

Personal Health Insurance application form



For HO use only:
ID number

Please PRINT clearly

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.

1 Applicant information

Proposed insured is applicant.
To avoid delays and to pay by credit card, complete your application on-line at www.sunlife.ca/personalhealth.

Name (first, middle, last)					
Mailing address (number and street)					
City		Province	Postal code		
If further information is needed, phone me at: Home telephone number () () Work telephone number () ()		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Language of preference <input type="checkbox"/> English <input type="checkbox"/> French	Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None		Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?		

2 Coverage you are applying for

- Basic plan**
 - Optional benefit - semi-private hospital room yes or no
- Standard plan**
 - Optional benefit - semi-private hospital room yes or no
 - Optional benefit - dental yes or no
- Enhanced plan**
 - Optional benefit - semi-private hospital room yes or no
 - Optional benefit - dental yes or 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 (d/m/y) _____
 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.

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3 List the members of your family who you want covered

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), signature of the parent or legally appointed guardian is required.

Spouse/Partner

Name (first, middle, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None			Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?	

Child #1

Name (first, middle, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None			Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?	
			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child #2

Name (first, middle, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None			Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?	
			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child #3

Name (first, middle, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None			Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?	
			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child #4

Name (first, middle, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y)	Height <input type="checkbox"/> ft./in <input type="checkbox"/> m/cm	Weight <input type="checkbox"/> lb. <input type="checkbox"/> kg
Do you have provincial health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a Quebec resident: 1) Do you have RAMQ health or group health coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None 2) Do you have RAMQ drug or group drug coverage? <input type="checkbox"/> Group <input type="checkbox"/> RAMQ <input type="checkbox"/> None			Any weight loss of 15 lbs. (6 kg) or more in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason?	
			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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4 Personal information

4.1 General information

If you, or any family member, has ever had health and dental insurance with Sun Life Assurance Company of Canada, please provide the policy and certificate numbers.

Policy N°	Certificate N°
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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 Child #1 Yes No Child #3 Yes No
 Spouse/Partner Yes No Child #2 Yes No Child #4 Yes No

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)
	<input type="checkbox"/> declined <input type="checkbox"/> rated <input type="checkbox"/> modified	
	<input type="checkbox"/> declined <input type="checkbox"/> rated <input type="checkbox"/> modified	
	<input type="checkbox"/> declined <input type="checkbox"/> rated <input type="checkbox"/> modified	
	<input type="checkbox"/> declined <input type="checkbox"/> rated <input type="checkbox"/> 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) acid reflux disease, irritable bowel syndrome, colitis, crohn's disease or other digestive system disorder,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) acne, rosacea, eczema, psoriasis or other skin disorder,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) allergies, asthma or other respiratory disorder,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) cancer or tumour,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) depression or anxiety disorder,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) drug or alcohol abuse,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) elevated blood sugar or diabetes,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) elevated cholesterol,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) heart disease or heart disorder,	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) high blood pressure or stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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4 Personal information (continued)

- 4. 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
- 5. In the **last 2 years**, have you had any doctor's visit or hospitalization, recommended treatment or prescribed medication? Yes No
- 6. Are you currently using or expect to use any drug, medication, serum, medical equipment or medical testing device in the **next 3 months**? Yes No
- 7. Have you received any advice to have any examination, test, treatment, hospitalization or surgery which has not yet been completed? Yes No
- 8. Do you have any symptoms for which you have not yet seen a health care professional? 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), 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 (d/m/y)	Date symptoms or condition ended (d/m/y)	Date of last treatment/service (d/m/y)	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-authorized chequing (PAC) authorization (if method of payment is monthly):
 If this application is approved, you authorize the Company to withdraw funds to pay all premiums from the account shown on the void cheque attached to this application or any account you designate. You guarantee all persons whose signatures are required to sign on this account have signed this agreement. We will charge a fee and may terminate this policy if any withdrawal is not honoured. You can cancel this PAC authorization by giving 10 days' written notice to us. 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.

- 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.
 I understand my first monthly payment will be withdrawn from this account once my policy is approved. 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.
 - Annually. I have enclosed a cheque for one year's premium. I agree I am responsible to tell any payor who is not me about any increase in premiums.

Please note for monthly or annual, that we will charge a fee if there is not enough money in the account to pay the premiums.

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

If payor is different from applicant, complete the following:

Name of PAC payor (if other than the proposed insured(s) or applicant(s))
Address

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6 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 on by Sun Life Assurance Company of Canada (“the 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 they’ve 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 pre-authorized chequing (PAC) payors confirm:

- they were present when their portion of this application with Sun Life Assurance Company of Canada was completed
- they reviewed all their answers and statements recorded in this application
- this information is full, complete and true, and may be relied upon by the Company
- 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
- 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
- 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
- they agree that their personal, medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada
- they agree to the pre-authorized chequing (PAC) authorization, if they are PAC payors, and
- 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).

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, Province)	Date (d/m/y)	Signature
		Applicant X
		Spouse/Partner X
		Dependant who has reached age of majority X
		Dependant who has reached age of majority X
		PAC payor (if the bank accountholder is not the applicant or spouse/partner) X
		Joint bank account (if the bank account is jointly held) X

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7 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.

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

Signed at	Date (d/m/y)	Signature of Advisor X	
Training supervisor's signature (Quebec only) X	Advisor no.	Advisor telephone no.	Advisor fax no.

Source of prospect:

Internet Call centre Existing customer Direct marketing

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8 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 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, or any other person whom you authorize. In some instances these persons may be located outside of 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 learn about our Privacy Policy, visit our website at www.sunlife.ca or call 1 877 SUN-LIFE (1 877 786-5433) and request that a copy of our Privacy Brochure be sent to you.

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 the 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 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 PAC Payor (if not the Applicant or Spouse/Partner) and any dependants who have reached the age of majority

Send the completed form to the following address:

Sun Life Assurance Company of Canada
Personal Health Insurance
227 King Street South
P.O. Box 1601 Stn Waterloo
Waterloo ON N2J 4C5
Fax: 1 866 487-4745

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