitioned into personal or corporate bankruptcy? ☐ Yes ☐ No
If '**yes**', provide details.

Circumstances regarding the bankruptcy	Date of discharge (dd-mm-yyyy)

13. Have you **ever** received treatment or been told to reduce use or frequency of use, seek treatment, counselling or medical advise due to your use of drugs or alcohol? ☐ Yes ☐ No
If '**yes**', indicate type of counselling or treatment and dates attended. Include any participation in organizations such as Alcoholics Anonymous and Narcotics Anonymous.

Type of counselling or treatment	**Dates attended (dd-mm-yyyy)**

14. Do you currently drink alcohol? ☐ Yes ☐ No
If '**yes**', indicate the type and amount you drink in an average week.

Product (spirits, wine or beer)	**Amount consumed in an average week**

15. In the **last 10 years**, have you been charged with, or convicted of, an alcohol or drug related driving offence or refusing a breathalyzer test? ☐ Yes ☐ No
If '**yes**', provide details.

16. In the **last 10 years**, have you used marijuana, hashish, cocaine, LSD, ecstasy or other psychoative drugs, heroin, fentanyl or other narcotics, anabolic steroids or other performance enhancing drugs? ☐ Yes ☐ No
If '**yes**', complete the chart below.

Product(s)	**Amount(s) and frequency of use**	**Date(s) last used (dd-mm-yyyy)**

17. In the **last 10 years**, have you been convicted of or imprisoned for any criminal offence; or are you currently on probation, parole or statutory release? ☐ Yes ☐ No
If '**yes**', provide details.

18. In the **last 5 years**, have you received a disability income benefit (for example, Worker's Compensation (WCB), Canada Pension Plan (CPP), long or short term disability) because of illness or injury for a period **exceeding 2 weeks**? ☐ Yes ☐ No
If '**yes**', provide details.

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3 Medical information

Note: If more space is required for any question in section 3, provide additional details in section 4.

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

1. Name and address of usual medical advisor or clinic.

a) Do you have a usual medical advisor or clinic? ☐ Yes ☐ No	If '**yes**', name of usual medical or health care advisor or medical clinic.		
Address		City	Province
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
Answer b) if '**yes**' to a). b) In the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).		
Answer c) if '**no**' to a). c) In the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).		
If '**yes**', name and address of doctor consulted.			

2. In the **last 3 years**, have you had a complete physical examination? ..... ☐ Yes ☐ No

3. Have you **ever** been treated for or had any symptoms or indication of:

	Yes	No
a) stroke or cerebrovascular accident (CVA), aneurysm, transient ischemic attack (TIA), mini-stroke, numbness or weakness of an arm or leg, paralysis, visual disturbance, optic neuritis, permanent or temporary loss of vision in either eye, dizziness, fainting, imbalance, loss of sensation, neuropathy, tremors or any other neurological disease or disorder	☐	☐
b) abnormal blood sugar, impaired glucose tolerance or diabetes	☐	☐
c) hepatitis (including hepatitis carrier state), jaundice, liver disease or disorder	☐	☐
d) high blood pressure	☐	☐
e) enlarged glands or lymph nodes, hemophilia, anemia or any other blood disease or disorder	☐	☐
f) cancer, tumour, cysts, polyps, abnormal pap smear or any other growth or malignancy	☐	☐
g) kidney, bladder or prostate disease or disorder, including protein or red blood cells in the urine, abnormal PSA or urinary incontinence	☐	☐
h) Crohn's disease, ulcerative colitis, peptic or gastric ulcer, bowel incontinence, rectal or intestinal bleeding, persistent diarrhea or any other, disease or disorder of the bowel, stomach or pancreas	☐	☐
i) epilepsy, cerebral palsy, concussion, fainting, loss of consciousness, dizziness, severe headaches or any other disease or disorder of the brain or nervous system	☐	☐
j) depression, anxiety, burnout, nervous breakdown or any other mental, emotional or nervous disease or disorder	☐	☐
k) fibromyalgia, fatigue, chronic fatigue syndrome, chronic pain syndrome, myofascial pain syndrome or temporomandibular joint disorder (TMJ)	☐	☐
l) arthritis, osteopenia, osteoporosis or amputation	☐	☐
m) heart attack, angina, chest pain, congestive heart failure (CHF), arteritis, coronary artery disease (CAD), irregular pulse, peripheral vascular disease (PVD) or any other disease or disorder of the heart or blood vessels	☐	☐
n) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, sleep apnea, shortness of breath, or any other lung problems or breathing conditions **(exclude colds and flu)**	☐	☐

4. In the **last 2 years**, have you been treated for or had any symptoms or indication of:

a) hyperthyroidism, hypothyroidism or any other thyroid or endocrine disease or disorder	☐	☐
b) blindness or deafness, or any other disease or disorder of the eye, ear, nose, throat or mouth (**exclude routine check-ups where no follow-up required, such as tonsillectomy and adenoidectomy, sinusitis, or any disease or disorder requiring eye-glasses, contact lenses or ear tubes**)	☐	☐
c) skin disease, skin lesions, chronic infections, abnormal moles or dysplastic nevi (**exclude poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema**)	☐	☐

5. In the **last 5 years**, have you had any falls? ..... ☐ Yes ☐ No

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3 Medical information (continued)

6. Give details for any '**yes**' answers to questions 3, 4 or 5.

Question number	Symptoms/conditions	Details including diagnosis, treatment and current status, and relevant dates for each	Names/addresses of physicians, medical facilities and hospitals consulted for symptoms/conditions

7. In the **last 12 months**, have you taken any prescribed or non-prescribed medications? ..... ☐ Yes ☐ No
If '**yes**', complete the following chart.

