



# Health Statement (Optional Life Only)

## 2 Member details (to be completed by the Member)

All information received by Sun Life Assurance Company of Canada is treated as strictly confidential and is used for the sole purpose of determining your eligibility and administering the group plan to which you belong. Returning your forms and medical information to us in a confidential envelope ensures that only our medical underwriters will have access to them. Please fully complete the address.

Complete this section only for person(s) applying for insurance.

Complete section(s) 2.4 and/or 2.5, as applicable, with any additional comments to these questions.

### 2.1 General information about the Member

Member's Name (First) _____ (Last) _____		Date of birth (d/m/y) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contract Number _____
Member's street address (street number and name) _____			Apartment/suite number _____	
City _____		Province _____	Postal code _____	
Please provide a phone number where you can be reached for any additional information:				
Member's home telephone number _____ ( _____ )		<input type="checkbox"/> Day <input type="checkbox"/> Evening	Member's business telephone number _____ ( _____ )	
			<input type="checkbox"/> Day <input type="checkbox"/> Evening	

### 2.2 Medical information

If you answer yes to any questions, please provide further details on the next page. Include dates, treatment and medications.

	<b>Member</b>
1. Do you have a regular attending doctor? (If yes, provide name, address, date last consulted and reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have a yearly check-up? (If yes, please specify date of last check-up and results)	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Within the last 12 months have you lost work due to illness or injury? (If yes, provide dates and reasons)	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Within the last three years have you:	
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than five consecutive days?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Received disability benefits for three months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Ever been declined for Life or Disability insurance? (If yes, specify name of insurer, date and reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Ever been offered Life or Disability insurance at a higher than standard risk? (If yes, specify name of insurer, date and reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you used any tobacco products within the last 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the last 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a doctor?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you consume alcoholic beverages?	Yes <input type="checkbox"/> No <input type="checkbox"/>
a) Average number of drinks per week:	Beer: _____ Wine: _____ Spirits: _____
b) Have you ever been advised to stop drinking or to drink less?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Who \_\_\_\_\_  
(e.g. spouse, friend, doctor, etc.)

Reason \_\_\_\_\_

Date \_\_\_\_\_

Continued on next page

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## 2 Member details (continued)

8. Are you presently under medical treatment by diet, medicine or other means? (provide details including names of all medications and reason(s) why you are using them)	<b>Member</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you have diabetes or impaired sugar levels?	Yes <input type="checkbox"/> No <input type="checkbox"/>
a) What is your current treatment for diabetes?	insulin: Yes <input type="checkbox"/> No <input type="checkbox"/> oral medication: Yes <input type="checkbox"/> No <input type="checkbox"/> diet only: Yes <input type="checkbox"/> No <input type="checkbox"/>
b) List your last 3 blood sugar readings	_____ _____ _____
10. a) Height	<input type="checkbox"/> ____ ft./in. <input type="checkbox"/> ____ m/cm
b) Weight	<input type="checkbox"/> ____ lb. <input type="checkbox"/> ____ kg
11. Within the last three years have you received treatment for, consulted a doctor or other health practitioner for, or been diagnosed as having any one of the following:	
a) Cancer, malignancy, leukemia or enlarged lymph nodes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Illnesses of the heart or circulatory system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Liver disorder or hepatitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Kidney disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Lung or respiratory disorder (including asthma)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Neurological disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Psychiatric or psychological problems (including anxiety, depression or panic disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Chronic fatigue syndrome or fibromyalgia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Musculoskeletal, joint or bone disorder (including arthritis)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Back or neck problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) High blood pressure or high cholesterol? (If yes, please list your last three readings below)	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____
l) Gastrointestinal disorder (including esophageal, colon or bowel disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you ever tested positive for AIDS, ARC or HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you ever suffered a heart attack or myocardial infarction?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you ever had a stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Have you ever had an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

### 2.3 Additional medical details - Member

**Question Further details**

Question	Further details

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## 3 Declaration and authorization

Please read and sign this section.

In this declaration and authorization, "I" applies to the member, 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 exchange information needed for underwriting, administrating and adjudicating claims under this Plan with any person or organization who has relevant information about me, pertaining to this Health Statement. This includes any health professionals, institutions, investigative agencies, insurers, reinsurers and any Third Party administrator retained by the plan sponsor to administer this group contract.

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.

Signature of Member X	Date (d/m/y)
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Sun Life Assurance Company of Canada must receive your completed Health Statement within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Health Statement.

**Send the completed form to the following address in an envelope marked "Confidential" and retain a copy for your records.**

**Fax: (514) 954-1081**  
Sun Life Assurance Company of Canada  
Medical Underwriting  
Private and Confidential  
PO Box 11010 Stn CVo  
Montréal QC H3C 4T9

**Toll free number 1-866-882-0884**

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.