SUTTON
SPECIAL RISK

OPTIONAL CRITICAL ILLNESS APPLICATION

GENERAL INFORMATION (to be completed by the employee)

Employee Name _____ Payroll ID: _____
Last First

Policyholder UCCM Anishnaabe Police Service Policy # 056CI/031835A

Applicant Name _____ ❒ Male ❒ Female
Last First

Date of Birth _____
Month Day Year

Address _____
Number, Street City Province Postal Code

Optional Benefit Amount Applied For: _____

Please indicate the total amount of insurance you are applying for, regardless of any existing insurance you may have under the plan or the amount you indicated on the enrollment card. Even if coverage is declined, the insurer will issue coverage equal to the non-evidence maximum under this plan.

MEDICAL HISTORY

1. Have you ever applied for life, critical illness or health insurance, which was declined, rated, or modified in any way? ❒ Yes ❒ No

   If Yes, please provide the type of coverage, date, insurer, the decision and the reason.

2. Have you ever received disability or other benefits following an accident or an illness? ❒ Yes ❒ No

   If Yes, please provide dates, reason, amount of time off work, treatment, complications, and residual issues (if any) or indicate if you are fully recovered.

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3. In the past 5 years have you been advised to reduce your alcohol consumption and/or have you sought treatment or been advised to seek treatment for alcohol use? ❒ Yes ❒ No

If you were asked to reduce your consumption, please explain why. _____

4. In the past 5 years have you used marijuana products, cocaine or any other type of illicit drugs or narcotics or have you sought treatment or been advised to seek treatment for drug use? ❒ Yes ❒ No

If Yes, please provide details such as dates, drugs used, frequency, date of last use and if still using.

5. Have you ever been treated for, exhibited symptoms of or been diagnosed with:

a) Respiratory disorder such as asthma, bronchitis, emphysema, chronic obstructive pulmonary disease, chronic cough, pulmonary hypertension, sleep apnea or any other lung disorder? ❒ Yes ❒ No

b) Disorder of the stomach, liver, pancreas, gallbladder, intestines, ulcer, colitis, Crohn's disease, hepatitis, cirrhosis or any other gastro-intestinal disorder or bleeding? ❒ Yes ❒ No

c) Disorder of the kidney, urinary tract, bladder, prostate, reproductive organs or breast (including lumps, cysts, unusual discharge or abnormal mammogram) or any other disorder of the genito-urinary system? ❒ Yes ❒ No

d) Chest pain, angina, palpitations, hypertension, elevated cholesterol, rheumatic fever, cardiomyopathy, heart enlargement, heart murmur, heart attack, pulmonary hypertension, ankle swelling, peripheral vascular disease, transient ischemic attack (TIA), stroke, or any other heart or blood vessel disease or disorder or have you had cardiac surgery? ❒ Yes ❒ No

e) Disorder of the nervous system, eyes, ears, dizziness, numbness or tingling, fainting, seizure, paralysis, multiple sclerosis, depression, mental or nervous disorder, Alzheimer's Disease, Parkinson's Disease, motor neuron disease, meningitis or impaired memory or any other neurological disorder? ❒ Yes ❒ No

f) Glandular or blood disorder, diabetes, anemia, thyroid disorder, cancer, polyp, growth, tumour, nodule, leukemia, lymphoma, melanoma, disorder of the skin (including abnormal skin lesions such as moles or dysplastic nevi) or any form of malignant disease? ❒ Yes ❒ No

g) Disorder of the muscles, bones, ligaments or cartilages, arthritis, amputation, injury, pain, fibromyalgia, abnormality of the neck, back, bones, spine or joints or muscular dystrophy? ❒ Yes ❒ No

h) Disorder of the immune system, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other deficiency of the immune system, or have you had a positive test revealing the AIDS virus or antibodies to the AIDS virus? ❒ Yes ❒ No

i) Any other disorder, disease, symptoms, operation, hereditary disorder or injury not mentioned above? ❒ Yes ❒ No

If Yes, please provide details, including dates, symptoms, and treatments or medications prescribed.

