Personal Health Insurance – Add family member Sun Life



| Policy | ID number | | | | | | | | | |
|--|--|-------------------------------------|-----------|------------------------|--------------|--|--|--|--|--|
| 037000 | | | | | | | | | | |
| First name of owner | | Last name | | | | | | | | |
| Are you a resident of Quebec? Yes No | | | | | | | | | | |
| A Plan information | | | | | | | | | | |
| I currently have a: | | | | | | | | | | |
| Personal Health Insurance policy where I completed underwriting questions at the time my policy was issued | | | | | | | | | | |
| Health Coverage Choice policy where I applied within 60 days of coming from a group plan (no underwriting was required) at the time my policy was issued | | | | | | | | | | |
| I would like to add the following family member to | my policy: | | | | | | | | | |
| Add my spouse/partner | | | | | | | | | | |
| Add my child. | | | | | | | | | | |
| Note - The dependant(s) will be added effective the nex | t coverage period fo | llowing approval. | | | | | | | | |
| Health Coverage Choice (HCC) plan | | | | | | | | | | |
| Does your HCC policy include a dental benefit? | ☐ Yes ☐ No | | | | | | | | | |
| To meet eligibility requirements, all family member | s being added mus | t have had previous gr | oup cove | rage within the las | t 60 days. | | | | | |
| Name of group benefits carrier: Sun Life Assurance Company of Canada Other | | | | | | | | | | |
| Group policy number | Group certificate number | Group benefits end date (dd-mm-yyy) | | | (dd-mm-yyyy) | | | | | |
| Name of employer | | | | Employer's phone numbe | er | | | | | |
| What coverage did your family member(s) have un | • | | | | | | | | | |
| Supplementary health (including physiotherapy, | chiropractic care, | etc.) L Prescription | drugs L | _ Dental | | | | | | |
| Other | | | | | | | | | | |
| | | | | | | | | | | |
| B Family members you want to add | | | | | | | | | | |
| If more space is required, use a separate sheet. Ense | | • | | | insured. | | | | | |
| If proposed insured is under age 16 (18 in Quebec), s | signature of the pa | rent or legally appointe | ed guardi | an is required. | | | | | | |
| Spouse/Partner | | | | | | | | | | |
| First name | | Last name | | | | | | | | |
| Sex Date of birth (dd-mm-yyyy) | | Height | ☐ ft/in | Weight | □ lb | | | | | |
| Male Female | | | ☐ m/cm | | ☐ kg | | | | | |
| , | Any weight loss of 10 lb (4.5 kg) or more in the last year? Yes No | | | | | | | | | |
| If yes, reason: If you are not a Quebec resident: If you are not a Quebec resident: | | | | | | | | | | |
| Do you have provincial health care coverage? Yes No September 1997 No September 2012 | | | | | | | | | | |
| | | | | | | | | | | |

| B Family members you want to add (cont | tinued) | | | | | | | |
|---|--------------------------------|-------------------|-------------------|-------------------|--------------------------------------|--|--|--|
| Quebec residents only: Confirmation of coverage | through a group benefit | s plan or thro | ugh Régie de l'a | ssurance n | naladie du Québec (RAMQ) | | | |
| Quebec residents must have health coverage through the Régie de l'assurance maladie du Québec (RAMQ) to be eligible for a PHI (Personal Health Insurance) or HCC (Health Coverage Choice) policy. Quebec residents must also have and continue to have group drug coverage provided by an employer or through membership in an order or association or, if not, through RAMQ to be eligible for a PHI or HCC policy. A person not covered under a group benefits plan or through RAMQ is not eligible for coverage under this policy. All prescription drug claims must first be submitted to your group benefits provider or RAMQ; any remaining unpaid portion that is eligible under this policy can then be submitted to Sun Life Financial for reimbursement. Please select the appropriate response: | | | | | | | | |
| ☐ I am confirming that I (and the applicant above | e if applicable) have ar | nd will conti | nue to have th | ne RAMO | prescription drug insurance and | | | |
| the RAMQ medi-care insurance. | | | | | , , | | | |
| I am confirming that I (and the applicant above group benefits plan and to have the RAMQ me | | nd will contii | nue to have th | ne prescrip | otion drug insurance through a | | | |
| Name of group insurance carrier | | Group policy | number | Group certificate | | | | |
| Benefits insured under this plan: | | ' | | | | | | |
| Prescription Drug Yes No | Supplementary health | Yes | □No | Denta | l □ Yes □ No | | | |
| First name of family member insured under this group plan | | Last name | | | | | | |
| | 1 C . A | | 1 111 | 1 20 | l. C 1.C E l. l | | | |
| I understand I/we need to submit claims to the g coordinated. | roup plan first. Any re | maining claii | ms should be | submitted | to Sun Life Financial to be | | | |
| \square I do not have RAMQ medi-care and RAMQ prewith my application. | escription drug insurar | nce or group | prescription | drug insur | ance. I do not wish to proceed | | | |
| Personal Health Insurance/Health Coverage Change a PHI or HCC policy. You must obtain RAM access to another group drug coverage. Personal information | | | | | | | | |
| General information | | | | | | | | |
| Has any application for life, critical illness, long tender in any way? \square Yes \square No | rm care, disability, dru | ig, dental or | health insurar | ce ever b | een declined, rated or modified | | | |
| If yes, please provide the following details: | | | | | | | | |
| Name of family member | | tails (type of in | | company, d | ate applied for, reason for decline, | | | |
| | ☐ declined☐ rated☐ modified☐ | | , | | | | | |
| Name and address of usual medical advisor or medical clir | nic (if different, please list | individual med | dical advisors or | clinics for e | ach member of the family separately | | | |
| | | | | | | | | |
| Medical information | | | | | | | | |

