Protected "B" when completed

CONFIDENTIAL QUESTIONNAIRE
EMPLOYEE GROUP INSURANCE
DECLARATION OF PERSONAL INSURABILITY

Group Policy No.	DISABILITY INSURANCE
12500-GD	
Individual Agency Number	

SECTION 1 - EMPLOYEE DETAILS

Surname	Given Name(s)	Date of Birth

Address (No. and Street, City, Province, Postal Code)

Employer	Present Occupation	Annual Salary

Personnel Officer: Complete the reverse side and forward this form, intact, to the applicant for completion and signature. The applicant should seal and return the original to your office for forwarding to Superannuation Directorate along with any necessary insurance cards. Superannuation Directorate will forward the documentation to SunLife.
Applicant: Read this form, then complete it carefully. If you require more space, you can use a separate sheet of paper which you will sign and date. Upon completion of this form: remove, fold, include any additional sheets of paper and seal the original. Return to your personnel officer for forwarding to Superannuation Directorate. Retain the copy for your files. You will be advised of SunLife's decision shortly.

SECTION 2 - STATEMENT OF HEALTH OF THE EMPLOYEE

1. A. Height ▶ ☐ m. ☐ ft. ☐ cm. ☐ in. B. Weight ▶ ☐ kg. ☐ lbs.

On a separate sheet, GIVE FULL DETAILS AND PRESENT CONDITION OF ALL "YES" ANSWERS.
(i.e. dates, durations, treatments, names and addresses of doctors and hospitals)

		"YES"		"NO"
2.	In the past five years, have you:			
	a) Consulted any doctor or other health practitioner?	☐	2a	☐
	b) Submitted to ECG, blood tests, X rays, or other tests?	☐	2b	☐
	c) Had surgery or been treated in a hospital?	☐	2c	☐
	d) Received or applied for disability benefits for three months or longer?	☐	2d	☐
	In the past twelve months, have you:			
	e) Been absent from work for more than five consecutive days due to illness or injury?	☐	2e	☐
	f) Had a urinary tract infection or any sexually transmitted diseases?	☐	2f	☐
3.	Are you currently under medical treatment by diet, medicine, or other means?	☐	3	☐
4.	Have you ever had or sought advice for:			
	a) Dizzy spells, epilepsy, a nervous disorder or a mental disorder?	☐	4a	☐
	b) Asthma, chronic cough, shortness of breath or a lung problem?	☐	4b	☐
	c) High blood pressure, pains in the chest or difficulty with the heart or blood vessels?	☐	4c	☐
	d) An ulcer, liver disorder, colitis, chronic diarrhea, hepatitis, or any complaint of the digestive organs?	☐	4d	☐
	e) Arthritis, rheumatism, back problems, disc disease, joint or bone disorders?	☐	4e	☐
	f) Cancer, tumor, diabetes or sugar in the urine, gout, enlarged glands or enlarged lymph nodes?	☐	4f	☐
	g) Urine, kidney or bladder disorders?	☐	4g	☐
	h) Anemia, bleeding or blood disorders?	☐	4h	☐
	i) Difficulty with the eyes or ears?	☐	4i	☐
	j) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex?	☐	4j	☐
	k) Any test indicating the presence of the HIV+ virus (AIDS)?	☐	4k	☐
5.	For female employees: a) Are you pregnant? Number of months? _____	☐	5a	☐
	b) Have you ever had any complications related to pregnancy?	☐	5b	☐
6.	a) Indicate your average weekly consumption of alcohol. _____			
	b) Have you ever been advised to stop drinking alcohol or to drink less alcohol?	☐	6b	☐
7.	Do you participate or expect to engage in any of the following activities: sky diving, scuba diving, vehicle or boat racing or in aviation, except as a passenger?	☐	7	☐
8.	Except as prescribed by a physician, have you ever used cocaine, heroin or other narcotics, marijuana, LSD or amphetamines?	☐	8	☐
9.	Have you ever been refused life or health insurance, or offered life or health insurance on special terms?	☐	9	☐
10.	In the past twelve months, have your duties been modified due to health reasons?	☐	10	☐

I declare, that to the best of my knowledge and belief, the above answers and those on any attached sheet are complete. I am working on a regular basis for the above named employer. I understand that I may be refused group insurance if, in the opinion of SunLife, I am not insurable for group insurance.

SECTION 3 - AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, to give to SunLife Assurance Company of Canada, any such information. A photocopy of this authorization shall be as valid as the original.

Signature of Employee _____ Date _____

Group Policy Number **12500-GD Disability Insurance**		Individual Agency Number
Employee Surname	Given Name(s)	
Department Name		
Department Address		
Date of Last Entry into the Public Service	Occupation	Salary

Date	Signature of Personnel Officer	Telephone Number

PLEASE DO NOT OPEN

Public Works and Government Services Canada
Superannuation Directorate
Client Insurance Section
P.O. Box 5010
Moncton, N.B.
E1C 8Z5

S.V.P. NE PAS OUVRIR

Travaux publics et Services gouvernementaux Canada
Direction des pensions de retraite
Section des assurances aux clients
C.P. 5010
Moncton (N.-B.)
E1C 8Z5

Private and Confidential