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6. Have any of your natural parents, brothers or sisters been diagnosed with any of the following:

Alzheimer's disease	Huntington's chorea	Polycystic kidney disease
Amyotrophic Lateral Sclerosis (ALS)	Motor neuron diseases	Primary pulmonary hypertension
Cancer or tumour (specific type)	Multiple Sclerosis	Stroke
Diabetes	Muscular Dystrophy	Any other hereditary disease
Heart disease	Parkinson's disease	

❒ Yes ❒ No ❒ Adopted and no knowledge of my family history

If Yes, please provide specific details:

	Specific Type of Condition	Age at Diagnosis	Age at Death	Cause of Death
Mother				
Father				
Brother				
Sister				

7. Have you smoked any cigarettes, cigarillos, cigars, pipes or used chewing tobacco or any nicotine products (patch, gum, etc.) within the past 12 months? ❒ Yes ❒ No

If Yes, please provide details _____

8. Do you have any symptoms for which you have not yet consulted a doctor; or further testing, investigations or treatments that have been advised but not yet completed? ❒ Yes ❒ No

If Yes, please provide details _____

9. Are you taking any prescribed medication? ❒ Yes ❒ No

If Yes, please provide details:

Prescribed Medication	Dosage	Reason/Treatment for

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10. Height and Weight deatils:

Height _____ cms or _____ ft/ins

Weight _____ kgs or _____ lbs

Have you lost 20 lbs (9 kgs) or more within the last year? ❒ Yes ❒ No

If Yes, how much? _____

Please provide reasons for the weight loss. _____

_____

_____

11. Have you consulted a doctor in the past 5 years (except for annual check ups)? ❒ Yes ❒ No

If Yes, please provide details of your last medical consultation.

a) Date (mm/dd/yyyy)_____

b) Reason _____

c) Describe any tests performed or advised

d) Results
- ❒ No tests required or test results normal
- ❒ Test results pending
- ❒ Other - please provide details _____

_____

e) Was any treatment prescribed? ❒ Yes ❒ No

If Yes, please provide details of the treatment_____

_____

12. Name and address of physician

Name _____

Address _____

Number, Street City Province Postal Code

Phone Number _____

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Based on your answers to the Medical History questions, we may require some additional information. If so, we will contact you to arrange a time that is convenient for you.

Please indicate below when the best time to contact you would be and provide a primary and secondary phone number.

Best time to call	
❒ Morning ❒ Afternoon ❒ Evening	Primary Phone Number: Secondary Phone Number:

SUTTON PRIVACY NOTICE

The information collected on this application for insurance is required for the purposes of reviewing and, if approved, processing this application for insurance. It may also be used to administer the insurance policy and investigate and determine any claims that may be made under this policy.

This information, and information in existing files, may be used by Sutton Special Risk Inc., its agents, affiliates, partners, reinsurers, and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force.

This information may also be used to provide you with information about products and services that may be of interest to you. We do not disclose personal information to other organizations for marketing purposes. If you do not want us to use your information for these optional purposes, you may contact us at privacy@suttonspecialrisk.com or Privacy Office, Sutton Special Risk Inc., 33 Yonge Street, Suite 270, Toronto, Ontario, M5E 1G4

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DECLARATION AND AUTHORIZATION

I hereby warrant that:

1. I understand that all statements, agreements, representations and answers made in this application, and any additional declarations or answers which may be made in any personal declaration required in connection with this application, together with all prior applications shall be considered as part of my Optional Critical Illness application.

2. The above statements are true and correct to the best of my knowledge and belief and that I have not withheld any information.

3. I have received and read, and confirm my agreement with the Sutton Privacy Notice.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau, consumer reporting agency, or policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the claimant to give Sutton Special Risk, or its legal representative any and all such information pursuant to this claim.

I UNDERSTAND the information obtained by use of this Authorization will be used by Sutton Special Risk, to determine eligibility for coverage or eligibility for benefits under existing coverage. Any information obtained will not be released by Sutton Special Risk, to any person or organization except to the Insurer, or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required, or as I may authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signature of Applicant _____ Date _____
Month Day Year