1. Have you **ever** consulted with any health care professional about the following, or had treatment for or had any known indication of:

| В | Far | nily members you v | want to add (continued) | | | | | | |
|---|--|---|---|--|--|---|--|-------------------------|--|
| ć | | art attack, stroke, trans culatory disease or dis | sient ischemic attack (TIA), high blo order, | ood pressure, l | nigh cholester | ol, or other he | art or | ☐ Yes ☐ No | |
| ł | o) car | ncer, tumour or other | growth or malignancy, | | | | | ☐ Yes ☐ No | |
| (| | betes, elevated blood disorder, | sugar, hyperthyroidism, hypothyr | oidism or othe | er thyroid, end | ocrine or kidn | ey disease | ☐ Yes ☐ No | |
| (| | d reflux disease, irritable ocreas or liver disease or | bowel syndrome, colitis, Crohn's disorder, | ease, hepatitis, o | cirrhosis or othe | er stomach, bov | vel, | ☐ Yes ☐ No | |
| • | | hma, emphysema, chro ease or disorder, | onic obstructive pulmonary diseas | se (COPD), slee | ep apnea, allerg | gies, or other r | espiratory | ☐ Yes ☐ No | |
| f | f) depression, anxiety, attention deficit disorder (ADD), eating disorder, autism, epilepsy, multiple sclerosis, migraines, Alzheimer's disease, dementia or any other psychological, emotional or nervous system disease or disorder, | | | | | | | | |
| 8 | g) acr | ne, rosacea, eczema, ps | soriasis, lupus, scleroderma or othe | er skin or conr | nective tissue o | disease or diso | order, | ☐ Yes ☐ No | |
| ł | | hritis, fibromyalgia, ost Isculoskeletal disease d | teoporosis, paralysis, chronic or pe or disorder, | ersistent pain o | or any other ba | ack, joint or | | ☐ Yes ☐ No | |
| i |) blir | ndness, glaucoma, loss | of vision, deafness, impaired hear | ing or other ey | ye or ear disea | se or disorder | , | ☐ Yes ☐ No | |
| j |) dru | ig or alcohol abuse? | | | | | | ☐ Yes ☐ No | |
| Have you ever had any consultation with any health care professional about, treatment for, or any known indication of AIDS, positive HIV or immunological disorder? | | | | | | | | | |
| | 3. In the last 5 years , have you received disability income replacement benefits, or had an illness or injury that prevented you from performing your usual activities or occupation for a period of more than 2 weeks? Yes \sum Yes \subseteq No | | | | | | | | |
| i | 4. Other than for conditions already disclosed, in the last 2 years have you seen any health care practitioner, including a naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or podiatrist? If yes, describe the type of practitioner and the reason. | | | | | | | | |
| | | last 2 years, has there ation? | been any doctor's visit or hospita | lization, recon | nmended treat | tment or preso | cribed | ☐ Yes ☐ No | |
| | | ou currently using any next 3 months? | prescribed medication, medical ed | quipment or te | esting device c | or do you expe | ect to do so | ☐ Yes ☐ No | |
| | | | oner recommended any tests, trea peen completed, or are you currer | | | , hospitalizatio | on or | ☐ Yes ☐ No | |
| 8. [| Оо уо | u have any symptoms | for which you have not yet seen | a health care p | orofessional? | | | ☐ Yes ☐ No | |
| If y | ou ans | swered yes to any que | estions in the previous section, ple | ase provide fu | ırther details ir | ncluding dates | , treatment a | and medications. | |
