Personal Health Insurance application form

Sun Life Financial

In this application, you and your refer to the proposed insured and the applicant. *We, us, our* and *the company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

For SLF use:
ID number

1 Applicant information

Proposed insured is applicant. To avoid delays, complete an application online at www.sunlife.ca/personalhealth.

First name	Last name				
Mailing address (street number and name)				Apartment or suite	
City				Province	Postal code
Home telephone number	Work telephone number	Sex ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Height ☐ ft/in ☐ m/cm	Weight ☐ lbs. ☐ kg
If you are not a Quebec resident: Do you have provincial health care coverage? ☐ Yes ☐ No		Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason?			Language preference ☐ English ☐ French
If you are a Quebec resident, complete section 6 **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)**					

2 Coverage you are applying for

☐ **Basic plan**

- Optional benefit – semi-private hospital room ☐ Yes ☐ No

☐ **Standard plan**

- Optional benefit – semi-private hospital room ☐ Yes ☐ No
- Optional benefit – dental ☐ Yes ☐ No

☐ **Enhanced plan**

- Optional benefit – semi-private hospital room ☐ Yes ☐ No
- Optional benefit – dental ☐ Yes ☐ No

Date your coverage begins (choose one):

If you don't make a selection, we'll start coverage the business day after your application is approved.
If we approve your coverage on or after the 28th of a month, your coverage will begin on the first business day of the following month.

☐ Coverage will start the business day after your application is approved.

☐ Tell us what future date you would like your coverage to start (dd-mm-yyyy)

This date must be between the 1st and 28th of a month. This date must be no more than 60 days from today. If we approve your application after your chosen date, coverage will start on the business day following approval.

PHIAPPE

3 List the members of your family for whom you want to purchase coverage

If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the applicant. If proposed insured is under age 16 (18 in Quebec), signature of the parent or legally appointed guardian is required.

Spouse/Partner

First name		Last name	
Sex ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Height ☐ ft/in ☐ m/cm	Weight ☐ lbs. ☐ kg
If you are not a Quebec resident: Do you have provincial health care coverage? ☐ Yes ☐ No	Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason?		
If you are a Quebec resident, complete section 6 **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)**			

Child # 1

First name		Last name	
Sex ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Height ☐ ft/in ☐ m/cm	Weight ☐ lbs. ☐ kg
If you are not a Quebec resident: Do you have provincial health care coverage? ☐ Yes ☐ No	Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason?		
If you are a Quebec resident, complete section 6 **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)**			

Child # 2

First name		Last name	
Sex ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Height ☐ ft/in ☐ m/cm	Weight ☐ lbs. ☐ kg
If you are not a Quebec resident: Do you have provincial health care coverage? ☐ Yes ☐ No	Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason?		
If you are a Quebec resident, complete section 6 **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)**			

Child # 3

First name		Last name	
Sex ☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Height ☐ ft/in ☐ m/cm	Weight ☐ lbs. ☐ kg
If you are not a Quebec resident: Do you have provincial health care coverage? ☐ Yes ☐ No	Any weight loss of 10 lbs. (4.5 kg) or more in the last year? ☐ Yes ☐ No If yes, reason?		
If you are a Quebec resident, complete section 6 **Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ)**			

4 Personal information

4.1 General information

Has any application for life, critical illness, long term care, disability, drug, dental or health insurance **ever** been declined, rated or modified in any way?

Applicant ☐ Yes ☐ No Spouse/Partner ☐ Yes ☐ No Child # 1 ☐ Yes ☐ No

Child # 2 ☐ Yes ☐ No Child # 3 ☐ Yes ☐ No

4 Personal information (continued)

If yes, please provide the following details:

Name of family member	Decision	Details (type of insurance, name of company, date applied for, reason for decline, rating or modification)
	☐ declined ☐ rated ☐ modified	
	☐ declined ☐ rated ☐ modified	
	☐ declined ☐ rated ☐ modified	
	☐ declined ☐ rated ☐ modified	

Name and address of usual medical advisor or medical clinic (if different, please list individual medical advisors or clinics for each member of the family separately)

4.2 Medical information

If you answer yes to any questions, please provide further details below. Include dates, treatment and medications.

