# Medical information and functional ability questionnaire for Long Term Care insurance

Name (first, middle, surname)  Policy No.

## A | Personal information for Proposed insured

1. **Citizenship**  
   - [ ] Canadian citizen  
   - [ ] Landed immigrant (permanent resident status)  
   - [ ] Other  
   If other, provide details: 

2. **Occupation**  
   - [ ] Employed or self-employed  
   - [ ] Homemaker  
   - [ ] Retired  
   - [ ] Student  
   - [ ] Unemployed  
   If employed or self-employed, please provide details by answering the following questions:  
   - Occupation:  
   - Job duties:  
   - If unemployed, are you unemployed for health reasons?  
   [ ] Yes  
   [ ] No  
   If ‘yes’, please provide details:  

If retired, please specify:  

- Date of retirement (d/m/y)  

Did you retire for health reasons?  
[ ] Yes  
[ ] No  
If ‘yes’, please provide details:  

3. Do you already have long term care insurance?  
[ ] Yes  
[ ] No  
If ‘yes’, specify total weekly benefit amount with Sun Life Assurance Company of Canada and with any other company as well as the amount that was purchased in the last 12 months in question 11.  

What is your total household income?  
$  
(only required if the total amount of LTCI exceeds $700 weekly)

4. Have you ever had any application for life, critical illness, disability or long term care insurance declined, rated or modified in any way?  
[ ] Yes  
[ ] No  
If ‘yes’, provide details, including date of application, decision and reason and name of company in question 11.  

5. Do you now have any application for long term care insurance pending with this company or any other company?  
[ ] Yes  
[ ] No  
If ‘yes’, provide details, including amount of insurance, name of company and if it will be replaced by this application in question 11.  

6. In the last 24 months, have you smoked cigarettes, cigarillos, cigars or pipes?  
[ ] Yes  
[ ] No  

7. In the last 24 months, have you used chewing tobacco?  
[ ] Yes  
[ ] No  

8. In the last 3 years have you smoked marijuana?  
[ ] Yes  
[ ] No  

9. a) In the last 5 years have you used alcoholic beverages?  
[ ] Yes  
[ ] No  
If ‘yes’, complete the following questions:  
   b) Have you ever received counselling or medical advice to reduce or discontinue your alcohol consumption?  
[ ] Yes  
[ ] No  
   c) Have you ever been treated for alcohol use or attended a meeting of an organization such as Alcoholics Anonymous for the purpose of rehabilitation?  
[ ] Yes  
[ ] No  
   d) In the last 5 years have you been found guilty of an alcohol-related driving offence? (Not applicable if offence was prior to age 18)  
[ ] Yes  
[ ] No  

10. In the last 5 years have you used cocaine, LSD or psychoactive drugs, heroin or other narcotics?  
[ ] Yes  
[ ] No
General eligibility

1. Have you ever been diagnosed with, treated for, or consulted with a medical advisor for the following:

   a) acquired immune deficiency syndrome (AIDS)  ☐ ☐
      or HIV positive, or AIDS related complications (ARC)  ☐ ☐
   b) Alzheimer’s disease  ☐ ☐
   c) amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease)  ☐ ☐
   d) cystic fibrosis  ☐ ☐
   e) diabetes requiring insulin (other than during pregnancy)  ☐ ☐
   f) Huntington’s chorea  ☐ ☐
   g) liver cirrhosis  ☐ ☐
   h) memory loss, senility, dementia, confusion or organic brain syndrome  ☐ ☐
   i) multiple sclerosis or demyelinating disease  ☐ ☐
   j) muscular dystrophy  ☐ ☐
   k) neurogenic bladder  ☐ ☐
   l) Parkinson’s disease  ☐ ☐
   m) post polio syndrome  ☐ ☐
   n) systemic lupus erythematosus  ☐ ☐
   o) two or more (individually or in combination):
      mini-stroke, transient ischemic attack (TIA), stroke, cerebrovascular accident (CVA)  ☐ ☐

If answered ‘yes’ to any of the above conditions, you are ineligible for Long Term Care Insurance with Sun Life.

2. Have any of your natural parents, brothers, sisters, whether now living or dead, ever had or suffered from Huntington’s Chorea?
   ☐ Yes ☐ No
   If yes, did you inherit the gene that causes Huntington’s Chorea? ☐ Yes ☐ No ☐ Unknown

3. In the last 12 months did you need the assistance or supervision of another person for bathing, dressing, transferring (such as moving to or from a bed or chair), toileting, continence or feeding?
   ☐ Yes ☐ No

4. For health reasons, in the last 12 months did you need the assistance or supervision of another person for using the telephone, managing finances, taking transportation, shopping, laundry, housework, preparing meals/cooking or taking medications?
   ☐ Yes ☐ No

5. In the last 12 months did you need to use any medical equipment such as a walker, wheelchair, motorized cart, multi-pronged cane, leg braces or artificial limbs?
   ☐ Yes ☐ No

6. In the last 5 years have you received a disability income replacement (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

7. Give details for all ‘yes’ answers to questions 1 to 6 above.

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<tr>
<th>Question number</th>
<th>Details</th>
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C Medical information

Please provide details for any yes answers in the chart on the following page (referenced as question 10).

