

# 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**

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- 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, on the "Medical Report on Proposed Insured" found on pages 3 and 4 of this form.
- On page 3, the Supplemental questions, to be answered by examiner on all applicants age 70 and over, numbers 16 – 19, have been grayed out. You should ***not*** complete these questions on our exam form. For ***all*** applicants age 70 and over you should complete the additional form containing the supplemental questions for applicants age 70 and over, which will be supplied by your company.
- Be sure that your proper identification information is completed on Page 4.
- Any observations you note while conducting the exam should be recorded in the "Details" section found on page 4.

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

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- 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 exam form is to be used for each insured.**

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

(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. 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



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(800) SUN-LIFE



**NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE  
AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your eligibility for insurance coverage, the Insurer (Sun Life) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially and will only be reported by the laboratory to the Insurer identified on this form. The Insurer may disclose test results to others solely involved in the underwriting process, such as its affiliates, reinsurers, or third party contractors.

If the HIV test is positive, the results will be reported to the local health department or the State Department of Health and if the Insurer is a member of the Medical Information Bureau, Inc. (MIB, Inc.), the Insurer may report the results in a generic code which signifies only nonspecific blood test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you. Upon your request, we will provide you with the names of the specific individuals or organizations named in this paragraph who will have access to your test results, insurance file or maintain test information in a data bank or file.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive are at high risk and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

You may choose to have the test results sent directly to you or designate another person such as a physician to whom you may authorize disclosure and with whom you wish to discuss the results. If you do not designate a physician, personal face-to-face counseling is available through the Virginia Health Department. To obtain information regarding counseling, you should contact your local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Virginia Health Department at 1-800-533-4148.

**CONSENT**

I have read and I understand this Notice of Consent for Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood, the testing of that blood, and the disclosure of the test results as described.

In the event of a positive HIV test result, I authorize the Insurer to send the test results to me  or  to the following person:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Please send negative HIV test results to me  or  to the above named individual.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
State of Residence