SUTTON
SPECIAL RISK

33 Yonge Street, Suite 270
Toronto, Ontario M5E 1G4
Tel: (416) 366-2223
Fax: (416) 366-4608
Toll Free: 800-461-3292

ACCIDENT AND SICKNESS RENEWAL DECLATION OF HEALTH

Name of Insured: _____ **Policy Number:**_____

Name of Insured Person:_____ **Date of Birth:** _____
Day/Month/Year

Current salary:_____ **Currency: CDN / US / Other (please specify)** _____

1. Has there been any change in your occupation or employment contract in the past 12 months?.... Yes/No
   If **Yes**, please give details:
   _____

2. Are you currently free from illness or injury and actively employed?..... Yes/No
   If **No**, please give details:
   _____

3. In the past 12 months have you applied for any new insurance, or any change on existing insurance?..... Yes/No
   If Yes, please give details:
   _____

4. In the past 12 months have you consulted, received treatment or advice from a physician or any medical practitioner for any illness, injury or condition?..... Yes/No
   If **Yes,** please give details below:

Doctor(s)/Practitioner Seen	Reason	Treatment Received	Date

5. Do you have reason to believe that you may need to undergo a surgical operation in the future?..... Yes/No
   If **Yes**, please give details:
   _____

6. Have your travel habits changes since the original application was signed?..... Yes/No
   If **Yes**, please give details:
   _____

7. Do you engage in any hazardous activities (such as sky-diving, operating an aircraft, glider or balloon, scuba-diving, automobile, motorcycle or boat racing ect.) which are not indicated on your original application?..... Yes/No
   If **Yes**, please give details:
   _____

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.

The Insurers do not bind themselves to accept renewal and reserve the right to request further information or impose specific exclusions as a result of information disclosed herein.

I agree that in respect of the Period of Insurance in question, this Renewal Declaration of Health, together with the original Application Form and any other forms, written statements or answers furnished as evidence of insurability, shall be the basis of renewal coverage.

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 or 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 the Insured Person Date: (day/month/year)