Application Form for Evidence of Insurability for RTO/ERO members

Policy numbers
141000, 141001

Please PRINT clearly.

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

1 General information

Information about you

First name	Initial	Last name	Former/maiden name (if applicable)
Date of birth (dd-mm-yyyy) — —	Province of birth	Country of of birth	☐ Male ☐ Female
Address (street number and name)			Apartment or suite
City	Province	Postal code	
Telephone number — —	E-mail address		

Information about your spouse (complete if applying for benefits)

First name	Initial	Last name	Former/maiden name (if applicable)
Date of birth (dd-mm-yyyy) — —	Province of birth	Country of of birth	☐ Male ☐ Female
Telephone number — —	E-mail address		

Information about your dependent child(ren) (complete if applying for benefits)

First name	Initial	Last name	Date of birth (dd-mm-yyyy)	
First name	Initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female
First name	Initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female
First name	Initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female

If you need more space, please complete on separate sheet of paper, and sign and date it.

For office use only

Certificate #:____________________

☐ Extended Health Care Plan: ☐ Single ☐ Couple ☐ Family

☐ Semi-Private Hospital & Convalescent Care Plan: ☐ Single ☐ Couple ☐ Family

Notes:

DC-100

2 Statement of insurability

Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled.

Do not tell us about genetic testing or genetic test results.

2.1 Background information

Information about you

Height ft. in.	m cm	Weight ☐ lbs. ☐ kg
Have you lost or gained more than 10lbs in the last 12 months? ☐ Yes ☐ No		If "Yes", please check Gain or Loss and the amount of weight change ☐ Gain ______ ☐ Loss ______ ☐ kg ☐ lbs
Name of attending physician		
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)		
Name of physician, diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them		

Information about your spouse (complete if applying for benefits)

Height ft. in.	m cm	Weight ☐ lbs. ☐ kg
Have you lost or gained more than 10lbs in the last 12 months? ☐ Yes ☐ No		If "Yes", please check Gain or Loss and the amount of weight change ☐ Gain ______ ☐ Loss ______ ☐ kg ☐ lbs
Name of attending physician		
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)		
Name of physician, diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them		

Information about your dependent child(ren) (complete if applying for benefits)

First name	Middle initial	Last name

First name	Middle initial	Last name

First name	Middle initial	Last name

If you need more space, please complete on separate sheet of paper, and sign and date it.

2 Statement of insurability (continued)

2.2 Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?	You	Your spouse	Your dependent child(ren)
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes* please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Price you pay per month (do not include cost covered by the Ontario Drug Benefit)	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

2 Statement of insurability (continued)

Do not tell us about genetic testing or genetic test results.

2.3 Health questionnaire

In the last 10 years has there been any treatment for, known indication of, or consultation with any health care professional about:	You	Your spouse Your spouse	Your dependent child(ren)
a) heart disease, stroke, TIA, circulatory disorder, chest pains or angina?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) blood disorders including cholesterol, high or low blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) tumours, cancer, moles, other growths or disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS),AIDS related complex (ARC), or other immune disorder including Hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) respiratory problems or any lung diseases?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) stomach, digestive problems, intestinal or colon problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) kidney problems or disease, liver problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) urinary tract problems, breast, prostate or genital problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) multiple sclerosis, seizures, paralysis or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) diabetes or high blood sugar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) depression, anxiety, or any other psychiatric problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) bone or joint problems, or any muscular pain including any neck or back pain?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) any other condition not listed above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) substance abuse (including drugs or alcohol)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) had his or her driver's license suspended or revoked, or had three or more moving violations in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) engaged or intend to engage in, any hazardous sport or activity (eg. auto or motorcycle racing, scuba or sky diving, or hang gliding)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) had an application for insurance declined, postponed, rescinded, cancelled or modified in any way, or been denied a renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details below for any *yes* answers in section 2.3 (a-q). 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	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results
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3 Declaration and authorization

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

I hereby certify that I have read the Medical Information Bureau (MIB) notice in section 4, 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.

With respect to this application, I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose relevant information needed for the purposes of underwriting, administration and adjudicating claims with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers, and to collect, use and disclose information with Johnson Insurance for the purpose of administration.

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

Your signature X		Your spouse's signature (if applying for benefits) X
City signed	Province signed	Date (dd-mm-yyyy) – –

Please return completed application to:

Johnson Inc.
18 Spadina Road, Suite 100
Toronto, ON M5R 2S7

4 Medical Information Bureau 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.

Write to the MIB at: **Medical Information Bureau**
330 University Avenue
Toronto, Ontario M5G 1R7
or call: 416-597-0590

5 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*.