Health Statement – Optional Life and Critical Illness

Sun Life Financial

Important

- Incomplete forms will delay processing.
- Part 1 is to be completed by the Plan Administrator, or the member with information provided by the Plan Administrator.
- Member to mail form directly to Sun Life Assurance Company of Canada.

Please PRINT clearly.

1 Plan Administrator / Member information

Coverage is not in effect until you receive notice of approval from Sun Life Assurance Company of Canada.

In this application, you and your refer to the person applying for insurance.

Member's name (first)	(last)		
Contract number 5993/17835	Member ID	Billing group	Class
Occupation	Current salary $ ☐ Hrly. ☐ Wkly. ☐ Bi-Wkly. ☐ Mthly. ☐ Ann.		
Company name Microsoft Canada Co.			
Plan Administrator's name		Telephone number ( )	

Reason for Application

☐ New Enrolment – Effective date _____
☐ Increased Coverage
☐ Annual Enrolment – Effective date _____

Benefits Requested (Please check off)	A. Existing Amount of Coverage (if applicable)	B. New Amount of Coverage Requested	C. Total Amount of Coverage (A + B)
☐ Optional Life - member	$	$	$
☐ Optional Life - spouse	$	$	$
☐ Critical Illness - member	$	$	$
☐ Critical Illness - spouse	$	$	$

For Sun Life Financial Use Only

Health Statement – Optional Life and Critical Illness

2 General information

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.

Member

Name (first, middle initial, last) ☐ Male ☐ Female	Date of birth (d/m/y)
Former name (if applicable)	Place of birth (province and country)
Residence address (street number and name)	Apartment/suite number
City	Province / Postal code
Preferred method of contact, select all that apply: ☐ Phone ☐ E-mail	
Please provide a phone number where you can be reached for any additional information: Member's home telephone number ( ) / Member's business telephone number ( )	Member's E-mail address
☐ Non-smoker ☐ Smoker — *Non-smoker* means that you have not used any tobacco products within the last 12 consecutive months.	

Height ft. in. | m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ lbs. No change ☐ Gain _____ ☐ Loss _____ ☐ kg	Reason for weight change

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

Complete this section only if applying for spousal coverage.

Spouse

Name (first, middle initial, last) ☐ Male ☐ Female	Date of birth (d/m/y)
Place of birth (province and country)	Former name (if applicable)
☐ Non-smoker ☐ Smoker — *Non-smoker* means that you have not used any tobacco products within the last 12 consecutive months.	

Height ft. in. | m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ lbs. No change ☐ Gain _____ ☐ Loss _____ ☐ kg	Reason for weight change

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

3 Insurance information

If you or your spouse have critical illness in-force or pending with another insurer, please provide details.

	Insurer name	Date of issue	Coverage amount	Indicate if any critical illness will be discontinued if this coverage is issued
MEMBER			$	☐ Yes ☐ No
SPOUSE			$	☐ Yes ☐ No

Health Statement – Optional Life and Critical Illness

4 Family history information

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had heart disease, polycystic kidney disease, stroke, diabetes, cancer (specify type below), multiple sclerosis, Huntington's Chorea, Alzheimer's, Parkinson's or any hereditary disease?
If *yes*, complete the chart below.

Member	Spouse
☐ Yes ☐ No	☐ Yes ☐ No

Member's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Spouse's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

5 Medical information

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

Have you or your spouse ever:	Member	Spouse
a) Had chest pain, heart attack, 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
b) 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
c) Had diabetes; sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No
d) Had a disease of the kidneys, urinary tract, bladder, prostate or reproductive organs?	☐ Yes ☐ No	☐ Yes ☐ No
e) Had tumours, cancer, polyps or other growth; including breast lumps, cysts or other breast changes, or had an abnormal mammogram?	☐ Yes ☐ No	☐ Yes ☐ No
f) Had moles or other growth or a disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No
g) Had a blood or lymph gland disorder or any other form of malignant disease; or had a biopsy?	☐ Yes ☐ No	☐ Yes ☐ No
h) Had chronic lung or respiratory disorder; disease or disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
i) Had any disorder of the colon, intestines, including colitis or disorder of the stomach?	☐ 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
Do you or your spouse ever:		
l) Consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please record the number of alcoholic beverages consumed in a week:		
Have you or your spouse ever:		
m) Received advice or treatment for the use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
n) Had a disorder of the liver including testing 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

Health Statement – Optional Life and Critical Illness

5 Medical information (continued)

		Member	Spouse
o)	Had any other illness, disease, disorder, condition, injury, diagnostic testing or surgical procedure 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
p)	Had a driver's licence suspended or ever been convicted for drunk or impaired driving, or had three or more speeding or moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No
q)	Used herbal supplements or remedies, sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No
r)	Used 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 within the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
s)	Had life, disability or critical illness insurance declined, postponed, rated, rescinded, cancelled or modified in anyway, or ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No
t)	Received disability benefits for three months or longer?	☐ Yes ☐ No	☐ Yes ☐ No
u)	Piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities? e.g.: skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No
v)	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
	Do you or your spouse need:		
w)	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 (a-w), please provide details below. 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	Duration	Diagnosis	Treatment	Name and address of physicians, hospitals, insurance companies

Health Statement – Optional Life and Critical Illness

6 Declaration and authorization

Please read and sign this section.

In this declaration and authorization, "I" applies to each of the member and the spouse 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.

If I am a spouse, I also authorize Sun Life Assurance Company of Canada to disclose information about this application to the member, for the purposes of assessing this application and managing the group benefits plan.

For the application of Critical Illness Insurance, I also authorize the Sun Life Assurance Company of Canada, its agents, service providers and reinsurers to use and exchange information with MIB as needed for underwriting, administration and adjudicating claims under this insurance coverage. I hereby certify that I have read the Medical Information Bureau (MIB) notice, and having read and understood 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.

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)
Signature of Spouse X	Date (d/m/y)

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.

For questions regarding your statement of health, please contact the following:

- Critical Illness insurance (English or French), 1-800-669-7921 or 416-408-7390
- Other Group Benefits (English or French), 1-866-882-0884

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

If your head office is located in Ottawa, Québec or an Eastern Province:
Fax: (514) 954-1081
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 11010 Stn CV
Montréal QC H3C 4T9

If your head office is in another location:
Fax: (519) 888-3477
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 578 STN Waterloo
Waterloo ON N2J 4B8

7 Authorization to furnish information

Please read and sign this section.

This portion may be provided to service intermediaries in order to obtain information.

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)
Signature of Spouse X	Date (d/m/y)

Sun Life Assurance Company of Canada must receive your completed Health Statement of within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Health Statement.

Health Statement – Optional Life and Critical Illness

Please detach and retain this page in reference to your health statement.

8 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 you also apply for insurance coverage or submit 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.

You may contact the MIB at:

Medical Information Bureau
330, University Avenue
Toronto, Ontario M5G 1R7
416-597-0590

9 Handling your medical and personal information

Your application for insurance may require Sun Life Assurance Company of Canada to gather medical and personal information beyond what you provide in this application. This could involve a medical examination, including tests such as that for HIV. We may also check the identity, full-time and part-time occupations, finances, hazardous activities, driving record and drug use of the person applying for insurance, and for evidence of any criminal record.

If this investigation reveals positive tests results for HIV or other communicable or reportable diseases, we will give the results to your doctor if you've authorized us to do so. If we do not have your written authorization, or if we are unable to provide the information to your doctor, then we may disclose the test results to the appropriate public health authorities.