

# Continuum

## Application 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.

Your application must be received by Sun Life Assurance Company of Canada within 30 days of when your coverage ends.

If you opted out of your student Health Plan, please note that proof of coverage by an equivalent extended health plan is required in order to be exempted from completing a health questionnaire. Acceptable proof must consist of either a letter from your insurer, your parent's/spouse's employer, a letter from your employer, a membership card indicating coverage, or a photocopy of a receipt from a recent claim indicating health coverage. Please attach proof of coverage to this form.

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)	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 number
Were you covered under your student Plan during the last academic year?			
<input type="checkbox"/> Yes If "Yes", what is the termination date of your coverage?		Date (dd-mm-yyyy)	
<input type="checkbox"/> No If "No", under which plan were you covered?		What is the contract number?	
What is the termination date for this plan?		Date (dd-mm-yyyy)	

If you opted out of your student Health Plan and you did not have coverage by an equivalent health care plan, you must complete the Continuum Application - Statement of Health Form for Health-Care and Dental Care Insurance located on [www.continuumplan.com](http://www.continuumplan.com).

#### 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)	Language	<input type="checkbox"/> English <input type="checkbox"/> French
Email address	Is your spouse a resident of Canada and covered under the provincial health plan in his/her 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](http://www.continuumplan.com)  
 for product details.

### Health Plan

Single  Couple  Family

### Health & Dental Plan

Single  Couple  Family

## 3 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](http://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](http://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](mailto: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) - -
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#### 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
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**Send no money with this application. You will be notified with a premium statement.**

#### 4 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 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 institutions, 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) — —

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**

#### 5 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](http://www.sunlife.ca), or send a written request by email to [privacyofficer@sunlife.com](mailto: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.