Inpatriate Health Plan Enrolment/Statement of Health For spouses and children only

Please PRINT clearly

In this form, *you* and *your* refer to the person applying for insurance (i.e the spouse). *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 Coverage applied for at this time

Who is applying for coverage:

- ☐ Spouse of Canadian employee
- ☐ Spouse and children of Canadian employee
- ☐ Children of Canadian employee

Type of coverage:

- ☐ Single
- ☐ Single + 1 dependent
- ☐ Single + 2 dependents or more

2 General information

Information about employee

Policy number			Member identification number
050137			
Employer's name			
First name of employee	Middle initial	Last name of employee	Employee date of birth (dd-mm-yyyy)

Information about the applicant (Employee's spouse)

First name of applicant	Middle initial	Last name of applicant	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Date of arrival in Canada (dd-mm-yyyy)	Language ☐ English ☐ French
Residence address (street number and name)			Apartment or suite
City	Province	Country	Postal code
Telephone (home)	Telephone (work)	Fax	
E-mail address			

DC-100

3 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.

3.1 Background information

Information about the applicant

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

Please complete if applying for

Single + 1 dependent or Single + 2 dependents or more

Information about your dependent(s) (if dependent(s) is applying)

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

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

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

If you need more space, please complete on a separate sheet of paper. Sign, date and attach the sheet to this form.

3.2 Medication and/or treatment information

	Applicant	Your dependent children
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?	☐ 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 Statement of insurability (continued)

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

3.3 Health questionnaire

Have you, your spouse or dependent(s) ever:

	Applicant	Your dependent children
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
b) had any other illness, injury, operation or treatment within the last five years?	☐ 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
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
e) received advice or treatment for the use of alcohol or drugs?	☐ 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
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
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
i) for female applicants only, are you currently pregnant and if so, have you ever had any complications of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details below for any *yes* answers in section 3.3 (a-i). 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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4 Declaration and authorization

I declare that my answers in this enrolment/statement of health form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this enrolment/ statement of health form will cause the insurance to be void.

I hereby certify that I have read and understood the Medical Information Bureau (MIB) notice in section 5, 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.

I authorize Sun Life Assurance Company of Canada, its agents, and service providers to collect, use and disclose 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.

I also authorize Sun Life Assurance Company of Canada, its agents, and service providers to share my non-medical information with my plan sponsor for benefits administration and to make necessary payroll deductions which may be required, if my coverage is approved.

I also authorize my plan sponsor to use non-medical information collected in this form for benefits administration and to make any necessary payroll deductions which may be required.

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

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

Please return this completed form to:

Sun Life Assurance Company of Canada
Client Solutions
P.O. Box 365 Stn Waterloo
Waterloo, ON N2J 4A4

5 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 the 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, ON M5G 1R7

or call: 416-597-0590

6 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*.