SUTTON
SPECIAL RISK

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Application for Personal Accident 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: $
Accidental Death Only (state CDN or US dollars): $			Accidental Death and Disemberment (state CDN or US dollars): $
Beneficiary if other than the Proposed Insured Person's Estate:			
Relationship to the Proposed Insured Person:			

HEALTH QUESTIONNAIRE

Are you now, and have you been in sound health for one year preceding this application?	☐ Yes	☐ No. Describe nature of impairment:
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:
Is your hearing impaired; have you ever suffered from any disease of the ears?	☐ No	☐ Yes. To what extent?
Is your sight in any way impaired; have you suffered from any disease of the eyes?	☐ No	☐ Yes. To what extent?
During the past five years have you undergone any surgical operation(s)?	☐ No	☐ Yes. State month, date, year, reason; physician name & address:
Have you any reason to think that you may need to undergo a surgical operation in the future?	☐ No	☐ Yes. State approximate date for surgery; reason for surgery:

Do you have insurance similar to that now being applied for?	☐ No	☐ Yes. Name of Insurer, policy benefits:
Have you made any claim(s) against an Insurer in respect of an accident?	☐ No	☐ Yes. Date of claim. 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. State details:
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:
Do you have you an application pending for any other Accident Insurance?	☐ No	☐ Yes. Date of application. name of Insurer. benefit(s) applied for:
Have you ever had your driver's license revoked for any period of time for driving while under the influence of drugs or alcohol?	☐ No	☐ Yes. State Details:
Do you sky dive or operate an aircraft, glider or balloon?	☐ No	☐ Yes. Explain:
Do you scuba dive or race automobiles, motorcycles or boats?	☐ No	☐ Yes. Explain:
Do you engage in other hazardous activities not mentioned 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 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