Responsibility to report Parkinson's disease and specified atypical parkinsonian disorders

Evidence number (for HO use only)
E#

To be completed by the insured person:

Insured person's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Policy number	Policy number	Policy number

I declare that within one year following:

- the date the application for insurance was signed
- the policy date
- the underwriting decision date, if included in the policy on the *Amendments to this policy* page, or
- the most recent date the policy was put back into effect (reinstatement)

I've had:

- a diagnosis of Parkinson's disease or any specified atypical parkinsonian disorders,
- signs or symptoms of Parkinson's disease or any specified atypical parkinsonian disorders, or
- medical consultations or tests that led to a diagnosis of Parkinson's disease or any specified atypical parkinsonian disorders.

Declaration: I declare that the above statement(s) are complete and true and form part of any claim made for a critical illness benefit. I understand that any misrepresentation by me may result in the denial of any claim.

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

Province signed	**Date (dd-mm-yyyy)**	**Signature**
	Signed on	Insured person X
	Signed on	Policy owner X

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

CIIREVE

Career Sales Force advisors submit only one copy – original or fax toll-free to 1-866-487-4745.
All others: Through your MGA or National Account.