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 in the postage-paid envelope supplied. **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.

Clear

1 Information about you (Applicant)

Last name	First name	☐ Male ☐ Female
Former last name	Date of birth (dd-mm-yyyy)	Birth country
Residence address (street number and name)		Apartment or suite
City	Province / Country	Postal code
Telephone (residence)	Telephone (other)	Email address**
☐ Smoker ☐ Non-smoker*	Occupation	

Information about your spouse if applying (Spousal Applicant)

Last name	First name
Former last name	
Date of birth (dd-mm-yyyy)	Birth country
Telephone (residence)	Telephone (other)
☐ Smoker ☐ Non-smoker*	☐ Male ☐ Female
Email Address**	Occupation

* *Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.

** Your email address may be used in the event we need to contact you in connection with this Application Form.

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 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.

DC-100

3 Background information

This application is not valid unless the application is signed by all applicants.

Please answer the questions in sections 3, 4 and 5 completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Do not tell us about genetic testing or genetic test results.

Your physician (name)	Telephone
	– –
Physician's address	
Date and reason 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 and reason 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	

4 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, Alzheimer's, Parkinson's, 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)				

5 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

6 Medical information – full questionnaire

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

Please answer the questions in section 6 completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Do not tell us about genetic testing or genetic test results.

		You	Your spouse
1.	Have you or your spouse ever had any other condition not listed in question 1 of section 5?	☐ 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 licence 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.

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 received, read and fully understand the content of the MIB, Inc. notification contained in the *ScotiaLife* Critical Illness Insurance brochure. **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 Scotiabank, including Scotia Life Insurance Company, (Scotia), in accordance with the Scotiabank 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.

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) – –

8 How would you like to pay your monthly premium?

☐ A. Pre-Authorized Debit (PAD)

Please attach a personal blank cheque marked VOID.

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize Sun Life Assurance Company of Canada (Sun Life), the underwriter, to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated on the accompanying void cheque. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge and agree that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Sun Life notify you of any payments after the first payment whether the amount of the monthly premium is changed or not.** You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically, immediately following the 31 day grace period, if Sun Life is unable to make a withdrawal from your account.

When you give us this authorization to debit your account, it is the same as delivering a notice to your financial institution where you maintain your account. Your financial institution will debit the account you specify in the same manner as if you had given written instructions. The financial institution listed will not check if the debit was in accordance with this authorization as a condition of honouring the debit.

This authorization is to remain in effect until Sun Life has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You will provide us with another authorization or Agreement if we require.

Sun Life may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, or to obtain a sample PAD cancellation form or more information on your right to cancel a PAD Agreement, contact your financial institution or visit *www.cdnpay.ca*.

You may contact us to provide notices, make inquiries, obtain information or seek recourse with respect to any debits under this Agreement, at:

Sun Life Assurance Company of Canada
P.O. Box 215 Stn Waterloo
Waterloo, ON N2J 3Z9
Telephone # 1-866-292-3512

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder	Date (dd-mm-yyyy)
X	– –
Signature of account holder	Date (dd-mm-yyyy)
X	– –

☐ B. Credit card payment (charge my premium to my Visa or MasterCard)

Payment frequency ☐ Monthly ☐ Annually

Once we have processed your application, you will be contacted by a Sun Life Financial call centre representative to obtain your credit card information.

Terms and conditions

In connection with you required premium under this benefit plan, you authorize us to: charge your credit card for the insurance premium owing, cancel this authorization 10 days after you have provided written notice to us, and to automatically cancel this agreement if we are unable to charge your credit card.

Send no money with this application. You will be notified with a premium statement.

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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