Medication	Reason for taking	Date first taken (dd-mm-yyyy)	Dosage	Most recent dosage change (dd-mm-yyyy)	Date last taken (dd-mm-yyyy)

8. In the **last 5 years**, have you consulted a medical or health care professional, or been treated for or had any symptoms or indication of any disease or disorder of the bones, joints, tendons, muscles or limbs including knees, hips, shoulders, neck or back? ..... ☐ Yes ☐ No

9. In the **last 2 years**, have you been treated for or had any pain that lasted **more than one week** or has recurred **more than once** in the same location of your body (regardless of the duration)? ..... ☐ Yes ☐ No
If '**yes**', complete and attach the required *Pain questionnaire – Long term care insurance* (E298).

10. In the **last 5 years**, have you had any X-rays, ECGs, scans, MRIs, ultrasounds, biopsies, blood or unine tests? **(Exclude any tests you've already told us about on this form. Do not tell us about genetic testing or genetic test results.)** .... ☐ Yes ☐ No
If '**yes**', complete the following chart.

Test/reason for test	**Date of test (mm-yyyy)**	**Test results**	**Details of any abnormalities**
		☐ Normal ☐ Abnormal	
		☐ Normal ☐ Abnormal	
		☐ Normal ☐ Abnormal	
		☐ Normal ☐ Abnormal	

11. Are you aware of any symptoms or complaints, regarding your health, for which you have not yet consulted a physician or received treatment? ..... ☐ Yes ☐ No

12. **Other than for conditions already disclosed**, in the **last 5 years**, have you had any medical condition for which you have been or are being investigated, under observation or treated for, or are there any medical consultations for which you are currently awaiting investigations or test results? **(Do not tell us about genetic testing or genetic test results.)** ..... ☐ Yes ☐ No

13. Has any surgery, diagnostic test or medical treatment been discussed, recommended or planned? ..... ☐ Yes ☐ No

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3 Medical information

14. In the **last 12 months**, have you received any physiotherapy, chiropractic treatment, massage therapy, acupuncture or any other treatment for any condition or symptom? ..... ☐ Yes ☐ No

If '**yes**', complete the following chart.

Type of treatment	Date treatment started (mm-yyyy)	Date of most recent treatment (dd-mm-yyyy)	Condition/symptom that prompted treatment and current status	Details including frequency of treatment, if ongoing or completed, and final treatment date if completed

15. **Other than for conditions already disclosed**, in the **last 5 years**, have you consulted any other physicians or health care professional, or been a patient in a hospital, clinic or other medical facility or had any surgery or other treatment? ..... ☐ Yes ☐ No

16. Give details for any '**yes**' answers to questions 8, 10, 11, 12, 13, or 15.

Question number	Date (mm-yyyy)	Details including conditions/symptoms, complaint, event, what was discussed, recommended and completed, as well as the results of all tests/treatments	Details including name/addresses of attending physicians and their specialties, all medical facilities/hospitals, dates consulted, seen and treated

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4 Additional details

Use this chart to provide additional details for any questions in sections 1 - 3, where enough space was not provided.

Question number	Details

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5 Declaration

The proposed insured confirms:

- they were present when their portion of this questionnaire was completed,
- they reviewed all their answers and statements recorded in this questionnaire,
- this information is complete and true and may be relied upon by Sun Life Assurance Company of Canada (company), and
- they understand that if they do not completely and truthfully answer all of the questions (if they misrepresent any of their answers or statements) the company may void the policy.

6 Authorization of the proposed insured

The proposed insured authorizes:

a) any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigation agencies, MIB, Inc., or other organization, institution or person, including members of the Sun Life Financial group of companies, which includes this company, that have records or knowledge about me, to give only that information necessary for underwriting, administration of insurance and claims purposes to the company, its representatives, service providers and reinsurers,

b) the performance of such examinations, electrocardiograms, blood profiles and tests for HIV (AIDS) antibody and hepatitis, if needed to underwrite this application, and

c) the company to release only the necessary personal information obtained during the underwriting process to my personal physician, to MIB, Inc., to any insurance company if an application has been made to that company for an insurance policy on my life, and for any infectious or communicable disease, to the Medical Officer of Health where required by law.

Province signed	Date (dd-mm-yyyy)	Signature of proposed insured
		X

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

7 LTCI specialist/advisor declaration

I confirm I've reviewed with the proposed insured, all of their answers in this questionnaire and, to the best of my knowledge, this information is complete, true, and has all the facts material to the insurance applied for.

I confirm I saw the proposed insured sign this form.

Date (dd-mm-yyyy)	Advisor/LTCI specialist's signature	Advisor/LTCI specialist's no.	Financial centre no.
	X		
Date (dd-mm-yyyy)	Supervisor's signature		
	X		

Please submit only one copy of this document.
Career Sales Force advisors: Original or fax toll-free to 1-866-487-4745.
All others: Through your MGA or National Account.

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