| | | | separate sheet. Ensure each shee 16 (18 in Quebec), the signature of | | | | | insured. If the | |
| - | estion nber | Name of family member | What was the diagnosis? | Date symptoms or condition started (dd-mm-yyyy) | Date symptoms or condition ended (dd-mm-yyyy) | Date of last treatment/ service (dd-mm-yyyy) | Type of treatm (include name and name of d | & dosage of medication) | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| B Family members ye | ou want to add (conti | nued) | | | | | | |
|--|---|---|---|---|--|-----------------------------|--|--|
| Child #1 Note: If adding more than one nave to be completed for that | | is within 30 days o | f birth or adoptic | on, the Persc | onal inform | ation sed | ction of this fo | orm does not |
| s this child within 30 days of b | oirth/adoption? \Box Y | ′es 🗌 No | | | | | | |
| First name | | | Last name | | | | | |
| Sex Male Female | Date of birth (dd-mm-yyyy) | | Height | | ft/in m/cm | Weight | | ☐ lb |
| Any weight loss of 10 lb (4.5 kg) or mo | ore in the last year? Yes | | | | | Full-time studen | | |
| If yes, reason: | | | | | | Yes 1 | No | |
| If you are not a Quebec resident: Do you have provincial health care co | overage? | | bec resident , comple blan or through Régie o | | | | | erage through a |
| Personal Health Insurance) coverage provided by an er HCC policy. A person not corescription drug claims mu under this policy can then be Please select the appropriat I am confirming that I (an the RAMQ medi-care ins | mployer or through menovered under a group bust first be submitted to be submitted to sun Life te response: Indeed the applicant above | mbership in an or penefits plan or th o your group bene e Financial for reir | der or association rough RAMQ is efits provider or mbursement. | on or, if no s not eligibl r RAMQ; ar | t, through e for cove y remainir | RAMQ erage ur ng unpa | to be eligibl nder this poli id portion th | le for a PHI or icy. All nat is eligible |
| I am confirming that I (ar group benefits plan and Name of group insurance carrier | | | | | e the preso | | drug insurar | nce through a |
| | | | | | | | | |
| Benefits insured under t | his plan: | | | | | • | | |
| Prescription Drug Y | es 🗌 No Su | upplementary hea | alth Yes | □No | Der | ntal _ | Yes 🗆 N | No |
| First name of family member inst | ured under this group plan | | Last name | | | | | |
| understand I/we need to soordinated. | submit claims to the gro | oup plan first. Any | remaining clair | ms should t | oe submitt | ed to S | un Life Finar | ncial to be |
| I do not have RAMQ me with my application. | edi-care and RAMQ pres | scription drug insu | ırance or group | prescription | on drug ins | surance. | . I do not wis | sh to proceed |
| Personal Health Insurance/ nave a PHI or HCC policy. ` access to another group di | You must obtain RAMQ | | | | | | | |
| Personal information | | | | | | | | |
| General information | | | | | | | | |
| Has any application for life, n any way? \square Yes \square N | _ | n care, disability, | drug, dental or | health insu | rance eve i | r been d | declined, rate | ed or modified |
| f yes, please provide the fo | ollowing details: | | | | | | | |
| Name of family member | | Decision | Details (type of ins | | e of compan | y, date ap | plied for, reaso | on for decline, |
| | | declined | | | | | | |

