# Personal Health Insurance – Add family member

Sun Life Financial

| Policy<br>**037000** | ID number |
|---|---|
| First name of owner | Last name |

## A Plan information

**Health Coverage Choice (HCC) plan** - Only complete section **A**, **B** and **D**.

☐ Add my spouse and/or child. I am aware that my spouse/child must meet eligibility requirements. They had previous group coverage within the last 60 days.

☐ Add my child who is within 30 days of birth and /or adoption.

Name of group benefits carrier: ☐ Sun Life Assurance Company of Canada

☐ Other

| Group policy number | Group certificate number | Group benefits end date (dd-mm-yyyy) |
|---|---|---|
| Name of employer | | Employer's phone number |

What coverage did your family member(s) have under this plan?

☐ dental ☐ supplementary health (including physiotherapy, chiropractic care, etc.) ☐ prescription drugs

☐ other

Note - The dependant(s) will be added effective the next coverage period following approval.

**Personal Health Insurance (PHI) plan –** Complete all sections of the form.

☐ Add my spouse and/or child.

☐ Add my child who is within 30 days of birth and /or adoption.

Nota : La ou les personnes à charge seront ajoutées à la prochaine période de couverture, si la proposition est acceptée.

## B Family members you want to add

If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the owner and each proposed insured. If proposed insured is under age 16 (18 in Quebec), signature of the parent or legally appointed guardian is required.

**Spouse/Partner**

| First name | | Last name | |
|---|---|---|---|
| Sex<br>☐ Male ☐ Female | Date of birth (dd-mm-yyyy) | Height ☐ ft/in ☐ m/cm | Weight ☐ lbs. ☐ kg |
| **If you are not a Quebec resident:**<br>Do you have provincial health care coverage? ☐ Yes ☐ No | | Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No<br>If yes, reason: | |
| If you are a Quebec resident, complete section D **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)** | | | |

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**Please send fax or original.**

## B Family members you want to add (continued)

### Child # 1

| First name | | Last name | |
|---|---|---|---|
| Sex ☐ Male ☐ Female | Date of birth (dd-mm-yyyy) | Height ☐ ft/in ☐ m/cm | Weight ☐ lb ☐ kg |
| **If you are not a Quebec resident:** Do you have provincial health care coverage? ☐ Yes ☐ No | Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason: | Full-time student? ☐ Yes ☐ No | |
| If you are a Quebec resident, complete section D **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)** | | | |

### Child # 2

| First name | | Last name | |
|---|---|---|---|
| Sex ☐ Male ☐ Female | Date of birth (dd-mm-yyyy) | Height ☐ ft/in ☐ m/cm | Weight ☐ lb ☐ kg |
| **If you are not a Quebec resident:** Do you have provincial health care coverage? ☐ Yes ☐ No | Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason: | Full-time student? ☐ Yes ☐ No | |
| If you are a Quebec resident, complete section D **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)** | | | |

### Child # 3

| First name | | Last name | |
|---|---|---|---|
| Sex ☐ Male ☐ Female | Date of birth (dd-mm-yyyy) | Height ☐ ft/in ☐ m/cm | Weight ☐ lb ☐ kg |
| **If you are not a Quebec resident:** Do you have provincial health care coverage? ☐ Yes ☐ No | Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason: | Full-time student? ☐ Yes ☐ No | |
| If you are a Quebec resident, complete section D **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)** | | | |

## C Personal information

### General information

Has any application for life, critical illness, long term care, disability, drug, dental or health insurance **ever** been declined, rated or modified in any way?

Spouse/Partner ☐ Yes ☐ No  Child # 1 ☐ Yes ☐ No  Child # 2 ☐ Yes ☐ No  Child # 3 ☐ Yes ☐ No

If yes, please provide the following details:

| Name of family member | Decision | Details (type of insurance, name of company, date applied for, reason for decline, rating or modification) |
|---|---|---|
| | ☐ declined ☐ rated ☐ modified | |
| | ☐ declined ☐ rated ☐ modified | |
| | ☐ declined ☐ rated ☐ modified | |