1. Have you seen your medical advisor in the last 3 years? □ Yes □ No
   If yes, provide medical advisor's name and address:
   Name
   Address (Street, City, Province)
   Postal Code

   If no, provide details, including:
   i) When was your last visit?
   Date d/m/y
   ii) What was the reason?
   iii) Was any treatment given?

2. Height (without shoes) □ cm □ ft & in □ Weight □ kg □ lb

3. Have you lost more than 22 lbs or 10 kgs in the past year (exclude any change due to pregnancy)? □ Yes □ No
   (If yes, provide details including how much weight has been lost and the reason for weight loss in question 10)

4. Have you ever been treated for or had any signs or symptoms of:
   a) stroke, mini-stroke, transient ischemic attack (TIA)
   b) elevated blood sugar, impaired glucose tolerance, diabetes
   c) hepatitis (including hepatitis carrier state), liver disease or disorder
   d) paralysis, numbness, tingling or loss of sensation, imbalance, tremors, weakness of the limbs or other neurological disease or disorder

5. In the last 5 years have you been treated for or had any signs or symptoms of:
   a) high blood pressure
   b) anemia or other blood disease or disorder
   c) cancer, tumour or any other growth or malignancy
   d) kidney, bladder disease or disorder, urinary incontinence
   e) Crohn’s disease, ulcerative colitis, peptic ulcer, bowel incontinence, disease or disorder of the bowel, stomach or pancreas
   f) epilepsy, fainting, loss of consciousness, dizziness, or other disease or disorder of the brain
   g) neuropathy or other disease or disorder of the nervous system
   h) depression, anxiety, nervous breakdown or other mental, emotional or nervous disease or disorder
   i) arthritis, osteopenia, osteoporosis, amputation, disease or disorder of the bones, joints, muscles, limbs or back
   j) fibromyalgia or chronic fatigue syndrome
   k) heart attack, angina, chest pain, congestive heart failure, arteritis, coronary artery disease, irregular pulse or other disease or disorder of the heart or blood vessels
   l) asthma, emphysema, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, shortness of breath, or other lung problems or breathing conditions (exclude colds and flu)
   m) falls

6. In the last 5 years have you had any of the following:
   a) abnormal blood or urine tests, or electrocardiograms?
   b) other tests including CT scans, MRI scans or x-rays (exclude dental)?
   c) consultation with a health professional for any reason not previously stated (exclude dentists and optometrists)?
Medical information (continued)

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

8. In the **last 2 years** have you been treated for or had any signs or symptoms of:
   a) 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 answered 'yes', a Pain Questionnaire will be required.)
   b) thyroid disease or disorder  □ Yes □ No
   c) disease or disorder of the eye, ear, nose, throat, or mouth (exclude eye-glasses, contact lenses, tonsillectomy and adenoidectomy)  □ Yes □ No
   d) skin ulcer or skin disease or disorder (exclude poison ivy, acne, sunburn and eczema)  □ Yes □ No

9. In the **last 12 months** have you received acupuncture, chiropractic treatments, massage therapy or physiotherapy?  □ Yes □ No

10. Give details for all 'yes' answers to questions 3 to 9 above.

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11. In the last six months, have you taken any prescription or over-the-counter medications?  □ Yes □ No

   If yes, complete the following chart:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for taking</th>
<th>Date started taking (d/m/y)</th>
<th>Current dosage</th>
<th>Date of most recent dosage change (d/m/y)</th>
<th>Date last taken (d/m/y)</th>
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D | Declaration

The insured person declares all answers and statements recorded in this questionnaire are full, complete and true, and may be relied upon by Sun Life Assurance Company of Canada. Any misrepresentation in the questionnaire, or any failure to disclose relevant facts, may result in the insurance being cancelled by Sun Life Assurance Company of Canada.

E | Authorization of the Proposed Insured

I authorize:

a) any health professional or medical practitioner, hospital, clinic or medically-related facility, insurance company, the Medical Information Bureau, or other organization or institution, including Sun Life Assurance Company of Canada, or person that has records or knowledge of my health to give only that information necessary for underwriting, administration and claims purposes to the Company, its representatives, its service providers and its reinsurers,

b) the performance of such examinations, x-rays, electrocardiograms, blood profiles and tests for HIV (AIDS) antibody as may be required to underwrite this application,

c) the Company to release only the necessary personal information obtained during the underwriting process to my physician, or the Medical Information Bureau,

d) information about me to be collected, used by and shared among the Canadian members of the Sun Life Financial group of companies*, their advisors and service providers to provide me with the investment and insurance products and services that will help me meet my financial objectives.

☐ No, I refuse permission

*The Companies in the Sun Life Financial group of companies mean only those companies identified in the Sun Life Financial Privacy Policy that is available on the Sun Life Financial website, www.sunlife.ca

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

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<th>Signed at</th>
<th>Date (d/m/y)</th>
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<tr>
<td>Proposed Insured Signature (if other than applicant)</td>
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F | Advisor Declaration

I certify that I have reviewed each of the questions in this Medical Information and Functional Ability Questionnaire with the insured person and this form fully records all information provided to me in connection with the application.

I confirm I saw every person sign this form.

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<th>Signed at</th>
<th>Date (d/m/y)</th>
<th>Training Supervisor (Quebec only)</th>
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<tr>
<td>Signature of Advisor</td>
<td>X</td>
<td>Advisor No.</td>
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