SUTTON
SPECIAL RISK

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APPLICATION FOR MAJOR MEDICAL INSURANCE

TO BE COMPLETED BY PROPOSED INSURED

PLEASE ANSWER ALL QUESTIONS

Proposed Insured:	Citizenship:
Address:	

Date of Birth (Day/Month/Year)	Sex:	Height:	Weight:

Profession or occupation:

Nature of duties:

Employer's name:

Employer's address:

COVERAGE BEING APPLIED FOR:

Maximum sum insured $

US or CDN dollars

BROKER INFORMATION

Broker/Agent/Consultant

Contact name and telephone no.

Are you now, and have you been, in sound health for one year preceding this application?	◯ yes	◯ no/describe nature of impairment
Have you consulted a doctor during the past two years?	◯ no	◯ yes/state date, reason and name and address of Physician
Have you, to your knowledge, during the past twenty-one days, been exposed to any infections or contagious disease?	◯ no	◯ yes/describe in detail
Do you intend to travel outside Canada or the U.S.A. during the next twelve months?	◯ no	◯ yes/state countries to be visited, length of stay, purpose

Within the past ten years have you consulted a physician, or had treatment or surgery, or taken prescribed medication, for a sickness or injury arising from any of the following:
If yes, please describe in detail including dates and prognosis.

High blood pressure, chest pain or disorder of the heart or circulatory system?	◯ no	◯ yes/describe in detail including dates and prognosis

	Diabetes, cancer, tumor or disorder of the glands, bone, blood or skin?	○ no	○ yes/describe in detail including dates and prognosis
	Disorder of the breasts, reproductive organs, kidneys or urinary system?	○ no	○ yes/describe in detail including dates and prognosis
	Hernia, or disorder of the liver, gall bladder, stomach, intestines or rectum?	○ no	○ yes/describe in detail including dates and prognosis
	Arthritis, rheumatism, or disorder of the limbs, back, neck or spine?	○ no	○ yes/describe in detail including dates and prognosis
	Neuritis, sciatica, gout or any disorder of the muscles, bones or joints?	○ no	○ yes/describe in detail including dates and prognosis
	Allergy, asthma, sinusitis, emphysema, or disorder of the lungs?	○ no	○ yes/describe in detail including dates and prognosis
	Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, tuberculosis or chronic respiratory disorder?	○ no	○ yes/describe in detail including dates and prognosis
	Disorder of the eyes, ears, nose or throat?	○ no	○ yes/describe in detail including dates and prognosis
	Epilepsy, stroke, dizziness, or disorder of the brain or spinal cord?	○ no	○ yes/describe in detail including dates and prognosis
	Emotional, mental or nervous disorder?	○ no	○ yes/describe in detail including dates and prognosis
	Any change of weight in the past year?	○ no	○ yes/describe in detail including dates and prognosis
FEMALES ONLY	Have you ever had any disorder of menstruation, of pregnancy or of the female organs or breasts?	○ no	○ yes
	To the best of your knowledge and belief are you now pregnant?	○ no	○ yes

FAMILY HISTORY

Is there, in your family, any history of diabetes, cancer, high blood pressure, heart disease, or mental illness or suicide?	○ no	○ yes/describe in detail		
	Age if Living		Age at Death	Cause of Death
Father				
Mother				
Brothers & sisters No. living [ ] No. dead [ ]				

HAVE YOU EVER: If yes, please describe in detail:

Smoked any tobacco products in the past twelve months?	○ no	○ yes/describe in detail
Required treatment for the use of alcohol or drugs, or used either to excess?	○ no	○ yes/describe in detail
Used cocaine, narcotics or any other habit forming drug?	○ no	○ yes/describe in detail
Have you ever had your drivers license revoked for any period of time, for driving while under the influence of alcohol?	○ no	○ yes/describe in detail
To the best of your knowledge, have you ever been treated for, or told you had, AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?	○ no	○ yes/describe in detail
Do you have an amputation of any kind, or any physical deformity, impairment or handicap?	○ no	○ yes/describe in detail
During the past five years have you undergone any surgical operation(s)?	○ no	○ yes/state month/date/year, reason, physician's name and address
Have you any reason to think that you may need to undergo a surgical operation in the future?	○ no	○ yes/approximate date for surgery, reason for surgery
Do you have insurance similar for that now being applied for?	○ no	○ yes/name of insurer, policy benefit(s)
In the event of accident or illness would the applicant be eligible for reimbursement under any Canadian Provincial or Federal Government Health Plan?	○ no	○ yes/please state duration
Have you made any claim(s) against an insurer in respect of an accident or illness?	○ no	○ yes/date & nature of claim, amount of claim

Have you ever been declined, or accepted on special terms, for Life Insurance or Accident and Health Insurance?	◯ no	◯ yes/describe in detail
Has any Life, or Accident and Health Insurer, ever cancelled or declined to renew your coverage?	◯ no	◯ yes/month/year of action, reason for action
Have you an application pending for any other Accident or Sickness Insurance?	◯ no	◯ yes/date of application, name of Insurer, benefit(s) applied for
Do you sky dive or operate an aircraft, glider or balloon?	◯ no	◯ yes/describe in detail
Do you scuba dive, or race motorcycles or boats?	◯ no	◯ yes/describe in detail
Do you engage in other hazardous activities not shown above?	◯ no	◯ yes/nature of activity, extent and frequency of participation

If you use a motor vehicle in connection with your business or occupation, give your approximate annual mileage if this will exceed 18,000 miles/30,000 km (business and pleasure) _____ or N/A

DECLARATION

I hereby warrant that the above statements are true and correct to the best of my knowledge and belief and, that I have not withheld any information which is calculated to influence the decision of the Insurer. I understand that non-disclosure or misrepresentation of a material fact will render this insurance null and void.

NOTE: A material fact is one likely to influence acceptance or assessment of this application by the Insurer. If you are in doubt as to what constitutes a material fact you should consult your agent, or SUTTON SPECIAL RISK INC.

I understand that signing this application does not bind me to complete the insurance but, I do agree that, should a Policy be concluded, this Application, and the statements made herein, shall form the basis of the Insurance. Further, that SUTTON SPECIAL RISK INC. is hereby authorized as the sole representative for placement of this insurance.

Signature of Proposed Insured Date

Applicant/Owner (corporation/partnership/trustee or individual other than Proposed Insured)

By (signature & title)

Witnessed, by Licensed resident agent

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 regarding me, or my health, to give SUTTON SPECIAL RISK INC. any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured Date

Signed at