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 in the postage-paid envelope supplied. **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.

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*	
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	First name	
Former last name		
Date of birth (dd-mm-yyyy)	Birth country	
Telephone (residence)	Telephone (other)	
Email address*		☐ Male ☐ Female
Are you a resident of Canada and covered under the provincial health plan in your province of residence? ☐ Yes ☐ No		

* Your email 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).

Last name	First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
Last name	First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
Last name	First name	☐ 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.

DC-100

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 Medical information – mini questionnaire

This application is not valid unless the application is signed by all applicants (18 years of age or older).

Please answer the questions in section 3 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** (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 4, 5, 6 and 7. If all applicants answered "No" to all the questions above, please complete sections 6 and 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

4 Background information (complete if you answered "Yes" to any question in section 3)

Please answer the questions in section 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	
Dates and reasons 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	
Dates and reasons 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	

5 Medical information – full questionnaire (complete if you answered "Yes" to any question in section 3)

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

*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.

6 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* Health & Dental 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 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 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) – –
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) – –

7 How would you like to pay your monthly premium?

☐ **A.** Pre-Authorized Debit (PAD)

Please attached 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)

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.