

Sun Life Assurance Company of Canada
Sun Life Assurance Company of Canada (U.S.)

One Sun Life Executive Park, Wellesley Hills, MA 02481

**Instructions for use of Part II of Application for
Life Insurance**



A. Instructions for examiner when completing Medical or Paramedical exam

- Completely ask and record all answers as given including full details, to the proposed insured's medical history on pages 1 and 2 of the Part II form. Be sure that the form is properly witnessed, signed and dated.
- Record the findings of your examination, and the proposed insured's answers to the supplemental questions for applicants age 70 and over, on the "Medical Report on Proposed Insured" found on pages 3 and 4 of this form. Be sure that your proper identification information is completed on Page 4.

B. Instructions for producer when completing a Non Medical Part II

- Completely ask and record all answers as given including full details, to the proposed insured's medical history on pages 1 and 2 of the Part II form. Be sure that the form is properly witnessed, signed and dated.

Please note that a separate form is to be used for each insured.

Sun Life Assurance Company of Canada
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(Hereinafter referred to as "the Company")
 One Sun Life Executive Park, Wellesley Hills, MA 02481



Part II of Application for Life Insurance

1. Name of Proposed Insured	Application Number
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Please provide full details for all "Yes" answers on Page 2.

2. Are you being treated by diet, drugs or other means? Yes No
3. Have you ever had, been told you have or been treated by a physician for:
- a. High blood pressure, chest discomfort, stroke, circulatory or heart disorder? Yes No
 - b. Diabetes, sugar in the urine, thyroid, or other glandular (endocrine) disorder? Yes No
 - c. Kidney, bladder, urinary, reproductive organ or prostate disorder? Yes No
 - d. Protein (albumin), blood or pus in the urine, sexually transmitted disease or venereal disease? Yes No
 - e. Cancer, tumor, polyp, or disorder of the skin or breast? Yes No
 - f. Asthma, pneumonia, emphysema, or any other respiratory or lung disorder? Yes No
 - g. Seizure, convulsion, fainting, loss of consciousness, tremor, paralysis, or other disorder of the nervous system? Yes No
 - h. Anxiety, depression, stress or any psychological or emotional condition or disorder? Yes No
 - i. Colitis, hepatitis, ulcers, or other disorders of the stomach, liver or digestive system? Yes No
 - j. Arthritis, gout, back or joint pain, bone fracture, or muscle disorder? Yes No
 - k. Anemia, bleeding, or blood disorder? Yes No
 - l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Yes No
 - m. For the purposes of obtaining insurance, a positive blood test for antibodies to the AIDS (HIV) virus? . . . Yes No
4. Have you:
- a. Regularly used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician? Yes No
 - b. Been treated or counseled for alcoholism or drug abuse? Yes No
 - c. Been advised to reduce your consumption of alcohol? Yes No
5. Do you have any health symptoms for which a physician has not been consulted or treatment received? For example, persistent fever, unexplained weight loss, loss of appetite, pain or swelling? Yes No
6. Other than previously stated, have you within the past five years:
- a. Consulted a physician or any other practitioner, had a checkup, illness, surgery or been hospitalized? . . . Yes No
 - b. Had an electrocardiogram, stress or exercise test, x-ray, blood test or other diagnostic test? Yes No
 - c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed? Yes No
7. Have any of your parents, brothers or sisters had diabetes, heart disease or high blood pressure?..... Yes No

8. Family History

	Age(s) if Living	Age(s) at Death	State of Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Medical Report on Proposed Insured

Name	Birth Date (m/d/y)	Age
Name of Agent	Sales Office	

Place of examination: My office Applicant's place of business Time _____ A.M. P.M.
 Applicant's residence Elsewhere

Please answer all questions as fully and carefully as possible and mail or deliver the report as indicated on Page 4.

9. Have you attended the applicant professionally? If so, for what and when? (Details on Page 4) Yes No

10. Height: (In shoes) _____ ft. _____ ins. Weight: (In clothing) _____ lbs.
 Have you measured him/her? Yes No
 Have you weighed him/her? Yes No

Change in weight: No change Gain Loss _____ lbs. Reason for change: _____
 Circumference of chest. In full inspiration: _____ In forced expiration: _____ Measure around abdomen: _____

11. Blood pressures. If the initial reading exceeds 140/90, read it again later and record all the readings in the order they were taken.

Systolic	(1)	(2)	(3)	Any history of hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diastolic				Pulse Rate

12. a. Has the applicant used tobacco, (cigarettes, cigars, chewing tobacco, etc.) or products containing nicotine (nicorette gum, nicotine patch, etc.) within the past 12 months? Yes No
 b. Has the applicant used tobacco or nicotine products in the past and stopped? Yes No
 If yes, date stopped: _____

Questions 13-15 to be filled out only if exam is performed by a medical examiner.

Please give details of questions answered "Yes" on Page 4.

13. Is there any abnormality:
 a. Of the oral cavity, eyes, ears, skin (including xanthelasma, xanthomata, arcus senilis)? Yes No
 b. Of the lymph nodes or the thyroid gland? Yes No
 c. Of chest, spine or extremities? Yes No
 d. Of lungs on percussion and auscultation? Yes No
 e. Of the heart with respect to size and sounds? Yes No

14. Is there:
 a. Edema of the ankles? Yes No
 b. Intra-abdominal abnormality (enlarged liver, palpable spleen, palpable mass)? Yes No
 c. Any surgical scar? Yes No
 d. A hernia? If so, describe. Yes No
 e. Abnormality of the nervous system (muscular power, reflexes, etc.)? Yes No
 f. Inequality or inadequacy of the pulsations of the femoral, dorsalis pedis and posterial tibial arteries? ... Yes No

15. a. Describe general appearance, e.g. vigorous and healthy, pale, sickly, etc.

b. Reviewing all the features, please give your medical diagnosis: Healthy and unimpaired Other (clarify)

Supplemental questions to be answered by examiner on applicants age 70 and over.

16. Did the Proposed Insured require any assistance, either by device (cane, walker, wheel chair, etc.) or third party, to arrive at and participate in this examination? Yes No
 17. Did the Proposed Insured require any assistance from a third party to understand and answer the questions from this exam? Yes No
 18. Does the Proposed Insured display any signs or symptoms of confusion, dementia or memory loss? Yes No
 19. Does the Proposed Insured understand that this exam is related to the purchase of a life insurance policy on his or her life? Yes No