	Applicant	Spouse/Partner	Child(ren)
1. Have you **ever** consulted with any health care professional about the following, or had treatment for or had any known indication of:			
a) heart attack, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, or other heart or circulatory disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) cancer, tumour or other growth or malignancy,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) diabetes, elevated blood sugar, hyperthyroidism, hypothyroidism or other thyroid, endocrine or kidney disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) acid reflux disease, irritable bowel syndrome, colitis, Crohn's disease, hepatitis, cirrhosis or other stomach, bowel, pancreas or liver disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, allergies, or other respiratory disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) depression, anxiety, attention deficit disorder (ADD), eating disorder, autism, epilepsy, multiple sclerosis, migraines, Alzheimer's disease, dementia or any other psychological, emotional or nervous system disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) acne, rosacea, eczema, psoriasis, lupus, scleroderma or other skin or connective tissue disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) arthritis, fibromyalgia, osteoporosis, paralysis, chronic or persistent pain or any other back, joint or musculoskeletal disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4 Personal information (continued)

i) blindness, glaucoma, loss of vision, deafness, impaired hearing or other eye or ear disease or disorder,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) drug or alcohol abuse?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you **ever** had any consultation with any health care professional about, treatment for, or any known indication of AIDS, positive HIV or immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. In the **last 5 years**, have you received disability income replacement benefits, or had an illness or injury that prevented you from performing your usual activities or occupation for a period of more than 2 weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Other than for conditions already disclosed, in the **last 2 years** have you seen any health care practitioner, including a naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or podiatrist? If yes, describe the type of practitioner and the reason.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. In the **last 2 years**, has there been any doctor's visit or hospitalization, recommended treatment or prescribed medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you currently using any prescribed medication, medical equipment or testing device or do you expect to do so in the **next 3 months**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has any health care practitioner recommended any tests, treatment, examination, surgery, hospitalization or referrals that have not yet been completed, or are you currently awaiting test results?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Do you have any symptoms for which you have not yet seen a health care professional?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the applicant and the proposed insured. If proposed insured is under age 16 (18 in Quebec), the signature of the parent or legally appointed guardian is required.

Question number	Name of family member	What was the diagnosis?	Date symptoms or condition started (dd-mm-yyyy)	Date symptoms or condition ended (dd-mm-yyyy)	Date of last treatment/service (dd-mm-yyyy)	Type of treatment provided (include name & dosage of medication) and name of doctor

5 Method of payment information (We do not accept cash payments, pre-paid credit cards or Visa debit cards)

For monthly pre-authorized chequing (PAC), monthly credit card or annual credit card payment

If this application is approved, you authorize Sun Life Assurance Company of Canada (Sun Life Financial) to withdraw funds to pay all premiums from the account shown on the void cheque attached to this application, credit card or any account you designate in the future.

I understand my first monthly payment will be withdrawn from this account or credit card once my policy is approved. For monthly PAC, if I am approved for coverage before the day I would like premiums withdrawn, I am aware my second monthly premium will be withdrawn on the date I chose. I understand this may result in two payments within the first 30 days of coverage.

IMPORTANT:

You and the payor if not yourself, understand and agree that premiums may increase from year to year and that we will provide 45 days' notice of any premium increase to the policy owner. Unless you notify us otherwise, you authorize us to withdraw the increased premium amount from your bank account or credit card. I agree I am responsible to tell any payor who is not me about any increase in premiums.

You can cancel this PAC or credit card authorization by giving 10 days' written notice to us.

Attach a void cheque marked 'VOID' here. A void cheque is the only reliable source for banking information.

Select one option:

☐ Monthly, through a pre-authorized chequing plan (PAC) from my bank account on the ____ day of each month. (The withdrawal date must be between the 1st and the 28th of each month.) I have attached a void cheque that shows the account to be used.

☐ Credit card

☐ Annual ☐ Monthly

Credit Card Information

First name	Last name	Expiry date (mm-yyyy)	Card type ☐ Visa ☐ Mastercard

Once your policy is approved, we will contact you to obtain the credit card number.

☐ Annually, by cheque. I have enclosed a cheque for one year's premium, payable to Sun Life Assurance Company of Canada.

Payor information (If payor is not the applicant)

First name		Last name		Date of birth (dd-mm-yyyy)
Relationship to owner	Contact first name (if name above is a business)	Contact last name		Telephone number
Street address (street number and name)				Apartment or suite
City	Province	Country		Postal code

6 Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ).

