Personal Health Insurance – Add optional benefit

Sun Life Financial

Policy	ID number
037000	
First name of owner	Last name

A Plan information

Health Coverage Choice (HCC) – Only complete sections **A** and **C.**

☐ Add dental coverage. I am within the 30 day review period and/or within 60 days of group benefits ending.

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

Personal Health Insurance (PHI)

☐ Add optional dental benefit. I am within the 30 day review period. Only complete sections A and C.

☐ Add optional semi-private hospital room coverage. Complete all sections of the form.

☐ Add emergency travel medical benefit (Not available on all plans). Complete all sections of the form.

Questions about adding an optional benefit to your policy can be directed to your advisor or to us at 1-877-SUNLIFE (1-877-786-5433).

Note – The optional benefit will be added at the next coverage period following approval.

B Personal information

General information

If you, or any family member, has **ever** had health and dental insurance with Sun Life Assurance Company of Canada, please provide the policy and certificate numbers.

Policy number	Certificate number

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?

Owner ☐ Yes ☐ No Spouse/Partner ☐ Yes ☐ No Child # 1 ☐ Yes ☐ No

PHIOPTAE

Please send fax or original.

B Personal information (continued)

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 modifications)
	☐ declined ☐ rated ☐ modified	

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

If you answer yes to any questions, please provide further details below. Include dates, treatment and medications.

	Owner	Spouse/Partner	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

Please send fax or original.

B Personal information (continued)

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
8. Do you have any symptoms for which you have not yet seen a health care professional?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you had a weight loss of 10 lbs (4.5 kg) in the last year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Height and weight	Height ☐ in ☐ cm Weight ☐ lbs ☐ kgs	Height ☐ in ☐ cm Weight ☐ lbs ☐ kgs	Height ☐ in ☐ cm Weight ☐ lbs ☐ kgs

If you answered yes to any questions in the previous section, please provide further details.

If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the owner and each dependant insured on this policy. If the dependant 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?	Reason for weight loss	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

C 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, spouse, dependants and payors 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 coverage. You must either accept the changes or cancel your application on written notification to us

(f) 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

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

(h) they agree if they are the payors that if this application is approved, the company may continue to withdraw funds to pay

Please send fax or original.

C Acknowledgement and agreement for Personal Health Insurance (continued)

premiums according to the authorization we currently have on file, and

(i) 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 our toll-free Customer Service Centre at 1-877-SUN-LIFE (1-877-786-5433).

Authorization of owner, spouse and dependants (the signature of the parent or legally appointed guardian is required if the dependant 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 the owner, spouse or any dependant'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 required by law.

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

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

D 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 X		
Supervisor's signature (Quebec only) 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.

Please send fax or original.

D Advisor declaration (continued)

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.