Application for Critical Illness Insurance

Sun Life Financial

Regroupement des Cabinets de Courtage d'Assurance du Québec

Please PRINT clearly.

In this application *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.

1 General information

Eligibility to apply:
All members/employees and their spouse who reside in Canada and have not attained the age of 60.

Information about you

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
				– –

Former name (if applicable)	☐ English ☐ French	Place of birth (province)	Place of birth (country)

☐ Non-smoker
☐ Smoker

Non-smoker means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.

Residence address (street number and name)	Apartment or suite

City	Province	Postal code

Telephone (office)	Fax	E-mail address
– –	– –	

Name of cabinet	Membership number	☐ Member ☐ Employee of a member

2 Amount applied for

Minimum $20,000 – Maximum $300,000 (in units of $10,000).

You

Amount of insurance **applied for at this time**
$

Minimum $20,000 – Maximum $300,000 (in units of $10,000).

Your spouse*

Amount of insurance **applied for at this time**
$

*Your spouse's coverage cannot exceed your coverage.

3 Insurance information

Do you currently have Critical Illness Insurance in-force or pending? ☐ Yes ☐ No If *yes*, please provide details below.

Amount of benefit	**Insuring company**	**Date of issue (dd-mm-yyyy)**
$		– –

Will any insurance be discontinued if this certificate is issued? ☐ Yes ☐ No If *yes*, please provide details.

Company	Type of coverage	Amount
		$

4 Financial information

Your net annual earned income	Your spouse's net annual earned income (if applying for insurance)
$	$

Doc code 100

5 Statement of insurability

5.1 Background information

Your information

If no attending physician, please state *none.*

Height (ft. in. / m cm)	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain ☐ Loss ☐ lbs. ☐ kg

Name regular attending physician	Address (street number and name)

City	Province	Postal code	Reason for weight change

Date of last consultation (dd-mm-yyyy)	Reason for last consultation
– –	

Diagnosis, treatment given, results, medication prescribed

Does your attending physician named above have the most complete records of your medical history?
☐ Yes ☐ No If *no,* please provide full name and address of the attending physician who has your complete medical records.

Your spouse's information

Please complete for Spousal coverage.

If no attending physician, please state *none.*

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
				– –

Place of birth (country)	Place of birth (province)

Former name (if applicable)	Height (ft/in)	Weight (lbs./kg)	Change in weight in the last 12 months ☐ No change ☐ Gain ☐ Loss ☐ lbs. ☐ kg

☐ Non-smoker *Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.
☐ Smoker

Name and address of regular attending physician	Reason for weight change

Date of last consultation (dd-mm-yyyy)	Reason for last consultation
– –	

Diagnosis, treatment given, results, medication prescribed

Does your attending physician named above have the most complete records of your medical history?
☐ Yes ☐ No If *no,* please provide full name and address of the attending physician who has your complete medical records.

5.2 Family history

Has any natural parent, brother or sister ever had cancer, heart disease, stroke, high blood pressure, diabetes, polycystic or other kidney disease, Alzheimer's, Parkinson's, multiple sclerosis, Huntington's Chorea or any other inherited disease?

You ☐ Yes ☐ No | **Your spouse** ☐ Yes ☐ No

Your family history

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

Your spouse's family history

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

5 Statement of insurability (continued)

5.3 Medical information

Have you or your spouse (if applying for coverage) ever:	You	Your spouse
a) Had chest pain, heart attack, abnormal ECG, high blood pressure, irregular pulse, heart murmur, 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), paralysis, seizures, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
c) Had diabetes; sugar, blood or protein in the urine; any disease of the kidneys, urinary tract, bladder, prostrate or reproductive organs including breast lumps, cysts or other breast changes; or had an abnormal mammogram?	☐ Yes ☐ No	☐ Yes ☐ No
d) Had tumours, cancer, polyps, or other growth; disorder of the skin or lymph glands; blood disorder or any other form of malignant disease; or had a biopsy?	☐ Yes ☐ No	☐ Yes ☐ No
e) Had chronic lung or respiratory disorder; disease or disorder of the eyes, ears, nose or throat; colitis or any other disorder of the colon, intestines, stomach or liver?	☐ Yes ☐ No	☐ Yes ☐ No
f) Had chronic fatigue;, neck or back pain;, spinal disorder; bone, muscle or joint disorder; fibromyalgia or rheumatic/arthritic disease; lupus?	☐ Yes ☐ No	☐ Yes ☐ No
g) Had a mental or nervous disorder; depression, anxiety state or panic attacks; eating disorder; or other emotional or psychiatric disorder; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No
h) Tested positive for Hepatitis B, Hepatitis C or HIV (Human Immunodeficiency Virus); been identified as a Hepatitis B carrier or have chronic Hepatitis B; been tested for, counselled for, or been told you have AIDS (Acquired Immune Deficiency Syndrome), or any other immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No
i) Had any other illness, disease, disorder, condition or injury 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

