

# Sun Life Assurance Company of Canada

## Evidence of Insurability Application – Health Questionnaire

California / Connecticut / Illinois / Iowa / Kentucky / North Dakota / Ohio / Wisconsin



### I Applicant Information (Please print clearly)

Complete pages 1 and 2 of this form and return to:  
 MGIS  
 P.O. Box 16110  
 Salt Lake City, UT 84116  
 Tel: 1-800-969-6447  
 Fax: (801) 990-2401

Your name (first, middle initial, last)		Name of your employer		Group policy no.	
Your street address		City		State	Zip Code
Social Security number	Daytime phone number		E-mail address		

This Application is for:  Employee  Spouse  Child  Male  Female

Name (if different than above)	Date of birth (m/d/y)	Height ft.      in.	Weight lbs.
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### II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

**Important:** You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 2 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

**1. In the past five years, have you:**

- a. Had transplant surgery, other surgery, injuries or been treated in a hospital? .....  Yes  No
- b. Been treated for alcoholism or advised by a physician to change your drinking habits? ..  Yes  No
- c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? .....  Yes  No
- d. Been off work for more than five consecutive days due to illness or injury? .....  Yes  No
- e. Lost 20 lbs. or more over a 12 month period? .....  Yes  No

**2. In the past five years, have you been diagnosed with, treated for or had any symptoms relating to any of the conditions listed below?**

- a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder .....  Yes  No
- b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder.....  Yes  No
- c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack .....  Yes  No
- d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs.....  Yes  No
- e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder .....  Yes  No
- f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus.....  Yes  No
- g. Sugar in urine, diabetes, kidney or bladder disorder.....  Yes  No
- h. Anemia, blood vessel disease, bleeding or any other blood disease or disorder.....  Yes  No
- i. Disorders of the eyes or ears.....  Yes  No
- j. Chronic fatigue or fibromyalgia.....  Yes  No

**3. In the past five years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS)?** .....  Yes  No

**4. Are you currently pregnant?**.....  Yes  No

Continued on next page

### III Activities

**Important:** If you answer “Yes” to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

**Do you engage in any of the following activities?**

- a. Skydiving.....  Yes  No
- b. Scuba diving .....  Yes  No
- c. Vehicle or boat racing .....  Yes  No
- d. Piloting an aircraft .....  Yes  No

### IV Detail (Provide detail below about any “Yes” answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you need more room, check here  and attach a separate sheet.

### V Signature

Please read the Certification and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

**Certification**

I hereby certify, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me the Fraud Warning:

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada (“The Company”) determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- If I have any questions regarding my EOI Application, I can write to Sun Life Assurance Company of Canada, Group Life Dept., SC 3227, One Sun Life Executive Park, Wellesley Hills, MA 02481.

Signature of Employee X	Date signed
Signature of Spouse (If Application is for spouse) X	Date signed