Quebec residents must have health coverage through the Régie de l'assurance maladie du Québec (RAMQ) to be eligible for Personal Health Insurance. Quebec residents must also have and continue to have group drug coverage provided by an employer or through membership in an order or association or, if not, through RAMQ to be eligible for Personal Health Insurance. A person not covered under a group benefits plan or through RAMQ is not eligible for coverage under this policy. All prescription drug claims must first be submitted to your group benefits provider or RAMQ; any remaining unpaid portion that is eligible under this policy can then be submitted to Sun Life Financial for reimbursement.

Please select the appropriate response:

☐ I am confirming that I (and spouse/dependants if applicable) have and will continue to have the RAMQ prescription drug insurance and the RAMQ medi-care insurance.

☐ I am confirming that I (and spouse/dependants if applicable) have and will continue to have the prescription drug insurance through a group benefits plan and to have the RAMQ medi-care insurance:

Name of group insurance carrier	Group policy number	Group certificate

6 Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ). (continued)

Benefits insured under this plan:

Prescription Drug ☐ Yes ☐ No Supplementary health ☐ Yes ☐ No Dental ☐ Yes ☐ No

First name of family member insured under this group plan	Last name
First name of family member insured under this group plan	Last name
First name of family member insured under this group plan	Last name

I understand I/we need to submit claims to the group plan first. Any remaining claims should be submitted to Sun Life Financial to be coordinated.

☐ I do not have RAMQ medi-care and RAMQ prescription drug insurance or group prescription drug insurance. I do not wish to proceed with my application.

Personal Health Insurance is not a substitute for RAMQ; therefore you cannot opt out of RAMQ because you have Personal Health Insurance. You must obtain RAMQ prescription drug insurance if your group drug coverage ends and you do not have access to another group drug coverage.

7 Acknowledgement and agreement for Personal Health Insurance

Please read and sign this section.

The intentional falsification, misrepresentation or omission of information on or relating to this form constitutes fraud and coverage granted may be voided.

Acknowledgement and agreement: You declare that your statements in this application are true and complete, and will be relied upon by Sun Life Assurance Company of Canada ("company"). The application, policy details and any written information you provide with this application, form the contract between you and the company. You will inspect the policy when you receive it, to verify its terms are satisfactory.

The applicant confirms he/she has received, read and agreed to:

- the Sun Life Financial Privacy Statement for Canada, and
- the brochure called 'A clear connection - Our relationship with you" (Only applicable if your advisor is a Sun Life Financial advisor).

Declaration: The applicant, spouse, dependants and payors confirm:

(a) they were present when their portion of this application with Sun Life Assurance Company of Canada was completed

(b) they reviewed all their answers and statements recorded in this application

(c) this information is full, complete and true, and may be relied upon by the company

d) they understand and agree that the following may not be covered by the contract:
- any injury that happened on or before the date of this application
- any illness, the signs of which first appeared on or before the date of this application

(e) they understand and agree that coverage will begin only if your application is approved by us. We will tell you if any medical history requires a higher premium or an exclusion to the coverage. You must either accept the changes or cancel your application on written notification to us

(f) they understand that if they do not fully, completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements), the company may void the policy

(g) they agree that their personal, medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada

(h) they agree to the payment method, if they are payors

(i) they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under "Products & Services" section of the website at *www.sunlife.ca* or by calling our toll-free Customer Service Centre at 1-877-SUN-LIFE (1-877-786-5433), and

(j) all Pre-authorized chequing (PAC) and credit card payors agree:
- Sun Life Assurance Company of Canada may make deductions, at any time, for regular recurring payments and/or one-

7 Acknowledgement and agreement for Personal Health Insurance (continued)

time payments from time to time, from their credit card or bank account indicated in this application

