

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

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.

Please PRINT clearly.

1 General information

Information about you

| | | | |
|---|-----------------------------------|--|--|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Former/maiden name (if applicable) | Date of birth (dd-mm-yyyy) _ _ | Place of birth (province/country) | Language <input type="checkbox"/> English <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Former/maiden name (if applicable) | Date of birth (dd-mm-yyyy) _ _ | Place of birth (province/country) | Language <input type="checkbox"/> English <input type="checkbox"/> French |
| Email address | | Are you a resident of Canada and covered under the provincial health plan in your province of residence? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Information about your dependent child(ren)

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

| | | | | | |
|------------|----------------|-----------|--|-----------------------------------|---|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) _ _ | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) _ _ | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) _ _ | Student <input type="checkbox"/> Yes <input type="checkbox"/> 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

3 Statement of insurability

3.1 Background information

Information about you

| | | |
|---|--|---|
| Height ft. in. m cm | Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg |
| Reason for weight change | | |
| Name of physician, address, date and reason for last consultation with physician (if none, please state <i>none</i>) | | |
| | | |
| Diagnosis, treatment given, results, medication prescribed | | |

If no attending physician, please state *none*.

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.

| |
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Information about your spouse

| | | |
|---|--|---|
| Height ft. in. m cm | Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg |
| Reason for weight change | | |
| Name of physician, address, date and reason for last consultation with physician (if none, please state <i>none</i>) | | |
| | | |
| Diagnosis, treatment given, results, medication prescribed | | |

Please complete if applying for spousal insurance.

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.

| |
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|--|

Information about your dependent child(ren)

| | | |
|---|--|-----------|
| First name | Middle initial | Last name |
| Height ft. in. m cm | Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg | |
| Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg | Reason for weight change | |
| First name | Middle initial | Last name |
| Height ft. in. m cm | Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg | |
| Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg | Reason for weight change | |
| First name | Middle initial | Last name |
| Height ft. in. m cm | Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg | |
| Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg | Reason for weight change | |

Please complete if applying for dependent children coverage.

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) |
|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) had any other illness, injury, operation or treatment within the last five years? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) received advice or treatment for the use of alcohol or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) had his or her driver's license suspended or revoked, or had three or more moving violations in the last two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h) had an application for insurance declined, postponed, rescinded, cancelled or modified in any way, or been denied a renewal or reinstatement? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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

Please complete this section if you'd like to have us collect your premium payment directly from your bank account.

a) Monthly pre-authorized debit (PAD)

| | | |
|---|----------------|-----------|
| First name of account holder | Middle initial | Last name |
| Name and address of your financial institution (street number 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.

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

Please complete this section if you'd like to have your insurance premium charged to your Visa® or MasterCard®

b) Monthly credit card payment

Type of card MasterCard® Visa®

| | | |
|---------------------------------------|-------------|----------------------------|
| Name of cardholder as appears on card | Card number | Expiry date (mm-yyyy) — |
|---------------------------------------|-------------|----------------------------|

Terms and conditions

In connection with your required premium under this benefit plan, you authorize us:

- to charge your credit card for the insurance premium owing
- to cancel this authorization 10 days after you have provided written notice to us
- to automatically cancel this agreement if we are unable to charge your credit card

| |
|----------------------------------|
| Signature of account holder 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 detached and kept the Medical Information Bureau (MIB) prenotification form, 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.

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

6 Authorization to furnish information

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

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 X | | Your spouse's signature (if applicable) 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

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 send a written request by email to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.



Please detach and retain this notice.

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