Print blank form

Health statement

Important information

- Incomplete forms will delay processing.
- Part 1 is to be completed by the plan administrator or the plan member with information provided by the plan administrator.
- Plan member to return completed form directly to Sun Life Assurance Company of Canada (Sun Life).
- Please see **Returning your completed form in section 6**, for details on return options.

Important information when using 'click to sign'

- Ensure member, spouse and child names have been correctly entered. Name changes cannot be made after using 'click to sign'.
- All required member, spouse and dependent information, if applicable, must be provided on this form before using 'click to sign'.

Please PRINT clearly.

1 Plan administrator information (to be completed by the plan administrator or the member)

Coverage is not in effect until you receive notice of approval from Sun Life.

Member's last name		Member's first name	
Contract number 103582	Class 01	Billing group 01	Member ID

Occupation	Current salary $	☐ Hrly. ☐ Wkly. ☐ Bi-Wkly. ☐ Mthly. ☐ Ann.	Number of hours worked per week

Company name	Plan administrator's name SDA CHURCH IN CANADA	Telephone number

Company street address	City	Province	Postal code

Reason for application

- ☐ New enrolment - effective date (dd-mm-yyyy) ______
- ☐ Increased coverage
- ☐ Late applicant (enrolled after 31 days)
- ☐ Re-application (previously declined)
- ☐ Annual enrolment - effective date (dd-mm-yyyy) ______

Benefits requested (Please check off)	**A. Existing amount of coverage**	**B. Additional amount of coverage requested**	**C. Total amount of coverage (A + B)**
☐ Basic Life - member	$	$	$
☐ Basic Life - spouse	$	$	$
☐ Basic Life - dependent	$	$	$
☐ Optional Life - member	$	$	$
☐ Optional Life - spouse	$	$	$
☐ Optional Life - dependent	$	$	$
☐ Critical Illness - member	$	$	$
☐ Critical Illness - spouse	$	$	$
☐ Critical Illness - dependent	$	$	$
☐ Long-term disability	$	$	$
☐ Short-term disability	$	$	$
☐ Other ______	$	$	$

- ☐ Extended Health - member* New benefit ☐ Yes ☐ No
- ☐ Extended Health - dependent* New benefit ☐ Yes ☐ No
- ☐ Dental - member* New benefit ☐ Yes ☐ No
- ☐ Dental - dependent* New benefit ☐ Yes ☐ No

* If applicable - Date of loss of comparable coverage (dd-mm-yyyy) ______

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 testing results.

2 Member and dependent details (To be completed by the member.)

2.1 General information about the member

Member's last name	Member's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female

Member's street address (street number and name)	Apartment or suite	City	Province	Postal code

Preferred phone number ☐ Home ☐ Cell ☐ Business	Alternate phone number (if preferred) ☐ Home ☐ Cell ☐ Business	Email address

Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg	In the **last 12 months**, have you lost **more than 4.5 kg (10 lbs)**? ☐ Yes ☐ No	If ***Yes***, provide details including amount of weight loss and cause of the weight loss.

What is your preferred language for all correspondence?
☐ English ☐ French

Medical information: Physician

Physician's first name	Physician's last name	City	Province

Date of your last appointment (dd-mm-yyyy)	Reason for your appointment
Treatment or medication prescribed	Outcome of visit

Indicate if any follow-ups recommended. ☐ Yes ☐ No If ***Yes***, indicate types of follow-ups recommended.

Indicate if any referrals recommended. ☐ Yes ☐ No If ***Yes***, indicate types of referrals recommended.

2.2 General information about the member's dependents

(Complete this section only if applying for dependent coverage.)

Spouse's last name	Spouse's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female

Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg	In the **last 12 months**, have you lost **more than 4.5 kg (10 lbs)**? ☐ Yes ☐ No	If ***Yes***, provide details including amount of weight loss and cause of the weight loss.

Medical information: Physician

Physician's first name	Physician's last name	City	Province

Date of your last appointment (dd-mm-yyyy)	Reason for your appointment
Treatment or medication prescribed	Outcome of visit

Indicate if any follow-ups recommended. ☐ Yes ☐ No If ***Yes***, indicate types of follow-ups recommended.

