Application form for Critical Illness Insurance

For members of the Canadian Dental Hygienists Association

Sun Life Financial

Please PRINT clearly.
Complete the questions for your spouse only if he/she is applying for coverage.

Policy #59956

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, a member of the Sun Life Financial group of companies.

1 General information (Please complete all)

You

			Gender ☐ Male ☐ Female	Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)
			Place of birth (province)		Place of birth (country)
			Telephone (home)		Telephone (business)
Height (ft/in)	Weight (lbs/kgs)	Change in weight in the last 12 months ☐ No change ☐ Gain ☐ Loss _____ lbs/kgs	Reason for weight change		
☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		E-mail address		

Are you actively at work for at least 20 hours per week?
☐ Yes ☐ No If no, please provide details. Include whether you have been hospitalized in the last six months and whether you can perform the six activities of daily living (bathing, dressing, feeding, continence, toileting, transferring).

Your spouse

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Former/maiden name (if applicable)
Occupation	Place of birth (province)	Place of birth (country)	Telephone (home)	Telephone (business)	
Height (ft/in)	Weight (lbs/kgs)	Change in weight in the last 12 months ☐ No change ☐ Gain ☐ Loss _____ lbs/kgs	Reason for weight change		
E-mail address			☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.	

Is your spouse actively at work for at least 20 hours per week?
☐ Yes ☐ No If no, please provide details. Include whether your spouse was hospitalized in the last six months and whether your spouse can perform the six activities of daily living (bathing, dressing, feeding, continence, toileting, transferring).

2 Coverage amount applied for at this time (Please complete all)

Enrol before June 15, 2011, and you and your spouse can receive your first $30,000 of Critical Illness Insurance coverage without having to answer any health questions!*

For coverage which does not require proof of good health, this coverage will be effective on the first of the month following receipt of your completed application. For coverage which requires proof of good health, this coverage will be effective on the 1st of the month following the approval date of the insurance.

For applications received after June 15, 2011, proof of good health will be required for any amount.

In order for your spouse to be eligible for $30,000 of Critical Illness Insurance coverage without answering any health questions, you must first apply for coverage under this benefit.

For you

Total coverage being requested: $ _____
(minimum $30,000, maximum $300,000, including any existing coverage, in units of $10,000)

For your spouse

Total coverage being requested: $ _____
(minimum $30,000, maximum $300,000, including any existing coverage, in units of $10,000)

* If you/your spouse are applying for coverage above $30,000, please complete the health questions in sections 3 and 4 of this form.
If you have already received up to $30,000 of coverage without proof of good health under previous campaigns, proof of good health will be required for all amounts of coverage requested at this time.

For SLF use:
DC-100

3 Background information (Please complete if applying for coverage above $30,000)

You

Date and reason 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

Your spouse

Date and reason 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

4 Medical information (Please complete if applying for coverage above $30,000)

a) Have any of your or your spouse's immediate family members (parents, brothers, sisters) had a heart attack, heart disease, polycystic kidney disease, stroke, diabetes, cancer **(specify type below)**, multiple sclerosis, Parkinson's disease, Alzheimer's disease, Amyotrophic lateral sclerosis, progressive muscular atrophy, motor neuron disease, Huntington's chorea, familial polyposis or any hereditary disease? ☐ Yes ☐ No | ☐ Yes ☐ No

If *yes*, please complete the chart below.

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)				

	You	Your spouse
b) Do you or your spouse consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please record the number of alcoholic beverages consumed in a week:		
c) Have you or your spouse ever received advice or treatment for the use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
d) In the last five years, have you or your spouse consulted any physician, chiropractor, psychologist, physiotherapist, psychiatrist or any other health care professional or been admitted to any hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No
Have you or your spouse ever:		
e) Had chest pain, heart attack, angina, abnormal electrocardiogram (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
f) Had a stroke, transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
g) Had diabetes; sugar, blood or protein in the urine; disease of the kidneys, urinary tract, bladder, prostate or reproductive organs including breast lumps, cysts or other breast changes; or had an abnormal mammogram?	☐ Yes ☐ No	☐ Yes ☐ No
h) Had tumours, cancer, moles, 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
i) Had chronic lung or respiratory disorder; disease or disorder of the eyes, ears, nose or throat; or colitis or any other disorder of the colon, intestines, stomach or liver?	☐ Yes ☐ No	☐ Yes ☐ No
j) Had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; fibromyalgia or rheumatic/arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No
k) Had a mental or nervous disorder; depression, anxiety state or panic attacks; eating disorder; other emotional or psychiatric disorder; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No
l) Tested positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepatitis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS) or any other immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No

4 Medical information – continued (Please complete if applying for coverage above $30,000)

Have you or your spouse ever:	You	Your spouse
m) 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
n) Had a driver's licence suspended, been convicted for drunk or impaired driving, or had three or more moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No
o) Used herbal supplements or remedies, sedatives, analgesics, hypnotics, tranquilizers and/or stimulants, 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
p) Had critical illness or life insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No
q) Made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No
r) 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
s) Used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker, artificial limb or hearing aid?	☐ Yes ☐ No	☐ Yes ☐ No
t) Need human assistance of any kind to perform any daily activities, such as bathing, continence, dressing, eating, using the toilet, or transferring (for example from bed to chair)?	☐ Yes ☐ No	☐ Yes ☐ No

IF YOU OR YOUR SPOUSE REPLIED YES TO ANY OF THE ABOVE QUESTIONS (c-t), please provide details.
If the space provided is insufficient, please provide details on a separate duly signed and dated sheet.

Question	Name of person	Nature of disorder	Date (m/y)	Duration	Diagnosis	Treatment	Name and address of physicians, hospitals, insurance companies

5 Premium payments (Please complete all)

I would like to pay by:

☐ **Monthly pre-authorized debit (PAD)** (collect my premium directly from my bank account)

First name of account holder	Middle initial	Last name of account holder		
Financial institution name	**Financial institution address (street # and name)**	**Transit #**	**Institution #**	**Account #**

Please attach a personal blank cheque, marked VOID across the front, to this application form.

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 Sun Life Assurance Company of Canada (Sun Life) to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. 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 Sun Life 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 Sun Life is unable to make a withdrawal from your account.

This authorization is to remain in effect until Sun Life 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**.

Sun Life 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**.

5 Premium payments (continued)

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

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

Telephone # 1-800-669-7921 email: **Can_AssocAndAffinity@sunlife.com**

6 Declaration and authorization (Please complete all)

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 authorize Sun Life Assurance Company of Canada, and its agents and service providers, to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the Medical Information Bureau (MIB), investigative agencies, insurers, and reinsurers. I acknowledge receipt of the MIB notification information, and having read the contents, I have, by my signature below, authorized the MIB to give Sun Life Assurance Company of Canada, or its reinsurers, any information it may have.

A photocopy or electronic version of this authorization is as valid as the original, and shall remain in effect for the duration of my insurance coverage.

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

7 Respecting your privacy

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 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.