☐ modified

| В | | Family members you want to add (continued) | |
|----|-----|---|----------------------------|
| | | | |
| Na | me | and address of usual medical advisor or medical clinic (if different, please list individual medical advisors or clinics for each member of | the family separate |
| | | | |
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| | | | |
| | | | |
| | | | |
| M | edi | ical information | |
| l. | | ave you ever consulted with any health care professional about the following, or had treatment for or had any lown indication of: | |
| | a) | heart attack, stroke, transient ischemic attack (TIA), high blood pressure, high cholesterol, or other heart or circulatory disease or disorder, | ☐ Yes ☐ No |
| | b) | cancer, tumour or other growth or malignancy, | \square Yes \square No |
| | c) | diabetes, elevated blood sugar, hyperthyroidism, hypothyroidism or other thyroid, endocrine or kidney disease or disorder, | ☐ Yes ☐ No |
| | d) | acid reflux disease, irritable bowel syndrome, colitis, Crohn's disease, hepatitis, cirrhosis or other stomach, bowel, pancreas or liver disease or disorder, | ☐ Yes ☐ No |
| | e) | asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, allergies, or other respiratory disease or disorder, | ☐ Yes ☐ No |
| | f) | depression, anxiety, attention deficit disorder (ADD), eating disorder, autism, epilepsy, multiple sclerosis, migraines, Alzheimer's disease, dementia or any other psychological, emotional or nervous system disease or disorder, | ☐ Yes ☐ No |
| | g) | acne, rosacea, eczema, psoriasis, lupus, scleroderma or other skin or connective tissue disease or disorder, | \square Yes \square No |
| | h) | arthritis, fibromyalgia, osteoporosis, paralysis, chronic or persistent pain or any other back, joint or musculoskeletal disease or disorder, | ☐ Yes ☐ No |
| | i) | blindness, glaucoma, loss of vision, deafness, impaired hearing or other eye or ear disease or disorder, | \square Yes \square No |
| | j) | drug or alcohol abuse? | \square Yes \square No |
| 2. | | ive you ever had any consultation with any health care professional about, treatment for, or any known dication of AIDS, positive HIV or immunological disorder? | ☐ Yes ☐ No |
| 3. | | the last 5 years , have you received disability income replacement benefits, or had an illness or injury that evented you from performing your usual activities or occupation for a period of more than 2 weeks? | ☐ Yes ☐ No |
| 4. | ind | ther than for conditions already disclosed, in the last 2 years have you seen any health care practitioner, cluding a naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or odiatrist? If yes, describe the type of practitioner and the reason. | ☐ Yes ☐ No |
| 5. | | the last 2 years , has there been any doctor's visit or hospitalization, recommended treatment or prescribed edication? | ☐ Yes ☐ No |
| 6. | | e you currently using any prescribed medication, medical equipment or testing device or do you expect to do so the next 3 months ? | ☐ Yes ☐ No |
| 7. | | is any health care practitioner recommended any tests, treatment, examination, surgery, hospitalization or ferrals that have not yet been completed, or are you currently awaiting test results? | ☐ Yes ☐ No |
| 8. | Do | you have any symptoms for which you have not yet seen a health care professional? | ☐ Yes ☐ No |
| - | | u answered yes to any questions in the previous section, please provide further details including dates, treatment a | |
| f. | | re chase is required use a congrete sheet. Ensure each sheet is signed and dated by the owner and each proposed | incurred If the |

If you answered yes to any questions in the previous section, please provide further details including dates, treatment and medications. If more space is required, use a separate sheet. Ensure each sheet is signed and dated by the owner and each proposed insured. If the proposed insured is under age 16 (18 in Quebec), the signature of the parent or legally appointed guardian is required.