Indicate if any referrals recommended. ☐ Yes ☐ No If ***Yes***, indicate types of referrals recommended.

Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Height ____ ft. ____ in. | ____ cm	Weight ☐ lb ☐ kg

2	Member and dependent details (to be completed by the member) (continued)

2.3 Family medical history information

Don't tell us about genetic testing or genetic test results.

Have any of your parents, brothers or sisters been diagnosed **before age 65** with:

	Member		Spouse	
• heart disease or cardiomyopathy. You don't need to tell us about high blood pressure or high cholesterol.	☐ Yes	☐ No	☐ Yes	☐ No
• stroke	☐ Yes	☐ No	☐ Yes	☐ No
• Parkinson's disease	☐ Yes	☐ No	☐ Yes	☐ No
• cancer	☐ Yes	☐ No	☐ Yes	☐ No
• Huntington's disease	☐ Yes	☐ No	☐ Yes	☐ No
• polycystic kidney disease	☐ Yes	☐ No	☐ Yes	☐ No
• multiple sclerosis	☐ Yes	☐ No	☐ Yes	☐ No
• muscular dystrophy	☐ Yes	☐ No	☐ Yes	☐ No
• Alzheimer's disease	☐ Yes	☐ No	☐ Yes	☐ No
• Amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, or	☐ Yes	☐ No	☐ Yes	☐ No
• any other hereditary disease or disorder?	☐ Yes	☐ No	☐ Yes	☐ No

If *Yes*, provide details below.

Person being insured	Relationship to family member	Condition(s) (If cancer, include type)	Age at onset
Member	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Member	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Member	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Member	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Spouse	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Spouse	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Spouse	☐ Mother ☐ Father ☐ Brother ☐ Sister		
Spouse	☐ Mother ☐ Father ☐ Brother ☐ Sister		

2.4 Personal medical history (Complete this section only for person(s) applying for insurance.)

Don't tell us about genetic testing or genetic test results.

For all *Yes* answers in 2.4, you must provide additional details in 2.5 *Details about your personal medical history*.

Have you **ever** been treated for, or had any symptoms or indication of the following:

	Member		Spouse		Child(ren)	
a) **Diabetes or a gland disorder** – Diabetes, elevated blood sugar, prediabetes, gestational diabetes, thyroid disorder, including nodule or any other endocrine disorder?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b) **Heart or blood vessel disease** – Irregular pulse, heart attack, chest pain, coronary artery disease (CAD), stroke or cerebrovascular accident (CVA), transient ischemic attack (also referred to as a mini-stroke or TIA), aneurysm, heart valve disorder or any other disease of the heart or blood vessels? You don't need to tell us about well-controlled high blood pressure or high cholesterol.	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c) **Cancer** – Cancer, melanoma, leukemia, lymphoma, tumour, cyst(s), polyp(s) or any other growth or malignancy?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

2 Member and dependent details (to be completed by the member) (continued)

	Member	Spouse	Child(ren)
d) **Mental health condition** – Anxiety, depression, schizophrenia, chronic fatigue syndrome, eating disorder or any other psychological, emotional or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) **Disorder of the kidney, bladder or reproductive organs** – Prostate disease, breast lump(s), abnormal pap smear, disease of the ovary or uterus, disorder of the genital organs, or any other kidney or bladder disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) **Immune system disorder** – Rheumatoid or psoriatic arthritis, ankylosing spondylitis, systemic lupus erythematosus (SLE), systemic scleroderma, AIDS or testing positive for HIV or any other disorder of the connective tissue or of the immune system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) **Digestive system disorder** – Hepatitis B or C, (including hepatitis carrier state), cirrhosis, Crohn's disease, ulcerative colitis, ulcer (peptic or gastric), rectal or intestinal bleeding, or any other disorder of the bowel, esophagus, stomach, pancreas or liver?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) **Disorder of the muscles, joints, limbs, neck, back or bones** – Arthritis, fibromyalgia, osteoporosis, chronic or persistent pain or any other disorder of the muscles, joints, limbs, neck, back or bones?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) **Brain or nervous system disorders** – Epilepsy or seizure(s), multiple sclerosis (MS), paralysis, Parkinson's disease, Alzheimer's disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, loss of balance, loss of consciousness, sensation or speech or any other disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) **Lung disease** – COPD (Chronic Obstructive Pulmonary Disease including emphysema), cystic fibrosis, sleep apnea or any other respiratory disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) **Skin disorder** – Dysplastic nevus (irregular mole) or any other disorder of the skin? You don't need to tell us about acne, dermatitis, eczema, rosacea.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) **Disorder of the eyes, ears, nose, throat or mouth** – Blindness, permanent or temporary loss of vision in either eye, glaucoma, optic neuritis, deafness, impaired hearing or any other disorder of the eyes or ears, nose, throat and mouth?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) **Blood disorder** – Anemia or any other blood or bleeding disorder? You don't need to tell us about Iron deficiency anemia.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2 Member and dependent details (to be completed by the member) (continued)

