

# Sun Life Assurance Company of Canada

## Evidence of Insurability Cover Page



### Employer Instructions

Complete this Cover Page and provide it to the employee/applicant along with the Evidence of Insurability (EOI) Application. The applicant then completes the application and includes this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

### Applicant Information (To be completed by employer)

Employer	Group policy no.	Location
Employee name (first, middle initial, last)	SSN (last 4 digits) 	Employee Class
Approval requested for <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child(ren): No. of Children:		

### Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverages for which EOI is required and fill in amounts. Sign and date this page. For more information and assistance, please see the **Administrator's Guide** and your **Group Policy**.

#### Life Insurance

	G.I. / Current Amount of Coverage	Requested Amount	Amount Subject to EOI
<input type="checkbox"/> Employee Basic	\$	\$	\$
<input type="checkbox"/> Employee Optional	\$	\$	\$
<input type="checkbox"/> Spouse Basic	\$	\$	\$
<input type="checkbox"/> Spouse Optional	\$	\$	\$
<input type="checkbox"/> Child Optional	\$	\$	\$

#### Other Coverages

<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Buy-Up LTD: \$

Name of person completing this cover page (employer contact)	Title
Signature of person completing this cover page X	Date

### Applicant Instructions

- Complete pages 1 and 2 of the EOI Application according to the instructions. Please remember to sign and date the form.
- Mail or fax this Application and Cover Page to us:
 

<b>MAIL TO:</b> Sun Life Assurance Company of Canada Group Life Dept. SC 3227 One Sun Life Executive Park P.O. Box 81100 Wellesley Hills, MA 02481	-or-	<b>FAX TO:</b> (781) 446-1517
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# Sun Life Assurance Company of Canada

## Evidence of Insurability Application – Health Questionnaire



### I Applicant Information (Please print clearly)

Complete and return pages 1 and 2 of this form, along with the cover page to:

Sun Life Financial  
Group Life Dept.  
One Sun Life Exec. Park  
P.O. Box 81100  
Wellesley Hills, MA 02481

Fax: (781) 446-1517

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: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Female					
Name (if different than above)		Date of birth (m/d/y)	Height ft. in.		Weight lbs.

### 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. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) .....  Yes  No
- i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder .....  Yes  No
- j. Disorders of the eyes or ears .....  Yes  No
- k. Chronic fatigue or fibromyalgia .....  Yes  No

- 3. 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
					<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 for my state on Page 3.

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

# Sun Life Assurance Company of Canada

Please read the applicable fraud warning before signing this form.

**State Law requires us to notify you of the following:**

**Fraud Warning** (for all states except those listed separately below): 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.

**Fraud Warning – Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Fraud Warning – Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Warning – New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Fraud Warning – Oklahoma:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Fraud Warning – Virginia and Washington:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.