| В | Far | nily members you | want to add (continued | 1) | | | | | | | | |
|--|--|--|----------------------------|---------------|--|-------------|--|---|---------|---|-----------|-----------|
| - | estion nber | Name of family member | What was the diagnosis? | | Date syr or cond started (dd-mm | | Date symptoms or condition ended (dd-mm-yyyy) | Date of last treatment/ service (dd-mm-yyyy) | (inc | pe of treatment pro clude name & dosag I name of doctor | | lication) |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Note have Is thi | Child # 2 Note: If adding more than one dependent child and one is within 30 days of birth or adoption, the Personal information section of this form does not have to be completed for that child. Is this child within 30 days of birth/adoption? | | | | | | | | | | | |
| First | name | | | | La | ast name | | | | | | |
| Sex | 1ale | Female | ate of birth (dd-mm-yyyy) | | Н | eight | | ft/in m/cm | Weight | | | |
| | _ | loss of 10 lb (4.5 kg) or more | in the last year? Yes | No | | | | • | | Full-time student? | | |
| If yo | | ot a Quebec resident: | | | | | | | | onfirmation of covera | ge throug | h a |
| ро у | ou nav | e provincial health care cove | rage? Yes No | group benefi | its plan o | r through I | Régie de l'assurance | maladie du Quél | ec (RAN | 1Q) | | |
| Que (Pers cove HCC pres unde Plea t | Quebec residents only: Confirmation of coverage through a group benefits plan or through Régie de l'assurance maladie du Québec (RAMQ) Quebec residents must have health coverage through the Régie de l'assurance maladie du Québec (RAMQ) to be eligible for a PHI (Personal Health Insurance) or HCC (Health Coverage Choice) policy. Quebec residents must also have and continue to have group drug coverage provided by an employer or through membership in an order or association or, if not, through RAMQ to be eligible for a PHI or HCC policy. A person not covered under a group benefits plan or through RAMQ is not eligible for coverage under this policy. All prescription drug claims must first be submitted to your group benefits provider or RAMQ; any remaining unpaid portion that is eligible under this policy can then be submitted to Sun Life Financial for reimbursement. Please select the appropriate response: I am confirming that I (and the applicant above if applicable) have and will continue to have the RAMQ prescription drug insurance and the RAMQ medi-care insurance. I am confirming that I (and the applicant above if applicable) have and will continue to have the prescription drug insurance through a | | | | | | | | | | | |
| | Name (| of group insurance carrier | | | | Group p | policy number | | Grou | up certificate | | |
| Р | rescr | its insured under thi iption Drug Yes me of family member insure | □ No Supple | ementary h | nealth | Ye | | Den | tal [| Yes No | | |
| L Luna | derst | and I/we need to sul | omit claims to the group p | olan first. A | Anv rer | naining | claims should | be submitte | ed to s | Sun Life Financ | al to b | |
| coo | rdina | ted. | | | | | | | | | | |
| | I do not have RAMQ medi-care and RAMQ prescription drug insurance or group prescription drug insurance. I do not wish to proceed with my application. | | | | | | | | | | | |

| B | ramily members you want to add (cont | inued) | | |
|-------|--|--------------------------|---|-----------------------|
| hav | | | ute for RAMQ; therefore you cannot opt out of RA g insurance if your group drug coverage ends and | |
| | rsonal information | | | |
| Ger | neral information | | | |
| | s any application for life, critical illness, long ten any way? | rm care, disability, o | drug, dental or health insurance ever been declined | , rated or modified |
| If ye | es, please provide the following details: | | | |
| | | | Details (type of insurance, name of company, date applied for, | reason for decline, |
| Nam | ne of family member | | rating or modification) | |
| | | declined rated modified | | |
| Nam | ne and address of usual medical advisor or medical clin | ic (if different, please | list individual medical advisors or clinics for each member of | the family separately |
| Med | dical information | | | |
| 1. H | | professional about | the following, or had treatment for or had any | |
| ā | a) heart attack, stroke, transient ischemic attac circulatory disease or disorder, | ck (TIA), high blood | pressure, high cholesterol, or other heart or | ☐ Yes ☐ No |
| ŀ | b) cancer, tumour or other growth or malignar | ncy, | | ☐ Yes ☐ No |
| (| c) diabetes, elevated blood sugar, hyperthyroi or disorder, | dism, hypothyroid | ism or other thyroid, endocrine or kidney disease | ☐ Yes ☐ No |
| (| acid reflux disease, irritable bowel syndrome, co pancreas or liver disease or disorder, | olitis, Crohn's disease | e, hepatitis, cirrhosis or other stomach, bowel, | ☐ Yes ☐ No |
| 6 | e) asthma, emphysema, chronic obstructive pu disease or disorder, | ulmonary disease (0 | COPD), sleep apnea, allergies, or other respiratory | ☐ Yes ☐ No |
| f | f) depression, anxiety, attention deficit disorded Alzheimer's disease, dementia or any other p | | order, autism, epilepsy, multiple sclerosis, migraines, ional or nervous system disease or disorder, | ☐ Yes ☐ No |
| 8 | g) acne, rosacea, eczema, psoriasis, lupus, scler | oderma or other s | kin or connective tissue disease or disorder, | ☐ Yes ☐ No |
| ŀ | arthritis, fibromyalgia, osteoporosis, paralys musculoskeletal disease or disorder, | is, chronic or persis | stent pain or any other back, joint or | ☐ Yes ☐ No |
| i | i) blindness, glaucoma, loss of vision, deafness | , impaired hearing | or other eye or ear disease or disorder, | ☐ Yes ☐ No |
| j | i) drug or alcohol abuse? | | | ☐ Yes ☐ No |
| | Have you ever had any consultation with any hindication of AIDS, positive HIV or immunologi | | ional about, treatment for, or any known | ☐ Yes ☐ No |
| | n the last 5 years , have you received disability prevented you from performing your usual act | | | ☐ Yes ☐ No |

