ScotiaLife Financial™

ScotiaLife® Health & Dental Insurance Application

Group Policy Number: 50183

PO Box 215, Stn Waterloo, Waterloo ON, N2J 3Z9

Simply **complete, sign** and **return** this Application Form. **NO NEED TO SEND MONEY NOW.** If approved for coverage, premiums will be conveniently processed using the payment information you provide. In this Application Form, *you* and *your* refer to the person applying for insurance except where the context indicates a contrary intention. *ScotiaLife* Health & Dental Insurance is underwritten by Sun Life Assurance Company of Canada under a Group Policy issued to The Bank of Nova Scotia.

1 Information about you (Applicant)

Last Name	☐ Male ☐ Female	Former Name	
First Name	Date of Birth DD | MM | YYYY		Birth Country
Telephone (Residence)		Telephone (Other)	
Residence address (street number and name, apartment or suite)			
City	Province	Country	Postal Code
E-mail Address*		Are you a resident of Canada and covered under the provincial health plan in your province of residence? ☐ Yes ☐ No	

Information about your spouse if applying (Spousal Applicant)

Last Name		Former Name	
First Name			
Date of Birth DD | MM | YYYY		Birth Country	
Telephone (Residence)		Telephone (Other)	
E-mail Address*		☐ Male ☐ Female	
Are you a resident of Canada and covered under the provincial health plan in your province of residence? ☐ Yes ☐ No			

* Your e-mail address may be used in the event we need to contact you for the administration of this application.

Information about your dependent child(ren). Please complete if applying for coverage for dependent child(ren).

Name (last, first)	☐ Male ☐ Female	Date of Birth DD | MM | YYYY	Student	☐ Yes ☐ No
Name (last, first)	☐ Male ☐ Female	Date of Birth DD | MM | YYYY	Student	☐ Yes ☐ No
Name (last, first)	☐ Male ☐ Female	Date of Birth DD | MM | YYYY	Student	☐ Yes ☐ No

If the space provided is insufficient, please provide details on a separate duly signed and dated sheet of paper.

2 Coverage applying for

Please check one plan type: ☐ Health Plan

or

☐ Health & Dental Plan

Please check coverage: ☐ Single

☐ Couple

plus

☐ Dependent Child(ren)

3 How would you like to pay your monthly premium?

☐ **A.** Pre-Authorized Chequing
Please attach a blank personal cheque marked VOID.

☐ **B.** Credit Card (choose one): ☐ Visa ☐ MasterCard

Name on Credit Card	Date of Expiry MM / YYYY
Card Number	

Authorization and Agreement:

- You authorize Sun Life Assurance Company of Canada, the underwriter, to debit your chequing account or charge your credit card account (identified above) each month for the premium payable for any insurance coverage issued to you in connection with this application. You acknowledge that your financial institution may treat any withdrawal made pursuant to this authorization as though it was made by you personally.
- You warrant and guarantee that all persons whose signatures are required on the identified chequing account or credit card account (as applicable) have signed below.
- You agree and authorize Sun Life Assurance Company of Canada to cancel this agreement and terminate coverage if the underwriter, Sun Life Assurance Company of Canada, is unable to debit your chequing account or charge your credit card (as applicable).

Signature(s) of Cardholder(s) or Accountholder(s)	Date DD | MM | YYYY
X X	

4 Medical information - mini questionnaire

This application is not valid unless the medical information requested is accurately completed and the application is signed by all applicants (18 years of age or older).

	YOU	YOUR SPOUSE (if applying)	DEPENDENT CHILD(REN)* (if applying)
1. In the last 5 years, has there been any claim for disability benefits, or has there been any illness or injury which prevented performance of your usual activities or occupation for a period of more than 2 weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. In the last 2 years, has there been any consultation, treatment, hospitalization, medical prescription or visit to the doctor for any physical or mental condition, disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. In the last 2 years, has there been any treatment or service from any health care professional, including naturopath, physiotherapist, massage therapist, chiropractor, psychologist, speech therapist or podiatrist?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Is there any current use, or expected use within the next 6 months, of any medication, medical equipment or medical device?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Has any application for life insurance, disability insurance, drug or health insurance ever been declined, rated or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If any questions above are answered as "Yes", please complete sections 5, 6 and 7. If all applicants answered "No" to all the questions above, please complete section 7 before returning this application form. *If you are applying for coverage for more than one dependent child, please note that each question applies to all of your dependent children.

IF ANY APPLICANT ANSWERED "YES" TO QUESTIONS 1-5, please give details below. If the space provided is insufficient, please provide details on a separate duly signed and dated sheet of paper.