2.5 Details about your personal medical history

If you answered *Yes* to any question in 2.4 *Personal medical history*, provide additional details below.

Important information

Under Details of condition, provide the diagnosis, date of diagnosis or date symptoms first started, if resolved (provide date) or ongoing, type of treatment(s) received, the date(s) and duration of treatment(s) and treatment results, the name and dosage of the medication(s), the names and addresses of the doctors involved. Also include the names and addresses of any hospitals and clinics you consulted or were treated at. If you need more space, use a separate sheet signed and dated by the person who has the condition.

Person being insured	Question	Name of condition or diagnosis	Details of condition

3 Lifestyle questions

Important information

- If you need more space, use a separate sheet signed and dated by the person answering the questions.
- Questions in section 3 do not need to be answered by any child under the age of 16.

3.1 Smoking and tobacco use

	Member	Spouse	Child(ren)
In the **last 12 months**, have you used tobacco or nicotine products in any form (cigars, cigarettes, vapor products, pipes, chewing tobacco, nicotine patches or nicotine gum)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3 Lifestyle questions (continued)

3.2 Alcohol consumption

	Member	Spouse	Child(ren)
In the **last 10 years**, have you consumed alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Amount & frequency of use
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
	Number: ___ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

3.3 Marijuana consumption

	Member	Spouse	Child(ren)
a) In the **last 12 months**, have you used marijuana or hashish?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) If *Yes*, do you mix the marijuana or hashish with tobacco?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you use marijuana or hashish **more than 7 times a week** or **more than once daily**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Date last used (mm-yyyy)	Person being insured	Date last used (mm-yyyy)

3.4 Drug consumption

	Member	Spouse	Child(ren)
In the **last 10 years**, have you used any drugs or narcotics such as cocaine, LSD, ecstasy, heroin, fentanyl, anabolic steroids or amphetamines, methadone, morphine or other?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Drug or narcotic	Date last used (mm-yyyy)

3	Lifestyle questions **(continued)**

3.5 Alcohol and drug abuse

	Member	Spouse	Child(ren)
a) In the **last 10 years**, have you been treated, counselled or gone to meetings for alcohol or drug abuse?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details including dates, treatments received, date of last drink (for alcohol use), name of physician or treatment facility last consulted for this condition and any other relevant information.

Person being insured	Details

	Member	Spouse	Child(ren)
b) Has a doctor or health care professional **ever** recommended you get treatment or counselling or limit the amount of alcohol or drugs you use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Details

4	Medical tests and consultations

Important information

If you need more space, use a separate sheet signed and dated by the person answering the questions.

4.1 Abnormal medical test results

	Member	Spouse	Child(ren)
Other than for conditions already disclosed, in the **last 5 years**, have you had any abnormal medical test results? This includes, but is not limited to abnormal ECG, MRI, ultrasounds, mammograms or blood tests. **Don't tell us about genetic testing or genetic test results.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details including name of the medical test(s), date the test was completed, results, diagnosis, date of diagnosis, names and addresses of the doctors involved, treatments received, the dates and duration of treatments and the treatment results. Also include the names and addresses of any hospitals and clinics you consulted or were treated at.

Person being insured	Details

4	Medical tests and consultations (continued)

4.2 Prescription medication or treatment

Other than for conditions already disclosed, in the **last 2 years**, have you been prescribed or are you currently using any prescription medications or treatments, or expecting to do so within the **next 3 months**? **You don't need to tell us about antibiotics or contraceptives.**

Member	Spouse	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details including the name of the medication or treatment, date you started using the medication or treatment and the reason you are using the medication or treatment.

