Application for Insurance under the Sun Association Plan

Sun Life

Policy number 17887

Please PRINT clearly.

In this application *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 group of companies.

Clear

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)	Place of birth (province)	Place of birth (country)
Name of association you are affiliated with	☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.	
Residence address (street number and name)			Apartment or suite
City		Province	Postal code
Telephone (home)	Telephone (office)	Fax	Email address

Information about your spouse (if applying for coverage)

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
Occupation			Amount of annual earned income $
☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		

2 Coverage applied for

Minimum $50,000 – Maximum $1,000,000 in units of $25,000

Member Life insurance

Amount of insurance **applied for at this time** $	Beneficiary's first name*	Beneficiary's last name*
Relationship to proposed insured	Beneficiary designation** ☐ Revocable ☐ Irrevocable	

Minimum $50,000 – Maximum $1,000,000 in units of $25,000

You must have Member Life insurance in order to apply for Spousal Life insurance.

Spousal Life insurance***

Amount of insurance **applied for at this time** $

Dependent(s) Life insurance***

$10,000 for each Dependent Child ☐ Yes

* If you do not designate a beneficiary, the proceeds of this insurance will be paid to your estate in the event of your death.

** You must check *revocable* or *irrevocable* for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

*** The member is automatically the beneficiary for the spousal and dependent child life coverage.

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Distributed Channel **WEB**

2 Coverage applied for (continued)

Accidental Death and Dismemberment (AD&D) insurance

Member:
Minimum – $25,000
Maximum – $250,000
in units of $25,000
(cannot exceed
Life coverage)

☐ Single ☐ Family

Amount of insurance **applied for at this time**
$

You must have Life insurance to be eligible for AD&D insurance.

Critical Illness (CI) insurance

Minimum $25,000 –
Maximum $250,000
in units of $25,000.

Amount of insurance **applied for at this time**
$

You must have member Critical Illness insurance to apply for Spousal Critical Illness insurance.

Spousal Critical Illness (CI) insurance

Amount of insurance **applied for at this time**
$

Extended Health Care (EHC) insurance and Dental insurance

If you are not covered under your provincial health plan or you do not have existing health and drug coverage, you are not eligible for EHC insurance.

Are you enrolled in your provincial health Plan?	Member ☐ Yes ☐ No	Spouse ☐ Yes ☐ No
If residing in Quebec, do you have drug coverage through RAMQ or an equivalent group/association plan?	Member ☐ Yes ☐ No	Spouse ☐ Yes ☐ No

Basic**
☐ Single
☐ Couple ☐ Family

Standard**
☐ Single
☐ Couple ☐ Family

Standard Plus (includes dental)**
☐ Single
☐ Couple ☐ Family

Enhanced**
☐ Single
☐ Couple ☐ Family

Enhanced Plus (includes dental)**
☐ Single
☐ Couple ☐ Family

** Please see brochure for more details.

Long-Term Disability (LTD) insurance

Minimum $1,000 –
Maximum $5,000
in units of $100.

Amount of insurance **applied for at this time** (per month)	Elimination period		
$	☐ 30 days	☐ 90 days	☐ 180 days

Professional Overhead Expense (POE) insurance

Minimum $500 –
Maximum $5,000
in units of $100.

You must have Long-Term Disability insurance to apply for POE insurance.

Amount of insurance **applied for at this time** (per month)	Elimination period	
$	☐ 14 days	☐ 30 days

3 Insurance information

Do you and/or your spouse have any Life, Critical Illness, Disability or Professional Overhead Expense insurance in-force or pending with any insurer, either as an individual policy, as a group benefit, or as part of an employment contract/partnership agreement?

☐ Yes ☐ No If *yes,* please provide details below.

	Type of coverage (Life, LTD, POE, CI)	Amount of benefit	Insurance company	Date of issue (mm-yyyy)	Benefit period	Taxable	Indicate if any insurance will be discontinued if this coverage is issued
You		$		–		☐ Yes	☐ Yes
Your spouse		$		–		☐ Yes	☐ Yes

4 Occupational information

Occupation/title	Are you self-employed? ☐ Yes ☐ No

Date employment started at current employer (dd-mm-yyyy)	Number of years in current occupation	Number of hours worked per week	Number of weeks worked per year
_ _			

Do you have any other occupation or contemplate changing your job duties and/or hours of work? ☐ Yes ☐ No
If *yes,* please describe fully.

5 Financial information

Only required if applying for LTD insurance.

	Current year-to-date from _ _ mm-yyyy to _ _ mm-yyyy	**Last year 201_**
Net annual earned income before tax	$	$
Is any portion of your income from a salaried position? ☐ Yes ☐ No	If *yes*, please provide salary and employer name $	
Do you have any unearned income? ☐ Yes ☐ No	If *yes*, indicate annual unearned income $	Sources of unearned income

Have you ever declared or are you contemplating bankruptcy? ☐ Yes ☐ No If *yes,* Date of discharge (mm-yyyy) _

6 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.

6.1 Background information

Information about you

Height ft. in. / m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ lbs. ☐ kg ☐ No change ☐ Gain _ ☐ Loss _	Reason for weight change
Name of physician, date and reason for last consultation with physician (if none, please state *none*)			
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 – Please complete if applying for Spousal coverage

Height ft. in. / m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ lbs. ☐ kg ☐ No change ☐ Gain _ ☐ Loss _	Reason for weight change
Name of physician, date and reason for last consultation with physician (if none, please state *none*)			
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.			