| B Fa | mily members you | want to add (continued |) | | | | | | | |
|-------------------------|--|--|------------------|---|--|---|--|-------------------------|--|--|
| includ | ding a naturopath, phys | lready disclosed, in the lassiotherapist, massage the heetype of practitioner a | erapist, chirop | ractor, psy | | | | ☐ Yes ☐ No | | |
| | last 2 years, has there cation? | been any doctor's visit | or hospitalizat | ion, recon | nmended treat | tment or pres | cribed | ☐ Yes ☐ No | | |
| | ou currently using any enext 3 months? | prescribed medication, 1 | medical equipi | ment or te | esting device c | or do you expe | ect to do so | ☐ Yes ☐ No | | |
| | 7. Has any health care practitioner recommended any tests, treatment, examination, surgery, hospitalization or referrals that have not yet been completed, or are you currently awaiting test results? | | | | | | | | | |
| 8. Do yo | ou have any symptoms | for which you have not | yet seen a he | alth care p | orofessional? | | | ☐ Yes ☐ No | | |
| If more | space is required, use a | estions in the previous se a separate sheet. Ensure e 16 (18 in Quebec), the sig | each sheet is s | igned and | dated by the | owner and ea | ch proposed | | | |
| Question number | Name of family member | What was the diagnosis? | or c star | e symptoms ondition ted mm-yyyy) | Date symptoms or condition ended (dd-mm-yyyy) | Date of last treatment/ service (dd-mm-yyyy) | Type of treatm (include name and name of de | & dosage of medication) | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| have to b | | | ithin 30 days of | birth or ad | option, the Pers | onal information | on section of t | his form does not | | |
| First name | | | | Last name | | | | | | |
| Sex Male | Female | te of birth (dd-mm-yyyy) | | Height | | ft/in M/cm | eight | ☐ lb ☐ kg | | |
| Any weigh If yes, reas | t loss of 10 lb (4.5 kg) or more in on: | the last year? Yes | No | | | | Full-time st | tudent? | | |
| If you are | not a Quebec resident: ve provincial health care covera | age? 🗌 Yes 🗌 No | | | omplete section D C Régie de l'assurance | | | f coverage through a | | |
| Quebec | residents only: Confi | rmation of coverage throug | gh a group bene | fits plan or | through Régie o | de l'assurance n | naladie du Qué | bec (RAMQ) | | |

Quebec residents must have health coverage through the Régie de l'assurance maladie du Québec (RAMQ) to be eligible for a PHI (Personal Health Insurance) or HCC (Health Coverage Choice) policy. Quebec residents must also have and continue to have group drug coverage provided by an employer or through membership in an order or association or, if not, through RAMQ to be eligible for a PHI or HCC policy. A person not covered under a group benefits plan or through RAMQ is not eligible for coverage under this policy. All prescription drug claims must first be submitted to your group benefits provider or RAMQ; any remaining unpaid portion that is eligible under this policy can then be submitted to Sun Life Financial for reimbursement.

Please select the appropriate response:

