Continuum

Application – Statement of Health Form for Health Care and Dental Care Insurance

Sun Life Financial

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 (the insurer), a member of the Sun Life Financial group of companies.

1 General information

Information about you

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)			Date of birth (dd-mm-yyyy) – –
Province of birth	Country of birth		Language ☐ English ☐ French
Residence address (street number and name)			Apartment or suite
City	Province		Postal code
Telephone (home) – –	Fax – –	Email address	
Are you a resident of Canada and covered under the provincial health plan in your province of residence? ☐ Yes ☐ No	Name of school attended in last academic year		Student ID

Information about your spouse

Please complete if applying for spousal insurance.

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)			Date of birth (dd-mm-yyyy) – –
Province of birth	Country of birth		Language ☐ Male ☐ Female
Email address	Are you a resident of Canada and covered under the provincial health plan in your province of residence? ☐ Yes ☐ No		

Information about your dependent child(ren)

Please complete if applying for dependent child(ren) insurance.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy) – –	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy) – –	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy) – –	Student ☐ Yes ☐ No

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

2 Coverage applying for

Please visit *www.continuumplan.com* for product details.

Health Plan

☐ Single
☐ Couple
☐ Family

Health & Dental Plan

☐ Single
☐ Couple
☐ Family

DC-127

3 Statement of insurability

3.1 Background information

Information about you

If no attending physician, please state *none*.

Height ft. in. | m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg
Reason for weight change		
Name of physician, address, date and reason for last consultation with physician (if non, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		

If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them.

Information about your spouse

Please complete if applying for spousal insurance.

Height ft. in. | m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg
Reason for weight change		
Name of physician, address, date and reason for last consultation with physician (if non, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		

If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them.

Information about your dependent child(ren)

Please complete if applying for dependent children coverage.

First name	Middle initial	Last name
Height ft. in. | m cm	Weight ☐ lbs. ☐ kg	
Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg	Reason for weight change	
First name	Middle initial	Last name
Height ft. in. | m cm	Weight ☐ lbs. ☐ kg	
Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg	Reason for weight change	
First name	Middle initial	Last name
Height ft. in. | m cm	Weight ☐ lbs. ☐ kg	
Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg	Reason for weight change	

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

3 Statement of insurability (continued)

3.2 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	Monthly cost	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			

3.3 Health questionnaire

Have any of the persons to be insured ever:	You	Your spouse	Your dependent child(ren)
a) consulted a physician for symptoms or had treatment for cancer or tumour, neurological disorder, cardiovascular disorder, high blood pressure, stroke, diabetes, liver or kidney disease, respiratory disorder, gastrointestinal disorder, mental or nervous disorder, substance abuse, hepatitis, endocrine disorder, blood disorder, genitourinary or reproductive system disorder, rheumatoid arthritis, multiple sclerosis, immunological disorder, or tested positive for HIV?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had any other illness, injury, operation or treatment within the last five years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) contemplated medical or surgical treatment, or a hospital stay in the next six months, and have you or your spouse in the last two years been unable to work for more than five consecutive days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had any symptoms and complaints for which a physician has not been consulted or been advised to have any further examinations or tests which have not been yet completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) received advice or treatment for the use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) 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
g) 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
h) 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 under sections 3.3 (a-h). Include the results of all physical examinations and check-ups.
If you need more space, please complete on a 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
		–		
		–		
		–		
		–		
		–		

4 Payment of premiums

Monthly pre-authorized debit (PAD)

Please complete the information below OR attach a personal blank cheque marked VOID across the front, to this application form, and sign below.

First name of account holder	Middle initial	Last name

Financial institution name	Financial institution address (street number and name)

Transit number	Institution number	Account number

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payor(s) name (first and last) or full legal name of corporation/entity	
If applicable, date of birth (dd-mm-yyyy) – –	Relationship to you

Address (street number and name)	Apartment or suite

City	Province	Country	Postal code

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.payments.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.payments.ca*.

Sun Life Assurance Company of Canada
Association & Affinity Business
P.O. Box 2001 Stn Waterloo
Waterloo, ON N2J 0A3
Telephone: 1-800-669-7921
Email: *Can_AssocAndAffinity@sunlife.com*

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

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

Send no money with this application. You will be notified with a premium statement.

5 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 (see section 8), and having read the contents, I have, by the signature(s) below, authorized the MIB to give Sun Life Assurance Company of Canada, or its reinsurers, any information it may have.

I authorize Sun Life Assurance Company of Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudication of claims under this insurance coverage with any person who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers and to use and exchange information with ASEQ/studentcare.net/works for the purpose of administration.

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

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

Please return your completed application to:
Sun Life Assurance Company of Canada
Association & Affinity Business
P.O. Box 2001 Stn Waterloo
Waterloo, ON N2J 0A3

7 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*.

8 Medical Information Bureau notice

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you or your spouse 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 and/or your spouse 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 and/or your spouse also applies for insurance coverage or submit(s) 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 write to MIB at: Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

or call 416-597-0590