SUTTON
SPECIAL RISK

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Application for Personal Accident and/or Sickness Insurance

Proposed Insured Person:		Citizenship:	
Address:			
Date of Birth: Day/Month/Year	Sex:	Height:	Weight:
Profession or Occupation:			
Nature of Duties:			
Employer's Name:			
Employer's Address:			
Average annual earnings for past three years, derived from your profession excluding income from other sources: $		Estimated earnings next twelve months: $	

Temporary Total Disability (state CDN or US dollars):	**Permanent Total Disability (state CDN or US dollars):**
Elimination Period: days	Elimination Period:
Monthly Benefit: $	Lump Sum Benefit:
Benefit Period: months	or Present Value Lump Sum:

Is this benefit taxable to the Insured Person? ❒ No	❒ Yes. State Social Insurance Number:

HEALTH QUESTIONNAIRE

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 diseases? ❒ 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

Diabetes, cancer, tumour or disorder of the glands, bone, blood or skin?	❒ No	❒ Yes
Disorder of the breasts, reproductive organs, kidneys or urinary system?	❒ No	❒ Yes
Hernia, or disorder of the liver, gall bladder, stomach, intestines or rectum?	❒ No	❒ Yes
Arthritis, rheumatism, or disorder of the limbs, back, neck or spine?	❒ No	❒ Yes
Neuritis, sciatica, gout or any disorder of the muscles, bones or joints?	❒ No	❒ Yes
Allergy, asthma, sinusitis, emphysema, or disorder of the lungs?	❒ No	❒ Yes
Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, tuberculosis or chronic respiratory disorder?	❒ No	❒ Yes
Disorder of the eyes, ears, nose or throat?	❒ No	❒ Yes
Epilepsy, stroke, dizziness, or disorder of the brain or spinal cord?	❒ No	❒ Yes
Emotional, mental or nervous disorder?	❒ No	❒ Yes
Any change of weight in the past year?	❒ No	❒ Yes
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 currently 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

	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
Required treatment for the use of alcohol or drugs, or used either to excess?	❒ No	❒ Yes
Used cocaine, narcotics, or any other habit forming drug?	❒ No	❒ Yes
Had your drivers license revoked, for any period of time, for driving while under the influence of alcohol?	❒ No	❒ Yes
To the best of your knowledge, been told you had or been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?	❒ No	❒ Yes
Had an amputation of any kind, or any physical deformity, impairment or handicap?	❒ No	❒ Yes
Undergone any surgical operation(s) in the past five years?	❒ No	❒ Yes. State month/day/year, reason, physician's name and address:
Had 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:

Please answer the following questions. If yes, please explain.

Do you have insurance similar to that now being applied for?	❒ No	❒ Yes. Name of insurer, policy benefit(s):

Have you made any claim(s) against an insurer in respect of an accident or illness?	❒ No	❒ Yes. State 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
Has any Life; or Accident and Health Insurer; ever cancelled or declined to renew your coverage?	❒ No	❒ Yes. State month/year of action, reason for action:
Do you have an application pending for any other Accident or Sickness Insurance?	❒ No	❒ Yes. State date of application, name of Insurer, benefit(s) applied for:
Do you sky dive or operate an aircraft, glider or balloon?	❒ No	❒ Yes
Do you scuba dive, or race automobiles, motorcycles or boats?	❒ No	❒ Yes
Do you engage in other hazardous activities not mentioned above?	❒ No	❒ Yes. State nature of activity, extent and frequency or participation:
If you use a motor vehicle in connection with your business or occupation, give your approximate annual mileage if this will exceed 30,000 km/18,000 miles (business and pleasure): _____ or N/A		

DECLARATION & AUTHORIZATION

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 Document of Insurance 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.

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 Proposed Insured Person Date