During the past 5 years, have you or your spouse (if applying for coverage) ever:	You	Your spouse
j) Consulted a physician, chiropractor, psychologist, physiotherapist, psychiatrist or any other health care professional or been admitted to any hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No
k) Had any symptoms or adverse findings or were you advised to have further examinations, diagnostic tests, hospitalization or surgery?	☐ Yes ☐ No	☐ Yes ☐ No
l) Submitted to ECG, blood tests, x-rays or other diagnostic tests?	☐ Yes ☐ No	☐ Yes ☐ No
m) Had any surgical operation, treatment, special diet, illness, ailment, abnormality or injury?	☐ Yes ☐ No	☐ Yes ☐ No
n) Had any disease or physical impairment or are you receiving any treatment or taking any medication at the present time, to the best of your knowledge and belief?	☐ Yes ☐ No	☐ Yes ☐ No
o) Been advised to have any further examinations, diagnostic tests, hospitalization or surgery which has not been completed or had any symptoms or complaints regarding your health for which a physician has not yet been consulted?	☐ Yes ☐ No	☐ Yes ☐ No

5.4 Additional information

You

a) Do you consume alcoholic beverages?
☐ Yes If *yes*, please record number of glasses in each category.
☐ No

Frequency	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

Your spouse (if applying for coverage)

Do you consume alcoholic beverages?
☐ Yes If *yes*, please record number of glasses in each category.
☐ No

Frequency	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

Have you or your spouse (if applying for coverage) ever:	You	Your spouse
b) Consumed substantially more alcohol than as outlined previously?	☐ Yes ☐ No	☐ Yes ☐ No
c) Consulted a doctor, received treatment or counselling, been charged with impaired driving or been arrested due to the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
d) Had a driver's license suspended or ever been convicted for drunk or impaired driving?	☐ Yes ☐ No	☐ Yes ☐ No
e) Had 3 or more moving violations in the last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No
f) Used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No
g) 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
h) Used tobacco or tobacco cessation products?	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please indicate the date last used.	(mm-yyyy)	(mm-yyyy)
i) Had Critical Illness insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No
j) Made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No
k) Piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities such as skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No
For females only		
l) Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please indicate expected due date.	(mm-yyyy)	(mm-yyyy)
m) Have you had any previous complications of pregnancy such as miscarriage, preeclampsia, caesarean section, etc.?	☐ Yes ☐ No	☐ Yes ☐ No

5 Statement of insurability (continued)

Please provide details below for any *yes* answers under sections 5.3 and 5.4.
Include the results of all physical examinations and check-ups.
If you need more space, please complete on separate sheet of paper and sign and date it.

Question	Name of person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Include (when applicable) all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results
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6 Premium payments - monthly pre-authorized debit (PAD)

Please complete this section.

First name of account holder	Middle initial	Last name

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions
You authorize the Vigilis Group (Vigilis) to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated on the accompanying void cheque. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Vigilis notify you of any payments after the first payment whether the amount of the monthly premium is changed or not.** You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Vigilis is unable to make a withdrawal from your account.

This authorization is to remain in effect until Vigilis has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting *www.cdnpay.ca*.

Vigilis may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit *www.cdnpay.ca*.

The Vigilis Group
2540 Daniel-Johnson Blvd., Suite 200
Laval, QC H7T 2S3
1 888 682-7772

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder	Date (dd-mm-yyyy)
X	– –
Signature of account holder	**Date (dd-mm-yyyy)**
X	– –

- **Send no money with this application. You will be notified with a premium statement.**
- **Please attach a personal blank cheque, marked VOID across the front, to this application form.**

7 Declaration and authorization

Please read and sign this section.

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I hereby certify that I have detached and kept the Medical Information Bureau (MIB) prenotification form, and having read the contents, I have, by my signature below, authorized the MIB to give to Sun Life Assurance Company of Canada, or its reinsurers, any information it may have.

I authorize Sun Life Assurance Company of Canada, its agents and service providers including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers including the plan administrator to use and exchange relevant information about me in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage.

A photocopy or electronic version of this authorization is as valid as the original.

Your signature X		Your spouse's signature X
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) – –

8 Authorization to furnish information

Please read and sign this section.

This portion may be provided to service intermediaries in order to obtain information.

I authorize Sun Life Assurance Company of Canada, its agents and service providers including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers including the plan administrator to use and exchange relevant information about me in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage.

A photocopy or electronic version of this authorization is as valid as the original.

Your signature X		Your spouse's signature X
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) – –

Please detach and retain this notice.

9 Medical Information Bureau notice

Please detach and retain this notice.

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you to its reinsurers. Sun Life Assurance Company of Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sun Life Assurance Company of Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to the MIB at:

Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

or call: 416-597-0590

Please detach and retain this notice.

10 Respecting your privacy

Please detach and retain this notice.

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.