

Health Statement



Important

- Incomplete forms will delay processing.
- Part 1 is to be completed by the Plan Administrator or the member with information provided by the Plan Administrator.
- Member to mail form directly to Sun Life Assurance Company of Canada.

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 Assurance Company of Canada.

Member's last name		Member's first name		Contract number 50813	
Occupation		Class	Billing group <input type="checkbox"/> 403 – Hourly <input type="checkbox"/> 406 – Salaried <input type="checkbox"/> 407 – SAAO		Member ID
Current salary \$ <input type="checkbox"/> Hrly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Bi-Wkly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Ann.		Company name McMaster University		Plan Administrator's name	
Company street address 1280 Main Street West		City Hamilton	Province ON	Postal code L8S 4L8	Telephone number 905-525-9140

Reason for application

- New enrolment – effective date (dd-mm-yyyy)
- Increased coverage
- Re-application (previously declined)

**Benefits requested
(Please check off)**

- Optional Life – member

A. Existing amount of optional coverage (if applicable)

 %

B. New amount of coverage requested

 %

C. Total amount of coverage (A + B)

 %

For Sun Life Financial Use Only

2 Member 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) — —		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member's street address (street number and name)			Apartment or suite	City		Province	Postal code
Please provide all applicable contact information where you can be reached for additional information:							
Home phone number:		Business phone number:		Email address:			
<input type="checkbox"/> Day <input type="checkbox"/> Evening — —		<input type="checkbox"/> Day <input type="checkbox"/> Evening — —					
Height		Weight		Change in weight in the last 12 months		Reason for weight change	
ft. in. m cm		<input type="checkbox"/> lbs. <input type="checkbox"/> kg		<input type="checkbox"/> lbs. <input type="checkbox"/> kg <input type="checkbox"/> No change <input type="checkbox"/> Gain <input type="checkbox"/> Loss			
Date and reason for your last consultation with attending doctor (if no attending doctor, please state none)							
Name of doctor, diagnosis, treatment given, results, medication prescribed							
If the doctor named above does not have the most complete records of your medical history, please provide full name and address of the doctor who does have them							

2.2 Family history information

Have any of your immediate family members (parents, brothers, sisters) had heart disease, heart attack, high blood pressure, polycystic kidney disease, familial polyposis of the bowel, stroke, diabetes, cancer (specify type below), multiple sclerosis, Huntington's Chorea, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis) or any hereditary disease? **Member**
 Yes No

If yes, complete chart below.

Member's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

2 Member details (continued)

2.3 Medical information (complete this section only for person(s) applying for insurance)

Complete section(s) 2.3 and/or 2.4, as applicable, with any additional comments to these questions.

If you answer "yes" to any questions, please provide further details on the next page. Include dates, treatment, medications and results.

	Member
1. Have you ever:	
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than five consecutive days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Received disability benefits for three months or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Been declined or offered Life, Disability or Critical Illness insurance at a higher than standard risk? (If yes, specify name of insurer, date and reason)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you used any tobacco products within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last 10 years, have you used cocaine, hashish, heroin, narcotics, marijuana, LSD, hallucinogens, amphetamines, except as prescribed by a doctor, or sought or received advice or treatment for the use of drugs (over-the-counter, prescribed or non-prescribed)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you consume alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) Average number of drinks per week	
b) Have you ever been advised to stop drinking, to drink less or received treatment for the use of alcohol? Who _____ (e.g. spouse, friend, doctor, etc.) Reason _____ Date (dd-mm-yyyy) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you presently under medical treatment by diet, medicine or other means? (provide details including names of all medications and reason(s) why you are using them)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever had diabetes, impaired sugar levels or ever had sugar, blood or protein in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your current treatment for diabetes?	Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Oral medication: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Diet only: <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had or received treatment for, consulted a doctor or other health practitioner for, or been diagnosed as having any one of the following:	
a) Cancer, malignancy, leukemia, enlarged lymph nodes, lymph gland disorder, tumours, polyps or other growths including moles, breast lumps or cysts, had a biopsy for any reason or had an abnormal cancer screening test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Illnesses of the heart or circulatory system, including chest pain, abnormal electrocardiogram (ECG), irregular pulse, heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Liver disorder or any type of hepatitis or blood disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Disease or disorder of the kidneys, urinary tract, bladder, prostate or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Chronic lung or respiratory disorder (including asthma and sleep apnea), disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Psychiatric or psychological problems (including anxiety, depression, panic attacks, eating disorders, any other emotional disorders) or been counselled for such?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Chronic fatigue syndrome, fibromyalgia, rheumatic/arthritis disease or lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Musculoskeletal, joint or bone disorders, paralysis or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Back and neck problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) High cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Gastrointestinal disorder (including esophageal, stomach, colon, colitis or bowel/intestinal disorders)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever tested positive for AIDS, ARC or HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever suffered a heart attack or myocardial infarction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever had a stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever had an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever had any other illness, disease or disorder, condition, injury, diagnostic testing or surgical procedure not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker, artificial limb or hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you require assistance of any kind to perform any daily activities, such as bathing, continence, dressing, eating, using the toilet or transferring (for example: bed to chair)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever had any health symptoms or complaints for which a doctor has not been consulted or been advised to have further examinations or tests which have not been completed yet?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2 Member details (continued)

If you answered yes to any questions in the previous section, please provide further details. Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

2.4 Additional medical details – Member

Question Further details

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

In this declaration and authorization, "I" applies to the member signing below.

I understand I may be refused those group benefits or any benefit amounts for which proof of good health is required if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. I certify that all the statements in this form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Health Statement, will cause the insurance to be void.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administrating and adjudicating claims under this Plan with any person or organization who has relevant information about me (if applicable), pertaining to this Health Statement. This includes any health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage under this group contract, unless withdrawn in writing.

Signature of Member X	Date (dd-mm-yyyy) — —
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Sun Life Assurance Company of Canada must receive your completed Health Statement within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Health Statement.

All information received by Sun Life Assurance Company of Canada is treated as strictly confidential and is used for the sole purpose of determining your eligibility and administering the group plan to which you belong. Returning your forms and medical information to us in a confidential envelope ensures that only our medical underwriters will have access to them. Please fully complete the address.

Send the completed form to the following address in an envelope marked "Confidential" and retain a copy for your records.

Toll-free fax number: 1-877-897-6605

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

Toll-free number 1-866-882-0884

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