- all PAC withdrawals be processed as personal under the Canadian Payments Association rules (this means they have 90 calendar days from the date the payment is processed, to claim reimbursement for any unauthorized payment)
- the withdrawal amount is considered variable under the Canadian Payments Association rules
- any notices, to be sent to them under this agreement, may be sent to the owner's most recent address that the company has on record at the time a notice is sent
- all persons, whose signatures are required to sign this authorization, have signed this application
- the company may charge a fee or terminate this policy for any withdrawal that is not honoured
- the company may not assign this authorization to another company or person, in order to permit them to debit the payors' account for these payments (eg. where there has been a change in control of the company) without providing at least ten days prior written notice
- they may cancel this authorization at any time, subject to providing the company ten days written notice. They should contact their financial institution about their rights regarding cancellation. A sample cancellation form is available at *www.cdnpay.ca*
- they have certain recourse rights if any debit does not comply with this agreement. For example, they have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAC agreement. To obtain more information on their recourse rights, they should contact their financial institution or visit *www.cdnpay.ca*, and
- **to waive the requirement that the company notify them of:**
  - **this authorization before the first payment is processed,**
  - **any subsequent payments, and**
  - **any changes to the amount or date of the payment initiated by them or the company.**

Authorization of applicant and additional proposed insureds: The applicant and additional proposed insureds (parent or legally appointed guardian, if additional proposed insured is under age 16 (18 in Quebec) authorize:

- any physician, medical practitioner, medically-related facility, insurance company, investigation agencies, the Medical Information Bureau or other organization, institution or person, including members of the Sun Life Financial group of companies, which includes this company, that have records or knowledge of any applicant or additional proposed insured's health, to give only that information necessary for underwriting, administration of insurance and claims paying purposes to the company, its representatives and its reinsurers, and
- the company to release only the necessary personal information obtained during the underwriting process to their personal physician, the Medical Information Bureau, the Medical Director of any insurance company, if an insurance application has been made to that company, and for any infectious or communicable disease, to the Medical Officer of Health where required by law.

A photocopy of this signed authorization is as valid as the original.

Signed at (City)	Signed at (Province)	Date (dd-mm-yyyy)	Signature
			Applicant X
			Spouse/Partner X
			Dependant who has reached age 16 (18 in Quebec) X
			Dependant who has reached age 16 (18 in Quebec) X
			Payor (if payor is not Applicant or Spouse/partner) X
			Joint bank accountholder (if the bank account is jointly held) X

8 Advisor declaration

I have reviewed each of the questions in this application with the Applicant, the Spouse/Partner and any dependant who has reached the age of majority, and this application fully records all information given to me for this application. To the best of my knowledge, the application discloses all facts material to the insurance being applied for.

8 Advisor declaration (continued)

☐ Check here if this application was taken by mail and was not reviewed with the client.

Signed at	Date (dd-mm-yyyy)	Advisor's signature X		
Supervisor's signature (Quebec only) X		Advisor number	Advisor telephone number	Advisor fax number

Source of prospect:

☐ Internet ☐ Call centre ☐ Existing customer ☐ Direct marketing

9 Important information you should know

Sun Life Financial Privacy Statement for Canada

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 purposeof 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, distribution partners (such as advisors and their companies) 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 to obtain information about our privacy practices, 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.

Access to your information

We or our reinsurers may also submit a brief report of our findings to the Medical Information Bureau (MIB), a non-profit 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.

To learn about MIB, you may visit their website at *www.mib.com*, call 416-597-0590 or write to:

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

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

About Sun Life Financial

As a leading international financial services organization, we're proud to offer a diverse range of wealth accumulation and protection products and services. Tracing our roots back to 1865, Sun Life Financial has operations in key markets around the world. But most importantly, we're in business to help people achieve and maintain the peace of mind that comes from having sound financial solutions in place. If you'd like more information about Sun Life Financial, please visit our website at *www.sunlife.ca* or call 1-877-SUN-LIFE (1-877-786-5433).

Before submitting this application, please make sure:

- a void cheque is attached below if paying monthly, through pre-authorized chequing plan
- a phone number to contact the credit cardholder is included if paying by credit card
- a cheque for the annual premium is attached if paying annually
- all questions have been answered for every member of the family you want covered
- for each yes answer in the Personal information section, full details including relevant dates have been included
- all signatures have been completed, including those of the Payor (if not the Applicant or Spouse/Partner) and any dependants who have reached the age 16 (18 in Quebec)

Please mail or fax the completed form to the address below.

You may contact us at:

Sun Life Assurance Company of Canada

9 Important information you should know (continued)

Personal Health Insurance
227 King Street South
P.O. Box 1601 Stn Waterloo
Waterloo ON N2J 4C5

Phone: 1-877-SUN-LIFE (1-877-786-5433)
Fax: 1-866-487-4745
www.sunlife.ca