ScotiaLife Financial™

ScotiaLife® Critical Illness Insurance Application

Group Policy Number: 50184

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

Simply **complete, sign** and **return** this Application Form. **NO NEED TO SEND MONEY NOW.** If you are 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* Critical Illness 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	☐ Smoker ☐ Non-Smoker*
E-mail Address**	Occupation	

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)
☐ Non-Smoker* ☐ Smoker	☐ Male ☐ Female
E-mail Address**	Occupation

*Non-Smoker means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months immediately prior to the application date.

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

2 Amount of insurance coverage applied for (minimum $25,000, sold in units of $25,000 to a maximum of $100,000)

FOR YOU	☐ $25,000	☐ $50,000	☐ $75,000	☐ $100,000
FOR YOUR SPOUSE	☐ $25,000	☐ $50,000	☐ $75,000	☐ $100,000

Do you or your spouse have any existing critical illness insurance coverage? ☐ Yes ☐ No If "Yes", please complete the following:

Name of Insured	**Insurance Company Name**	**Coverage Amount**	**Do you intend to replace this coverage?**
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new Certificate of Insurance.

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 the underwriter, Sun Life Assurance Company of Canada, 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 the underwriter, Sun Life Assurance Company of Canada, to cancel this agreement and terminate coverage if 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
X X	DD | MM | YYYY

4 Background information

This application is not valid unless the medical information requested is completed accurately and the application is signed by all applicants.

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
Change in Spouse's weight in the last 12 months ☐ No Change ☐ Gain ☐ Loss	Change in weight: __________ ☐ lbs. ☐ kg
Reason for Spouse's weight change	

5 Family history

Have any of your or your spouse's immediate family members (parents or siblings) had cancer **(specify type)**, heart disease, stroke, diabetes, polycystic kidney disease, multiple sclerosis, Huntington's Chorea or any other hereditary disease? If "Yes", please complete the chart(s) below.

YOU ☐ Yes ☐ No | **YOUR SPOUSE** ☐ Yes ☐ No

Your family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Your spouse's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

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

6 Medical information - mini questionnaire

		YOU	YOUR SPOUSE
1.	Have you or your spouse consulted a health care professional, undergone a medical exam or medical follow-up, suffered or been diagnosed, tested or treated for any of the following:		
a)	heart attack, heart disease, chest pain, angina, high or low blood pressure, high cholesterol, high blood sugar or diabetes, abnormal electrocardiogram (ECG) or any circulatory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b)	stroke, Transient Ischemic Attack (TIA), or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
c)	cancer, tumour, polyp, mole, lump or growth, lymph glands, blood disorder or other forms of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No
d)	breast lumps, cysts, unusual discharge, other physical changes, abnormal mammogram findings or biopsy?	☐ Yes ☐ No	☐ Yes ☐ No
e)	human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or other immune disorders including Hepatitis or Hepatitis carrier state?	☐ Yes ☐ No	☐ Yes ☐ No
f)	respiratory problems, including any nose or throat problems, or any lung disease?	☐ Yes ☐ No	☐ Yes ☐ No
g)	any disorder of the colon, intestines, including colitis, or disorder of the stomach?	☐ Yes ☐ No	☐ Yes ☐ No
h)	reproductive organs, kidney, bladder, prostate, urinary tract or liver problems or disease?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Have you or your spouse ever had any symptoms or complaints regarding your or your spouse's health for which you or your spouse have not yet consulted a physician, or been advised to have any test or surgery which has not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No

If you or your spouse answered "yes" to any of the questions 1(a-h) or 2, 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

7 Medical information - full questionnaire

Please complete this section only if you or your spouse are applying for coverage greater than $25,000.

		YOU	YOUR SPOUSE
1.	Have you or your spouse ever had any other condition not listed in question 1 of section 6?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Have you or your spouse ever used cocaine, narcotics, hallucinogens, heroin, amphetamines or barbiturates?	☐ Yes ☐ No	☐ Yes ☐ No
3.	Have you or your spouse received advice or treatment for the use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
4.	Have you or your spouse ever had your driver's license suspended or revoked, or been charged with impaired driving or had three or more moving violations in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No
5.	Have you or your spouse in the last 5 years engaged in or intend to engage in any hazardous sport or activity (e.g. auto or motorcycle racing, scuba or sky diving, hang gliding or other similar hazardous sport or activity)?	☐ Yes ☐ No	☐ Yes ☐ No
6.	Have you or your spouse ever had a critical illness insurance application declined, rated or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
7. a)	Do you or your spouse ever consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No
b)	If yes, please record the number of alcoholic beverages consumed in a week:		

If you or your spouse answered "Yes" to any of the questions 1-6, 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

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.

8 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, 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* Critical Illness 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

ScotiaLife Critical Illness Insurance is underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial Group of Companies.

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