Critical Illness Insurance – Claimant statement

Sun Life Financial

Policy number

Do not tell us about genetic testing or genetic testing results.

1 Personal information

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Gender ☐ Male ☐ Female
Provincial health insurance plan number			Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment	City
Province	Postal code		Daytime telephone number

2 Claim details

Describe the nature and extend of your critical illness.			
Date your condition was diagnosed (dd-mm-yyyy)	Date surgery was performed, if applicable (dd-mm-yyyy)	Date the symptoms of your illness first appeared (dd-mm-yyyy)	Date you first consulted a physician for your illness (dd-mm-yyyy)
Last name of the physician consulted		First name	
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number

Have you undergone any tests or investigations related to the diagnosis? ☐ Yes ☐ No
If 'yes' provide details including dates.

Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No
If 'yes', provide details including dates.

3 Medical consultations

Last name of your physician	First name		
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number

3 Medical consultations (continued)

Provide details of any other physicians or specialists who have been consulted in connection with your illness.

Physician's last name	First name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's last name	First name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's last name	First name	Dates seen (dd-mm-yyyy) to
Address		Telephone number

If you have been treated at a hospital or health facility, provide the following information.

Name of hospital/facility	Dates admitted (dd-mm-yyyy)
Address	Dates discharged (dd-mm-yyyy)
Name of hospital/facility	Dates admitted (dd-mm-yyyy)
Address	Dates discharged (dd-mm-yyyy)

4 General information

Has your father, mother or any of your brothers or sisters **ever** suffered from a similar or related condition? ☐ Yes ☐ No

If '**yes**', provide details below.

Relationship	Name of condition	Year diagnosed	Age at diagnosis

Are you insured for critical illness benefits under any other Sun Life Financial policy or with another company? ☐ Yes ☐ No

If '**yes**', provide details below.

Name of insurer	Policy number	Amount of benefits insured $	Has a claim been submitted? ☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No

If '**yes**', indicate amount per day. ☐ How long have you used tobacco? ☐

If '**no**', did you previously use tobacco products? ☐ Yes ☐ No If '**yes**', to the best of your knowledge, in what year did you quit? ☐

5 Authorization

I authorize Sun Life Assurance Company of Canada, it's agents and service providers to collect, use and exchange information about the insured person or this claim (including medical history, autopsy results, toxicological or pathological findings), needed for underwriting, administration and adjudicating this claim, form and with any person or organization, including, health professionals, hospitals, medically-related facilities, government agencies, provincial health care plans, institutions, the MIB, Inc., investigative agencies, law enforcement agencies, insurers and reinsurers.

I uderstand this authorization continues to have effect beyond the duration of this claim.

Signature of insured X		Date (dd-mm-yyyy)
Name of claimant/benefit payee		Relationship to insured
Date (dd-mm-yyyy)	Signature of claimant/benefit payee X	

A copy of this authorization is as valid as the original.

Sun Life Assurance Company of Canada, by providing this form for the claimant's convenience, doesn't admit any liability to pay or waive any of its rights.

Please send the completed original form to:

Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5

You can fax this form to fax number 1-866-487-4745. If you do, please keep a copy for your future reference and ensure the original form is sent to the address above.

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