Person being insured	Details

4.3 Symptoms for which a health care professional has not been seen

Other than for conditions already disclosed, do you have any symptoms for which you have not yet consulted a health care professional or received treatment? **You don't need to tell us about the common cold, flu or seasonal allergy symptoms.**

Member	Spouse	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Details

4.4 Pending tests, referrals, test results and treatment or surgery

Other than for conditions already disclosed, are you currently awaiting treatment or surgery or has a health care professional requested any tests or referrals that have not been completed or are you currently awaiting test results? **Don't tell us about genetic testing or genetic test results.**

Member	Spouse	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details below.

Person being insured	Details

5 Insurance history

History of an adverse decision on an insurance application

	Member	Spouse	Child(ren)
In the **last 5 years**, have you had any applications for life, disability or critical illness insurance declined, rated, postponed, cancelled or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *Yes*, provide details including type of insurance, date you applied for insurance, outcome, and reason for decision.

Person being insured	Details

6 Declaration and authorization (please read and sign this section)

By signing below, the member acknowledges, confirms and declares they understand they may be refused coverage or any benefit amounts for which proof of good health is required if, in the opinion of Sun Life (the company), they are not insurable.

By signing below, the member, spouse and any children, age 18 or older, acknowledge, confirm and declare that each:
- reviewed all of the answers and statements relevant to them, and
- provided true and complete information.

By signing below, the member, spouse and any children, age 18 or older, understand and agree if they don't completely and truthfully answer all of their questions or if they misrepresent any of their answers or statements, the company may void the insurance.

By signing below, the member, spouse and any children, age 18 or older, confirm they've received, read and agree to the Sun Life Privacy Statement for Canada (Privacy Statement). They authorize:
- the company to collect, use and disclose their personal, medical and financial information as set out in the Privacy Statement, and
- any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigation agencies or other organization, institution or person, including members of the Sun Life group of companies, which includes this company, that have records or knowledge of me, to give only that information necessary for underwriting, administration of insurance and claims paying purposes to the company, its representatives and its reinsurers.

By signing below, the spouse and any children, age 18 or older, authorize the company to disclose information about this form to the member, for the purposes of assessing this application and managing the group benefits plan.

By signing below, the member acknowledges having:
- received a French version of this application and having expressly chosen to complete the English version, and
- also expressly chosen to receive all documents related to this contract in English, as per section 2.1.

A copy of this authorization is as valid as the original.

Signature of member X	Date (dd-mm-yyyy)
Signature of spouse X	Date (dd-mm-yyyy)
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy)
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy)
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy)
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy)

Sun Life must receive your completed Health statement **within 60 days** of the date you signed and dated the form. If we haven't received by the required date, you'll need to submit a new Health statement.

The company:
- handles all the information they receive as confidential, and
- uses this information only for determining your eligibility and administering the group plan you belong to.

6 Declaration and authorization (please read and sign this section) (continued)

Returning your completed form

The completed form may be returned to the company using one of the below options.

Option 1: By mail or fax (printed and signed version only)

Mail the completed form in an envelope marked "Confidential" and retain a copy for your records to one of the following addresses:

Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 11691 Stn CV
Montreal QC H3C 6J9

Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 578 Stn Waterloo
Waterloo ON N2J 4B8

Please ensure you've indicated the full address on your envelope.

Fax the completed form to one of the following fax numbers:
Montreal medical underwriting fax number: 1-877-897-5519
Waterloo medical underwriting fax number: 1-877-897-6605

Option 2: By email, using the 'Click to sign' button

Use the 'Click to sign' button to electronically sign the form.

Download and save a pdf version of your completed form.
Email an attached copy of your completed form to medicaluw@sunlife.com. See **important information** below.

Important information for option 2:

Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy and security of email communications cannot be guaranteed.

If you have any questions on how to complete or submit this form, you may call us at 1-866-882-0884.

Sun Life Assurance Company of Canada is a member of the Sun Life group of companies.

Sun Life Privacy Statement for Canada

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at www.sunlife.ca/privacy or call us for a copy.