6 Statement of insurability (continued)

Information about your dependent(s)* — Please complete if applying for Dependent coverage

First name	Last name	☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Date of birth (dd-mm-yyyy)
First name	Last name	☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Date of birth (dd-mm-yyyy)

* A Dependent child is a child under age 21, or age 21 to 25 (26 in Quebec) if attending school full-time; or any age if physically or mentally infirm

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

6.2 Family history (do not tell us about genetic testing or genetic testing results).

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had cancer (**specify type**), heart disease, stroke, diabetes, polycystic or other kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), Muscular Dystrophy, familial polyposis of the bowel, Huntington's Chorea or any other hereditary disease?

You	Your spouse
☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the chart(s) 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)				

6.3 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 children
☐ 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
			$			
			$			

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

6.4 Medical information (do not tell us about genetic testing or genetic testing results).

Have any of the persons to be insured ever:	You	Your spouse	Your dependent(s)
a) had chest pain, angina, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, peripheral vascular disease, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had a stroke, transient ischemic attack (TIA or 'mini stroke'), phlebitis, paralysis, dizziness, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or neurological system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) had diabetes, impaired fasting glucose, sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or abnormal pap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) had disorder of the breast including lumps, cysts, abnormal mammogram findings or biopsy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) had tumours, cancer, polyps, moles or other growth; disorder of the skin or lymph glands; blood or immune disorder, leukemia or any other form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had sleep apnea or chronic lung or respiratory disorder; disease or disorder of the eyes (excluding near or far sightedness), ears, nose or throat or had loss of speech?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) had any disorder of the colon, rectum, intestines (including Crohn's or colitis), ulcer, gallbladder, stomach or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; amputation; fibromyalgia or rheumatic/arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) had any psychiatric disorder; depression, suicide attempts or ideations; anxiety state or panic attacks; eating disorder; other emotional disorders; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) had a disorder of the liver, 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)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6 Statement of insurability (continued)

	You	Your spouse	Your dependent(s)
l) 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	☐ Yes ☐ No
m) Are you contemplating any medical treatment or planning to undergo surgery, or are you currently suffering from a disability or fulfilling an elimination period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past five years, have any of the persons to be insured:			
n) consulted a physician, chiropractor, psychologist, physiotherapist, psychiatrist, or any other health care professional, or been admitted to a hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) had any symptoms or adverse findings, or were advised to have further examinations, diagnostic tests, hospitalization or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) submitted to ECGs, blood tests, x-rays, a biopsy or any other diagnostic tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) had any surgical operation, treatment, ailment, abnormality or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
r) received any treatment or are currently taking any medication, over-the-counter medications, including any herbal supplements or remedies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
s) been advised to have any further examinations, diagnostic tests, hospitalization or surgery which has not been completed, or had any symptoms or complaints regarding your health for which a physician has not yet been consulted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 12 months:			
t) have you, your spouse or dependent child(ren) been unable to work for more than five consecutive days or made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6.5 Additional information

You

a) Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes,* please record how much and how often.

Your spouse

Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes,* please record how much and how often.

	You	Your spouse	Your dependent(s)
Within the past 10 years, have any of the persons to be insured:			
b) consumed substantially more alcohol than outlined previously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) been charged with impaired driving or been arrested, due to the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had your driver's license suspended or revoked, or had three or more moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use and/or abuse of non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had Life, Critical Illness, or Disability insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years, have any of the persons to be insured:			
h) 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	☐ Yes ☐ No
Do any of the persons to be insured:			
i) expect to change country of residence or expect to travel outside Canada or the USA within the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For female applicants only			
j) Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please indicate expected due date.	(mm-yyyy)	(mm-yyyy)	(mm-yyyy)
k) Have you had any previous complications of pregnancy such as miscarriage, preeclampsia, caesarean section, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details below for any yes answers under sections 6.4 and 6.5. 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. Do not tell us about genetic testing or genetic testing results.

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

7 Premium payment method

a) Pre-authorized debit (PAD) ☐ Monthly ☐ Anually

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

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 or annual 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 or annual 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 or annual premium is changed or not. You understand that either the monthly premium is due the first of each month or the annual premium is due every March 1st.**. 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.

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

b) Credit card payment (charge my premium to my Visa or MasterCard)

Payment frequency ☐ Monthly ☐ Annually

Once we have processed your application, you will be contacted by a Sun Life call centre representative to obtain your credit card information.

Terms and conditions

In connection with you required premium under this benefit plan, you authorize us to: charge your credit card for the insurance premium owing, cancel this authorization 10 days after you have provided written notice to us, and to automatically cancel this agreement if we are unable to charge your credit card.

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

8 Payor information

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)		City
Province	Country	Postal code

9 Declaration and authorization

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 hereby certify that I have read the Medical Information Bureau (MIB) notice (see section 10), and having read the contents, I have, by the signature(s) below, authorized the MIB to give to 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 adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers.

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	Your spouse's signature
X	X

Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)
		__ __

Please return your completed application to:

Sun Life Assurance Company of Canada
Client Solutions
P.O. Box 2001 Stn Waterloo
Waterloo ON N2J 0A3

10 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

11 Respecting your privacy

Respecting your privacy is a priority for the Sun Life 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*.