

Pain questionnaire – long term care insurance



Evidence no. (For H.O. use only)
E #

Proposed insured's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
LTCL specialist/advisor's first name	Middle initial	Last name	LTCL specialist/advisor's no.

1. Describe the part(s) of your body where you do experience or have experienced pain.

2. What condition (diagnosis) causes or caused your pain?

3. When was the first time you experienced the pain?

Date (dd-mm-yyyy)
 - -

4. When was the last time you experienced the pain?

Date of (dd-mm-yyyy)
 - -

5. How often has the pain occurred in the last 2 years? daily weekly monthly other
If 'other', provide full details.

6. For each episode, provide details on how long the pain lasted (number of hours, days, weeks, months).

7. What activities aggravate your pain?

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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Pain questionnaire – long term care insurance (continued)

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8. Have you changed your activities because of your pain? Yes No If 'yes', provide details in the box below.

9. Do you have difficulty sleeping because of your pain? Yes No If 'yes', provide details in the box below.

10. Do you have any limitations to activities such as standing, sitting, bending or lifting? Yes No
If 'yes', provide details in the box below.

11. In the last 2 years, have you needed medication because of your pain? Yes No
If 'yes', provide details in the chart below.

Medication	Date first taken (mm-yyyy)	Current dosage	Date of most recent dosage change (mm-yyyy)	How often taken (daily, weekly, monthly, etc.)	Date last taken (mm-yyyy)
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-

Declaration: I declare that the answers and statements to all of the questions are complete and true and shall form part of my application for insurance on my life with the Sun Life Assurance Company of Canada (company). I understand that if I do not completely and truthfully answer all of the questions (if I misrepresent my answers or statements) the company may void the policy.

Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) - -	Signature of proposed insured X
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