| В | Family members you want to add (conti | nued) | | | | | | |
|------|--|------------------------------|--------------------|----------------------|-----------------|-------------------|--------------------------|--|
| | am confirming that I (and the applicant above the RAMQ medi-care insurance. | if applicable) have ar | nd will contir | nue to have the | RAMQ | prescription | drug insurance and | |
| | am confirming that I (and the applicant above group benefits plan and to have the RAMQ me | | nd will contir | nue to have the | e prescrip | otion drug in: | surance through a | |
| | Name of group insurance carrier | | Group policy | number | | Group certificate | e | |
| E | Benefits insured under this plan: | | | | | | | |
| F | Prescription Drug Yes No S | upplementary health | ☐Yes | □No | Denta | l □Yes | □No | |
| | First name of family member insured under this group plan | | Last name | | | | | |
| | | | | | | | | |
| | derstand I/we need to submit claims to the grandinated. | oup plan first. Any re | maining clair | ns should be su | ubmitted | l to Sun Life | Financial to be | |
| | do not have RAMQ medi-care and RAMQ preswith my application. | scription drug insurar | nce or group | prescription d | rug insur | ance. I do no | ot wish to proceed | |
| hav | sonal Health Insurance/Health Coverage Choi ve a PHI or HCC policy. You must obtain RAMC ess to another group drug coverage. | | | | | | | |
| | rsonal information | | | | | | | |
| Ger | neral information | | | | | | | |
| | any application for life, critical illness, long termony way? | m care, disability, dru | g, dental or | health insuranc | e ever b | een declined | l, rated or modified | |
| If y | es, please provide the following details: | | | | | | | |
| | | De | tails (type of ins | surance, name of c | ompany, d | ate applied for, | reason for decline, | |
| Nam | ne of family member | | ng or modificat | | | | | |
| | | declined | | | | | | |
| | | rated | | | | | | |
| | | modified | | | | | | |
| Nan | ne and address of usual medical advisor or medical clini | c (if different, please list | individual med | lical advisors or cl | inics for e | ach member of | f the family separately) | |
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| | | | | | | | | |
| Me | dical information | | | | | | | |
| | Have you ever consulted with any health care p known indication of: | professional about th | e following, | or had treatme | ent for o | r had any | | |
| ć | a) heart attack, stroke, transient ischemic attac circulatory disease or disorder, | k (TIA), high blood pr | essure, high | cholesterol, or | other he | eart or | ☐ Yes ☐ No | |
| ł | b) cancer, tumour or other growth or malignan | су, | | | | | ☐ Yes ☐ No | |
| | diabetes, elevated blood sugar, hyperthyroic or disorder, | , | or other th | yroid, endocrin | e or kidr | ney disease | ☐ Yes ☐ No | |
| (| d) acid reflux disease, irritable bowel syndrome, colitis, Crohn's disease, hepatitis, cirrhosis or other stomach, bowel, pancreas or liver disease or disorder, | | | | | | | |

| | В | Family members you | want to add (continued) | | | | | |
|---|-------|--|---|--|--|---|--|-------------------------|
| | | asthma, emphysema, chr disease or disorder, | onic obstructive pulmonary disea | ase (COPD), slee | ep apnea, allerg | gies, or other r | espiratory | ☐ Yes ☐ No |
| | | | ntion deficit disorder (ADD), eating entia or any other psychological, e | | | | | ☐ Yes ☐ No |
| | g) | acne, rosacea, eczema, p | soriasis, lupus, scleroderma or otl | her skin or conr | nective tissue o | disease or diso | order, | ☐ Yes ☐ No |
| arthritis, fibromyalgia, osteoporosis, paralysis, chronic or persistent pain or any other back, joint or musculoskeletal disease or disorder, | | | | | | | | |
| | i) | blindness, glaucoma, loss | s of vision, deafness, impaired hea | aring or other e | ye or ear disea | se or disorder | , | ☐ Yes ☐ No |
| | j) | drug or alcohol abuse? | | | | | | ☐ Yes ☐ No |
| 2 | | | sultation with any health care pro HIV or immunological disorder? | ofessional abou [.] | t, treatment fo | or, or any know | vn | ☐ Yes ☐ No |
| 3. | | | received disability income replac ming your usual activities or occu | | | | hat | ☐ Yes ☐ No |
| 4. Other than for conditions already disclosed, in the last 2 years have you seen any health care practitioner, including a naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or podiatrist? If yes, describe the type of practitioner and the reason. | | | | | | | | |
| 5. In the last 2 years , has there been any doctor's visit or hospitalization, recommended treatment or prescribed medication? | | | | | | | | |
| 6. Are you currently using any prescribed medication, medical equipment or testing device or do you expect to do so in the next 3 months ? | | | | | | | | |
| 7 | | | oner recommended any tests, tre oeen completed, or are you curre | | | , hospitalizatio | on or | ☐ Yes ☐ No |
| 8 | . Do | you have any symptoms | s for which you have not yet seer | n a health care p | orofessional? | | | ☐ Yes ☐ No |
| lf | mor | e space is required, use a | estions in the previous section, pl a separate sheet. Ensure each shee 16 (18 in Quebec), the signature o | et is signed and | dated by the | owner and ead | ch proposed | |
| - 1 | Quest | | What was the diagnosis? | Date symptoms or condition started (dd-mm-yyyy) | Date symptoms or condition ended (dd-mm-yyyy) | Date of last treatment/ service (dd-mm-yyyy) | Type of treatn (include name and name of d | & dosage of medication) |
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Acknowledgement and agreement for Personal Health Insurance

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.

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.