Question	Name of Applicant	Nature of Disorder	Date & Duration	Treatment & Current Status	Attending Physician or Hospital

5 Background information (complete if you answered "Yes" to any question in section 4)

Your Physician (Name)	Telephone
Physician's Address	
Date, reason and results of last consultation	
Your Height ft. in. | m cm	Your Weight ☐ lbs. ☐ kg
Change in weight in the last 12 months ☐ No Change ☐ Gain ☐ Loss Change in weight: _____	☐ lbs. ☐ kg
Reason for weight change	

Spouse's Physician (Name)	Telephone
Physician's Address	
Date, reason and results of last consultation	
Spouse's Height ft. in. | m cm	Spouse's Weight ☐ lbs. ☐ kg
Spouse's change in weight in the last 12 months ☐ No Change ☐ Gain ☐ Loss Change in weight: _____	☐ lbs. ☐ kg
Spouse's reason for weight change	

6 Medical information - full questionnaire (complete if you answered "Yes" to any question in section 4)

Has there ever been any treatment for, known indication of, or consultation with any health care professional about:	YOU	YOUR SPOUSE (if applying)	DEPENDENT CHILD(REN)* (if applying)
a) Heart disease, stroke, Transient Ischemic Attack (TIA), circulatory disorder, chest pains or angina?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Blood disorders including cholesterol, high or low blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Tumours, cancer, moles, other growths or disorders of the skin?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or other immune disorders including Hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Respiratory problems, asthma or any lung diseases?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Stomach, digestive problems, ulcers, colitis, intestinal or colon problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Kidney or liver problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Urinary tract problems, infertility, complications of pregnancy, breast, prostate or genital problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Headaches, migraines, multiple sclerosis, seizures, paralysis or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Diabetes or high blood sugar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Depression, anxiety, or any other psychiatric problems?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Fibromyalgia, arthritis, lupus, bone or joint problems, or any muscular pain including any neck or back pain?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Substance abuse (including drugs or alcohol)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Any disease or disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) Any other condition not listed above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

IF ANY APPLICANT ANSWERED YES TO QUESTIONS a-o, please provide details below. If the space provided is insufficient, please provide details on a separate sheet of paper duly signed and dated.
*If you are applying for coverage for more than one dependent child, please note that each question applies to all of your dependent children.

Question	Name of Applicant	Nature of Disorder	Date & Duration	Treatment & Current Status	Attending Physician or Hospital

Sun Life Assurance Company of Canada reserves the right to request additional medical information in order to assess your application and also reserves the right to accept or decline applications. You may receive a telephone call requesting additional information.

7 Declaration and authorizations (please complete all)

You declare that all of the information you have provided in this application or in any other statement or answer submitted in connection with this application is true and complete. **You understand and agree** that any false statement, material misrepresentation or omission in this application or in any other statement or answer submitted in connection with this application may cause any insurance coverage issued as a result of this application to be null and void.

You acknowledge that you have read and fully understand the content of the MIB, Inc. notification displayed below. **You authorize** MIB, Inc. to give Sun Life Assurance Company of Canada, any information it may have about you necessary for the risk assessment relating to this application or investigation of any claim. A photocopy or electronic version of this authorization is as valid as the original; this authorization shall remain in effect for the duration of your insurance coverage. If you are a Spousal Applicant or dependent child age 18 or older, you also authorize Sun Life Assurance Company of Canada to disclose information about this application to the Applicant for the purposes of Sun Life Assurance Company of Canada assessing this application and managing the Group Policy.

You understand and agree: (i) that in order to administer any coverage issued to you, Sun Life Assurance Company of Canada can release your personal information to third party administrators (some of which may be located outside of Canada and subject to local law), (ii) to be bound by the terms of the Sun Life Assurance Company of Canada Privacy Policy, a copy of which is available at www.sunlife.ca.

You authorize Sun Life Assurance Company of Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under the *ScotiaLife* Health & Dental Insurance Group Policy with any person or organization that has relevant information about you including health care professionals, institutions, MIB, Inc., investigative agencies, insurers, plan administrators and reinsurers.

You also authorize Sun Life Assurance Company of Canada to disclose your personal information to the Scotiabank Group of Companies, including Scotia Life Insurance Company, ("Scotia"), in accordance with the Scotiabank Group Privacy Agreement ("Agreement"), a copy of which is available at www.scotiabank.com/privacy and will be given to you with your insurance documents if you are approved for coverage. Scotia may use this information for all purposes set out in the Agreement, and in addition for determining your eligibility for products and services, administration and to better manage its business relationship with you. Scotia will obtain your consent for Sun Life Assurance Company of Canada to release your health information if needed by Scotia. For marketing purposes only, you may withdraw your consent to use your information at any time by calling 1-800-387-9844.

NOTIFICATION - PLEASE READ CAREFULLY

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you to its agents and service providers. Sun Life Assurance Company of Canada may also release information in its files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. Sun Life Assurance Company of Canada may also submit a brief report on its findings to MIB, Inc (MIB), a non-profit medical organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you also apply for insurance coverage or submit a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information in its files. You may ask to see your personal information on file with MIB and request to correct anything that is inaccurate or incomplete.

You may contact MIB at:
MIB, Inc.
330 University Avenue
Toronto, Ontario M5G 1R7
(416) 597-0590
www.mib.com

Your Signature X	Signed at (City/Town)	Date DD | MM | YYYY	Your Spouse's Signature (if applying) X	Signed at (City/Town)	Date DD | MM | YYYY
Signature of Dependent Child, 18 years or older X	Signed at (City/Town)	Date DD | MM | YYYY	Signature of Dependent Child, 18 years or older X	Signed at (City/Town)	Date DD | MM | YYYY
Signature of Dependent Child, 18 years or older X	Signed at (City/Town)	Date DD | MM | YYYY	Signature of Dependent Child, 18 years or older X	Signed at (City/Town)	Date DD | MM | YYYY

ScotiaLife Health & Dental Insurance is underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial Group of Companies.

Please mail completed Application Form to:
ScotiaLife Financial
c/o PO Box 215, Stn Waterloo
Waterloo, Ontario, N2J 3Z9