**Please send fax or original.**

## C Personal information (continued)

Name and address of usual medical advisor or medical clinic (if different, please list individual doctors for each person)

| | Spouse/Partner | Child(ren) | Child(ren) |
|---|---|---|---|
| 1. Have you **ever** consulted with any health care professional about the following, or had treatment for or had any known indication of: | | | |
| a) heart attack, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, or other heart or circulatory disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) cancer, tumour or other growth or malignancy, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) diabetes, elevated blood sugar, hyperthyroidism, hypothyroidism or other thyroid, endocrine or kidney disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) acid reflux disease, irritable bowel syndrome, colitis, Crohn's disease, hepatitis, cirrhosis or other stomach, bowel, pancreas or liver disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, allergies, or other respiratory disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) depression, anxiety, attention deficit disorder (ADD), eating disorder, autism, epilepsy, multiple sclerosis, migraines, Alzheimer's disease, dementia or any other psychological, emotional or nervous system disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g) acne, rosacea, eczema, psoriasis, lupus, scleroderma or other skin or connective tissue disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h) arthritis, fibromyalgia, osteoporosis, paralysis, chronic or persistent pain or any other back, joint or musculoskeletal disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| i) blindness, glaucoma, loss of vision, deafness, impaired hearing or other eye or ear disease or disorder, | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| j) drug or alcohol abuse? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you **ever** had any consultation with any health care professional about, treatment for, or any known indication of AIDS, positive HIV or immunological disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. In the **last 5 years**, have you received disability income replacement benefits, or had an illness or injury that prevented you from performing your usual activities or occupation for a period of more than 2 weeks? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Other than for conditions already disclosed, in the **last 2 years** have you seen any health care practitioner, including a naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or podiatrist? If yes, describe the type of practitioner and the reason. | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. In the **last 2 years**, has there been any doctor's visit or hospitalization, recommended treatment or prescribed medication? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Are you currently using any prescribed medication, medical equipment or testing device or do you expect to do so in the **next 3 months**? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Has any health care practitioner recommended any tests, treatment, examination, surgery, hospitalization or referrals that have not yet been completed, or are you currently awaiting test results? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |



**Please send fax or original.**

## C Personal information (continued)

8. Do you have any symptoms for which you have not yet seen a health care professional? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If you answered yes to any questions in the previous section, please provide further details including dates, treatment and medications.

If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the owner and each proposed insured. If the proposed insured is under age 16 (18 in Quebec), the signature of the parent or legally appointed guardian is required.

| Question number | Name of family member | What was the diagnosis? | Date symptoms or condition started (dd-mm-yyyy) | Date symptoms or condition ended (dd-mm-yyyy) | Date of last treatment/service (dd-mm-yyyy) | Type of treatment provided (include name & dosage of medication) and name of doctor |
|---|---|---|---|---|---|---|
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## D Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ).

Quebec residents must have health coverage through the Régie de l'assurance maladie du Québec (RAMQ) to be eligible for a PHI (Personal Health Insurance) or HCC (Health Coverage Choice) policy. Quebec residents must also have and continue to have group drug coverage provided by an employer or through membership in an order or association or, if not, through RAMQ to be eligible for a PHI or HCC policy. A person not covered under a group benefits plan or through RAMQ is not eligible for coverage under this policy. All prescription drug claims must first be submitted to your group benefits provider or RAMQ; any remaining unpaid portion that is eligible under this policy can then be submitted to Sun Life Financial for reimbursement.

Please select the appropriate response:

☐ I am confirming that I (and spouse/dependants if applicable) have and will continue to have the RAMQ prescription drug insurance and the RAMQ medi-care insurance.

☐ I am confirming that I (and spouse/dependants if applicable) have and will continue to have the prescription drug insurance through a group benefits plan and to have the RAMQ medi-care insurance:

| Name of group insurance carrier | Group policy number | Group certificate |
|---|---|---|
| | | |

Benefits insured under this plan:

Prescription Drug ☐ Yes ☐ No Supplementary health ☐ Yes ☐ No Dental ☐ Yes ☐ No

| First name of family member insured under this group plan | Last name |
|---|---|
| First name of family member insured under this group plan | Last name |
| First name of family member insured under this group plan | Last name |

I understand I/we need to submit claims to the group plan first. Any remaining claims should be submitted to Sun Life Financial to be coordinated.

☐ I do not have RAMQ medi-care and RAMQ prescription drug insurance or group prescription drug insurance. I do not wish to proceed with my application.

*Personal Health Insurance/Health Coverage Choice is not a substitute for RAMQ; therefore you cannot opt out of RAMQ because you*



**Please send fax or original.**

## D Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ). (continued)

*have a PHI or HCC policy. You must obtain RAMQ prescription drug insurance if your group drug coverage ends and you do not have access to another group drug coverage.*

## E Acknowledgement and agreement for Personal Health Insurance

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.

