

# Statement of Health



**Important**

- Incomplete forms will delay processing.
- Plan Administrator is to fill in Part 1 and then give form to Member for completion.
- Member to mail form directly to the Plan Administrator in a sealed envelope.

Please PRINT clearly.

**1 Plan Administrator information**

This section is to be completed by the Plan Administrator.

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

Member's name (first)		(last)	
Contract number <b>45745</b>	Member ID	Facility name	Class
Occupation		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 <b>NSAHO</b>		Plan Administrator's name <b>Benefits Department</b>	
Company address (street, city, province, postal code) <b>2 Dartmouth Road, Bedford Professional Centre, Bedford NS B4A 2K7</b>			Telephone number (     )

**Reason for Application**

- New Enrolment
- Increased Coverage
- Late Applicant (enrolled after 31 days)
- Re-application (previously declined)
- Annual Enrolment - effective date \_\_\_\_\_

Benefits Requested (Please check off)	A. Existing Amount of Coverage (if applicable)	B. New Amount of Coverage Requested	C. Total Amount of Coverage (A + B)
<input type="checkbox"/> Basic Life - Member	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Basic Life - Spouse	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Basic Life - Dependent	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - Member	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - Spouse	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Optional Life - Dependent	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Long Term Disability	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Short Term Disability	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Other	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Extended Health - Member*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Extended Health - Dependent*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Dental - Member*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Dental - Dependent*	New Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	

\* If applicable - Date of loss of comparable coverage \_\_\_\_\_

For Sun Life Financial Use Only
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# Statement of Health

## 2 Member and Dependent details (to be completed by the Member)

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.

Complete this section only if applying for dependent coverage.

Complete this section only for person(s) applying for insurance.

Complete section(s) 2.4 and/or 2.5, as applicable, with any additional comments to these questions.

### 2.1 General information about the Member

Member's Name (First) (Last)		Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contract Number
Member's street address (street number and name)			Apartment/suite number	
City		Province	Postal code	
Please provide a phone number where you can be reached for any additional information:				
Member's home telephone number ( )		<input type="checkbox"/> Day <input type="checkbox"/> Evening	Member's business telephone number ( ) <input type="checkbox"/> Day <input type="checkbox"/> Evening	

### 2.2 General information about the Member's Dependents

Spouse's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name (first) (last)	Date of birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female

### 2.3 Medical information

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

	Member	Spouse	Child(ren)
1. Do you have a regular attending physician? (If yes, provide name, address, date last consulted and reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have a yearly checkup? (If yes, please specify: date of last check-up and results)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Within the past 12 months have you lost work due to illness or injury? (If yes, provide dates, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Within the last 3 years have you:			
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than 5 consecutive days?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Received disability benefits for 3 months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Ever been declined for Life or Disability insurance? (If yes, specify name of insurer, date, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Ever been offered Life or Disability insurance at a higher than standard risk? (If yes, specify name of insurer, date, reason)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you used any tobacco products within the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 10 years have you used cocaine, heroin, narcotics, marijuana, LSD or amphetamines except as prescribed by a physician?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you consume alcoholic beverages?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
a) Confirm usual weekly consumption:	# of drinks : _____	_____	_____
	beer: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	wine: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	spirits: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Have you ever been advised to stop drinking or to drink less?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Who _____			
Reason _____			
Date _____			

Continued on next page

# Statement of Health

## 2 Member and Dependent details (continued)

	Member	Spouse	Child(ren)
8. Are you presently under medical treatment by diet, medicine or other means? (include names of all medications and reason(s) why you are using them)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you have diabetes or impaired sugar levels?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
a) What is your current treatment for diabetes?	insulin: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	oral medication: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	diet only: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) List your last 3 blood sugar readings	_____ _____ _____	_____ _____ _____	_____ _____ _____
10. a) Height	<input type="checkbox"/> ____ ft./in. <input type="checkbox"/> ____ m/cm	<input type="checkbox"/> ____ ft./in. <input type="checkbox"/> ____ m/cm	<input type="checkbox"/> ____ ft./in. <input type="checkbox"/> ____ m/cm
b) Weight	<input type="checkbox"/> ____ lb. <input type="checkbox"/> ____ kg	<input type="checkbox"/> ____ lb. <input type="checkbox"/> ____ kg	<input type="checkbox"/> ____ lb. <input type="checkbox"/> ____ kg
11. Within the past three years have you 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 or enlarged lymph nodes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Circulatory or illnesses of the heart?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Liver disorder or hepatitis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Kidney disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Lung or respiratory disorder (including asthma)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Neurological disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Psychiatric or psychological problems (including anxiety, depression, panic disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Chronic fatigue syndrome or fibromyalgia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Musculoskeletal, joint or bone disorder (including arthritis)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Back or neck problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) High blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
l) Gastrointestinal disorder (including colon, esophageal, bowel disorders)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you ever tested positive for AIDS, ARC, HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you ever suffered a heart attack or myocardial infarction?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you ever had a stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Have you ever had an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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**


# Statement of Health

## 2 Member and Dependent details (continued)

Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

### 2.5 Additional medical details - Dependent Spouse/Children

Question	Dependent Name	Further details

## 3 Declaration and authorization

Please read and sign this section.

The intentional falsification, misrepresentation or omission of information on or relating to this form constitutes fraud and coverage granted may be voided.

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 application are true and complete.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administrating and adjudicating claims under this Plan with any person or organization who has relevant information about me, my spouse and/or dependents (if applicable), pertaining to this application, including any Third Party administrator retained by my plan sponsor to administer this group contract, health professionals, institutions, insurers and reinsurers.

If this application is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administrating and adjudicating claims.

I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada to disclose information about this application to me, for the purposes of assessing this application and managing my group benefits plan.

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.

Signature of Member X	Date (d/m/y)
Signature of Spouse X	Date (d/m/y)
Signature of Dependent Child 14 years or older X	Date (d/m/y)
Signature of Dependent Child 14 years or older X	Date (d/m/y)

Sun Life Assurance Company of Canada must receive your completed Statement of Health within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Statement of Health.

**When you have completed the form, place in a sealed envelope and attach either your Employee Enrolment form or Employee Change form to the outside. Send it to the address below:**

NSAHO  
Benefits Department  
2 Dartmouth Rd  
Bedford Professional Centre  
Bedford NS B4A 2K7

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