My Health Statement

Optional Critical Illness Insurance

Sun Life Financial

Only complete this form if you are applying for coverage amounts above $50,000 for yourself and/or your spouse, or applying for any amount of coverage after the initial eligibility period. Return this completed health statement to Sun Life Financial.

In this health statement, *you* and *your* refer to the person applying for insurance. *We, us, our* and the *Company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Group Critical Illness Insurance Contract No.: **50090**

1 My information

First name	Middle initial
Last name	Date of birth (dd-mm-yyyy)
Address (street number and name)	Apartment or suite
City / Province / Postal code	
Employer's name	Member ID
Location/Billing group	Class/Plan
Telephone (home)	Telephone (business)
Gender ☐ Male ☐ Female / ☐ Smoker ☐ Non-smoker[1]	Email address

My spouse's information

Please complete your spouse's information only if you are applying for spousal insurance.

First name	Middle initial
Last name	
Email address	Occupation
Date of birth (dd-mm-yyyy)	Telephone (business)
Gender ☐ Male ☐ Female	☐ Smoker ☐ Non-smoker[1]

Reason for application
☐ New benefit ☐ Increase coverage

[1]**Non-smoker** means that you have not used any nicotine products (tobacco, e-cigarettes, patches, etc.) within the last 12 months.

2 My coverage

How much total Optional Critical Illness Insurance coverage are you applying for at this time[2]?

$

[2]Coverage is available between $25,000 and $200,000 in units of $25,000.

My spouse's coverage

How much total spousal Optional Critical Illness Insurance coverage are you applying for at this time[2]?

$

3 My health

Height (ft. / in. / m / cm)	Weight ☐ lbs. ☐ kg
Change in weight in the last 12 months ☐ Gain ☐ Loss ☐ No change ☐ lbs. ☐ kg	Reason for weight change
Name of attending physician[3]	
Date of last consultation (mm-yyyy)	Reason for last consultation
Results of last consultation	
If the doctor named above does not have the most complete records of your medical history, please provide the full name of the doctor who does have them	

[3]If you or your spouse do not have an attending physician, please state "none".

My spouse's health

Height (ft. / in. / m / cm)	Weight ☐ lbs. ☐ kg
Change in weight in the last 12 months ☐ Gain ☐ Loss ☐ No change ☐ lbs. ☐ kg	Reason for weight change
Name of attending physician[3]	
Date of last consultation (mm-yyyy)	Reason for last consultation
Results of last consultation	
If the doctor named above does not have the most complete records of your medical history, please provide the full name of the doctor who does have them	

4 Family history information

Have any of your biological family members (father, mother, brother(s) or sister(s)), whether living or dead, ever had or suffered from any of the following conditions: stroke, heart attack, heart disease, diabetes, cancer (include type), polycystic or other kidney disease, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease), muscular dystrophy, Huntington's Chorea, familial polyposis of the bowel, or any other hereditary disease?

☐ Yes ☐ No If yes, please complete the chart(s) below:

My family

	Condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

My spouse's family

	Condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

For SLF use:
DC-100

5 Medical information

Have you or your spouse ever:	Me	My spouse
a) Had chest pain, angina, heart attack, abnormal electro cardiogram (ECG), high blood pressure, irregular pulse, heart murmur, peripheral vascular disease, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No
b) Had a stroke, transient ischemic attack (TIA), phlebitis, paralysis, seizure, epilepsy, dizziness, numbness, loss of consciousness, recurrent headaches or migraines, meningitis, multiple sclerosis, Alzheimer's, Parkinson's, Amyotrophic Lateral Sclerosis (ALS) or any other disease or disorder of the brain or neurological system?	☐ Yes ☐ No	☐ Yes ☐ No
c) Had diabetes, impaired fasting glucose; sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No
d) Had a disease of the kidneys, urinary tract, bladder, prostate, reproductive organs, abnormal pap, breast changes, or abnormal mammogram?	☐ Yes ☐ No	☐ Yes ☐ No
e) Had cancer, tumour, polyp, lump, other growth, or any form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No
f) Had moles, lesions, other skin growth, or disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No
g) Had a blood disorder, anemia, immune disorder, leukemia, lymph or thyroid gland disorder, malignancy; or had a biopsy?	☐ Yes ☐ No	☐ Yes ☐ No
h) Had chronic lung disorder, respiratory disorder, sleep apnea; disease or disorder of the eyes, ears, nose, or throat?	☐ Yes ☐ No	☐ Yes ☐ No
i) Had any disorder of the colon, intestines, rectum, digestive system, including colitis, Crohn's, ulcer, or disorder of the stomach?	☐ Yes ☐ No	☐ Yes ☐ No
j) Had neck or back pain, spinal disorder, bone, muscle or joint disorder; amputation; fibromyalgia, rheumatic/arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No
k) Had a psychiatric disorder, depression, anxiety state or panic attacks, chronic fatigue, eating disorder; suicide attempts or ideations; other emotional or psychiatric disorder; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No
l) Do you ever consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please record the number of alcoholic beverages consumed in a week:		
m) Been advised to seek treatment, or have been treated for the use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
n) Had a disorder of the liver including testing positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepatitis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS) or any other immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No
o) Had any other illness, disease, disorder, condition, injury, diagnostic testing or surgical procedure not listed above; had any health symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No
p) Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use of drugs, prescribed or non-prescribed or obtained over the counter?	☐ Yes ☐ No	☐ Yes ☐ No
q) Had critical illness, disability, or life insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No
r) Received disability benefits for three months or longer?	☐ Yes ☐ No	☐ Yes ☐ No
s) Do you need assistance of any kind to perform any daily activities, such as bathing, continence, dressing, eating, using the toilet, or transferring (for example from bed to chair)?	☐ Yes ☐ No	☐ Yes ☐ No
t) Do you currently use any prescribed or non-prescribed medication, including herbal supplements or remedies, and over the counter medication?	☐ Yes ☐ No	☐ Yes ☐ No

IF YOU REPLIED YES TO ANY OF THE QUESTIONS (a-t), please provide details below. If the space provided is insufficient, please provide details on a separate duly signed and dated sheet.

Question	Name of person	Nature of disorder	Date (mm-yyyy)	Duration	Diagnosis	Treatment	Name and address of physicians, hospitals, insurance companies
			_				
			_				

6 Declaration and authorization

In this declaration and authorization, "I" applies to the member and the spouse signing below.

I understand I may be refused those group benefits or any benefit amounts for which proof of good health is required if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. I certify that all the statements in this form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Health Statement will cause the insurance to be void.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and disclose information needed for underwriting, administering and adjudicating claims under this plan with any person or organization who has relevant information about me and/or my spouse (if applicable) pertaining to this Health Statement. This includes any health professionals, institutions, investigative agencies, insurers, reinsurers.

If I am a spouse, I also authorize Sun Life Assurance Company of Canada to disclose information about this application to the member, for the purposes of assessing this application and managing the group benefits plan.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage under this group contract, unless withdrawn in writing.

Your signature X	Date (dd-mm-yyyy) _ _
Your spouse's signature (if applying) X	Date (dd-mm-yyyy) _ _

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Please return this health statement to Sun Life Financial at the address below:

Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 578 STN Waterloo
Waterloo ON N2J 4B8
Toll-free fax number: 1-877-897-6605