Acknowledgement and agreement: You declare that your statements in this application are true and complete, and will be relied upon by Sun Life Assurance Company of Canada (company). The application and any written amendment to your policy resulting from this application, together with your current policy, form the contract between you and the company. You will inspect the amendment to verify its terms are satisfactory.

Declaration: The owner, proposed insured and payor confirm:

- (a) they were present when their portion of this application with Sun Life Assurance Company of Canada was completed
- (b) they reviewed all their answers and statements recorded in this application
- (c) this information is full, complete and true, and may be relied upon by the company
- (d) they understand and agree that the following may not be covered by the contract:
 - any injury that happened on or before the date of this application
 - any illness, the signs of which first appeared on or before the date of this application
- (e) they understand and agree that coverage will begin only if your application is approved by us. We will tell you if any medical history requires a higher premium or an exclusion to the policy. You must either accept the changes or cancel your application on written notification to us
- (f) if a resident of Quebec, they understand and agree they must be covered for health and drug coverage under RAMQ or a group plan and continue to be covered to be eligible for coverage under the policy
- (g) they understand that if they do not fully, completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements), the company may void the policy
- (h) they agree that their personal medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada
- (i) they agree, if they are the payors, that if this application is approved, the company may continue to withdraw funds to pay premiums according to the authorization we currently have on file, and
- (j) they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under "Products & services" section of the website at www.sunlife.ca or by calling us toll-free at 1-877-SUN-LIFE (1-877-786-5433)

Authorization of owner and proposed insureds: The owner and proposed insureds (parent or legally appointed guardian, if proposed insured is under age 16 (18 in Quebec) authorize:

any physician, medical practitioner, medically-related facility, insurance company, investigation agencies, the Medical
Information Bureau or other organization, institution or person, including members of the Sun Life Financial group of
companies, which includes this company, that have records or knowledge of any proposed insured's health, to give only
that information necessary of underwriting, administration of insurance and claims paying purposes to the company, its
representatives and its reinsurers, and

E Acknowledgement and agreement for Personal Health Insurance (continued)

• the company to release only the necessary personal information obtained during the underwriting process to their personal physician, the Medical Information Bureau, the Medical Director of any insurance company, if an insurance application has been made to that company, and for infectious or communicable disease, to the Medical Officer of Health where required by law.

A photocopy of this signed authorization is as valid as the original.

| Signed at (Province) | Date (dd-mm-yyyy) | Signature |
|----------------------|-------------------|--|
| | | Owner |
| | | X |
| | | Spouse/Partner |
| | | X |
| | | Dependant who has reached age 16 (18 in Quebec) |
| | | X |
| | | Dependant who has reached age 16 (18 in Quebec) |
| | | X |
| | | Payor (if payor is not Owner or Spouse/Partner) |
| | | X |
| | | Joint bank accountholder (if the account requires more than one signature) |
| | | X |

| F | A | dviso | r dec | laration |
|---|---|--------------|-------|-----------|
| | | 4 134 | ucc | tai ativi |

I have reviewed each of the questions in this application with the Owner, the Spouse/Partner and any dependant who has reached the age of 16 (18 in Quebec), and this application fully records all information given to me for this application. To the best of my knowledge, the application discloses all facts material to the insurance being applied for.

| Check her | e if this application | was taken by mail a | and was not reviev | ved with the Owner. |
|-----------|-----------------------|---------------------|--------------------|---------------------|
|-----------|-----------------------|---------------------|--------------------|---------------------|

| Signed at | Date (dd-mm-yyyy) | Advisor's signature | | | | |
|--------------------------------------|-------------------|---------------------|----------------|--------------------------|--------------------|--|
| | | X | | | | |
| Supervisor's signature (Quebec only) | | | Advisor number | Advisor telephone number | Advisor fax number | |
| X | | | | | | |

Before submitting this application, please make sure:

- all questions have been answered for every member of the family you want covered
- for each yes answer in the Personal information section, full details including relevant dates have been included
- all signatures have been completed, including those of the Payor (if not the Owner or Spouse/Partner) and any dependants who have reached the age 16 (18 in Quebec)
- if premiums are paid annually by cheque, a cheque for the number of full months before the next renewal date is required.

Please mail or fax the completed form to the address below:

Sun Life Assurance Company of Canada Personal Health Insurance P.O. Box 1601 Stn Waterloo Waterloo, ON N2J 4C5

Phone: 1-877-SUN-LIFE (1-877-786-5433)

Fax: 1-866-487-4745 *www.sunlife.ca*