**Acknowledgement and agreement:** You declare that your statements in this application are true and complete, and will be relied upon by Sun Life Assurance Company of Canada ("company"). The application and any written amendment to your policy resulting from this application, together with your current policy, form the contract between you and the company.

You will inspect the amendment to verify its terms are satisfactory.

**Declaration:** The owner, proposed insured and payor confirm:

(a) they were present when their portion of this application with Sun Life Assurance Company of Canada was completed

(b) they reviewed all their answers and statements recorded in this application

(c) this information is full, complete and true, and may be relied upon by the company

(d) they understand and agree that the following may not be covered by the contract:
- any injury that happened on or before the date of this application
- any illness, the signs of which first appeared on or before the date of this application

(e) they understand and agree that coverage will begin only if your application is approved by us. We will tell you if any medical history requires a higher premium or an exclusion to the policy. You must either accept the changes or cancel your application on written notification to us

(f) if a resident of Quebec, they understand and agree they must be covered for health and drug coverage under RAMQ or a group plan and continue to be covered to be eligible for coverage under the policy

(g) they understand that if they do not fully, completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements), the company may void the policy

(h) they agree that their personal medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada

(i) they agree, if they are the payors, that if this application is approved, the company may continue to withdraw funds to pay premiums according to the authorization we currently have on file, and

(j) they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under "Products & services" section of the website at *www.sunlife.ca* or by calling us toll-free at 1-877-SUN-LIFE (1-877-786-5433)

**Authorization of owner and proposed insureds:** The owner and proposed insureds (parent or legally appointed guardian, if proposed insured is under age 16 (18 in Quebec) authorize:

- any physician, medical practitioner, medically-related facility, insurance company, investigation agencies, the Medical Information Bureau 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 of any proposed insured's health, to give only that information necessary of underwriting, administration of insurance and claims paying purposes to the company, its representatives and its reinsurers, and
- the company to release only the necessary personal information obtained during the underwriting process to their personal physician, the Medical Information Bureau, the Medical Director of any insurance company, if an insurance application has been made to that company, and for infectious or communicable disease, to the Medical Officer of Health where requitred by law.

A photocopy of this signed authorization is as valid as the original.



**Please send fax or original.**

## E Acknowledgement and agreement for Personal Health Insurance (continued)

| Signed at (City) | Signed at (Province) | Date (dd-mm-yyyy) | Signature |
|---|---|---|---|
| | | | Owner<br>X |
| | | | Spouse/Partner<br>X |
| | | | Dependant who has reached age 16 (18 in Quebec)<br>X |
| | | | Dependant who has reached age 16 (18 in Quebec)<br>X |
| | | | Payor (if payor is not Owner or Spouse/partner)<br>X |
| | | | Joint bank accountholder (if the bank account is jointly held)<br>X |

## F Advisor declaration

### Advisor declaration

I have reviewed each of the questions in this application with the Owner, the Spouse/Partner and any dependant who has reached the age of 16 (18 in Quebec), and this application fully records all information given to me for this application. To the best of my knowledge, the application discloses all facts material to the insurance being applied for.

☐ Check here if this application was taken by mail and was not reviewed with the Owner.

| Signed at | Date (dd-mm-yyyy) | Signature of advisor/broker<br>X | | |
|---|---|---|---|---|
| Supervisor's signature (Quebec only)<br>X | | Advisor number | Advisor telephone number | Advisor fax number |

**Before submitting this application, please make sure:**

- all questions have been answered for every member of the family you want covered
- for each yes answer in the Personal information section, full details including relevant dates have been included
- all signatures have been completed, including those of the Payor (if not the Owner or Spouse/Partner) and any dependants who have reached the age of 16 (18 in Quebec)
- If premiums are paid annually by cheque, a cheque for the number of full months before the next renewal date is required.

I have reviewed each of the questions in this application with the Owner, the Spouse/Partner and any dependant who has reached the age of 16 (18 in Quebec), and this application fully records all information given to me for this application.

**Please mail or fax the completed form to the address below:**

Sun Life Assurance Company of Canada
Personal Health Insurance
227 King Street South
P.O. Box 1601 Stn Waterloo
Waterloo ON N2J 4C5

Phone: 1-877-SUN-LIFE (1-877-786-5433)
Fax: 1-866-487-4745
www.sunlife.ca



**Please send fax or original.**