Application for policy change, reinstatement and/or reconsideration of rating

Sun Life Financial is a leading financial services organization with offices in key markets worldwide. The Sun Life Financial group of companies* offers its clients value-based lifetime financial solutions.

*The companies in the Sun Life Financial group of companies mean only those companies identified in the Sun Life Financial Privacy Policy that is available on the Sun Life Financial website, *www.sunlife.ca*.

Sun Life Financial life and health insurance products are underwritten and issued by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Advisor instructions

1. A separate form must be completed for each person insured who is applying for a reinstatement or coverage change that increases the risk.
2. This form may be used to add a life insured to an existing policy, including Child term benefit (CTB) or Term insurance benefit on second proposed insured.
3. This form may be used for changes to the smoking status of an existing policy, **with an increase in coverage that requires underwriting**.

   For changes to the smoking status of an existing policy only (no other changes made), complete the *Declaration of smoking status (for changes on existing policies only) form* (E18) instead of this application.
4. Use this form for reconsideration of a rating.
5. If your client qualifies for temporary insurance, and wants it, complete the *Certificate of temporary insurance* pages, **tear off and give to your client.** Make sure you get a cheque for the initial payment, made payable to Sun Life Assurance Company of Canada. If your client does not apply for temporary insurance, or does not qualify for it, do not collect any payment.

   Please carefully review the *Certificate of temporary insurance* pages with your client so they understand the terms, conditions and exclusions that apply to temporary insurance.
6. If the policy change being applied for does not involve an increase in risk and this is a request to:
   a) decrease basic insurance benefits, or
   b) cancel a benefit

   complete the *Application for change to an existing life insurance policy* form (E87-W) instead of this application.
7. If the policy change being applied for does not involve an increase in risk and this is a request to change an investment mix, complete the *Investment account change and allocation* form (E154-W) instead of this application.

Application for policy change, reinstatement and/or reconsideration of rating

Sun Life Financial

Policy number

This application may be used to amend, reinstate or reconsider a rating on an existing life or critical illness insurance policy.

Notes:

- For changes or reinstatements on a joint plan, a separate form must be completed on each proposed insured.
- Form 4830 must also be completed with the application if:
  - the policy to be reinstated is a universal or permanent life policy, and
  - the lapsed/terminated policy contains a reinstatement provision that allows for a reinstatement of greater than 2 years after lapse/termination.

Note: Important information regarding the possible loss of grandfathering on policies issued before January 1, 2017.

Policies issued January 1, 2017 and later fall under the new tax rules. Policies issued before January 1, 2017 are considered grandfathered and will remain so unless certain changes are made. These generally include changes that increase the amount of insurance coverage and require underwriting, for example adding an insurance coverage. There are some changes that can be made that may not cause a loss of grandfathering including changing ownership or changes to smoking status.

The grandfathering provisions available with policies issued before January 1, 2017 are an important component of your life insurance protection. Policy changes that can result in a loss of grandfathering may not be allowed in order to preserve the tax benefits that these provisions provide.

Note: Important information regarding the FATCA & CRS questions in this application.

- The international tax residency self-certification for FATCA/CRS questions in this application should be answered only by an individual owner (including a sole proprietor)/proposed insured. Non-individual (corporate or other entity) information must be completed on the *International tax classification for an entity* (4545-E) form.
- Canadian financial institutions are required under Part XVIII (Foreign Account Tax Compliance Act – FATCA) and Part XIX (Common Reporting Standard – CRS) of the Income Tax Act (Canada) to collect the information you provide on this application to determine if they have to report your financial account to the Canada Revenue Agency (CRA). The CRA may share that information with the government of a foreign jurisdiction that you are resident of for tax purposes. Additionally, if you are a United States person (which includes a United States citizen or resident for tax purposes), the CRA may share your account information with the Internal Revenue Service (IRS).
- You must notify us within 30 days of any changes and provide us with a new *International tax self-certification for individuals* (4573-E) form. A change includes information that affects your tax residency outside of Canada, such as a change in address or telephone number. We will update the information in our records when you advise us of a change.

Type of application (choose one): ☐ Policy change ☐ Reinstatement ☐ Reconsideration of ratings/exclusions/extras or class ☐ Add Long term care conversion option

In this application, *I*, *you* and *your* refer to the proposed insured and the proposed owner. *We, us, our* and *the company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

1 Proposed insured's general information

In this section, *you* refers to the proposed insured.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Former last name (if any)	Country of birth	City of birth

Residential address (street number and name)	Apartment or suite

City	Province	Country	Postal code

Please submit only one copy of this document to Sun Life through your MGA or National Account.

1 Proposed insured's general information (continued)

What is your residency status?

☐ Canadian citizen ☐ Permanent resident status (landed immigrant) ☐ Other

If '**Permanent resident**' or '**Other**', provide details including number of years in Canada.

FATCA

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

☐ Reason A: I have applied for a TIN but have not yet received it.

☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other: Specify the reason _____

Does the proposed owner want to retain age? ☐ Yes ☐ No **Note**: Age may be retained up to 90 days.

2 Proposed owner's general information (if other than proposed insured)

In this section, *you* refers to the proposed owner.

Note: If the mailing address differs from the residential address, provide details in the *Advisor's report*.

☐ Address is same as Person 1 above. If you've ticked this box, you may leave the address boxes blank.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Former last name (if any)	Country of birth	City of birth

Residential address (street number and name)	Apartment or suite

City	Province	Country	Postal code

FATCA

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

☐ Reason A: I have applied for a TIN but have not yet received it.

☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other: Specify the reason _____

3 Policy changes and reconsiderations of ratings/exclusions/extras or class

In this section, *you* refers to the proposed owner.

Terms and conditions of change:

a) Changes to policies issued prior to 2017 may result in the loss of grandfathering protection which may result in negative tax consequences.

b) Any change may be subject to restrictions on the amount of premium and death benefit or critical illness insurance amount, as determined by the company at the time of the change.

c) Some changes are available on certain plans only, as determined by the company.

d) The company may require evidence of insurability. In some situations, the client is responsible for the cost of a doctor's report.

e) A fee may be charged, as determined by the company, at the time of the change. Payment of the service fee is required at the time of application to change the policy.

f) If there is a credit from this change, it will be applied to one of the following:
- premium fund or reserve,
- policy fund, subject to applicable minimum/maximum limits, or
- refunded to the policy owner if this is a Term plan.

Note: Not all benefits or changes shown below are available with every type of insurance plan. Advisors should refer to our illustration software or to the applicable product information section on the advisor web site for availability.

3.1 Additions, changes or reconsiderations

a) Adding a new benefit

☐ Total disability waiver benefit $

Indicate type from original policy, if applicable: ☐ Protection ☐ Savings

☐ Term insurance benefit on insured person $

☐ 10 Year Term ☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

☐ Term insurance benefit on additional insured person $

☐ 10 Year Term ☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

Additional insured's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

☐ Accidental death $

☐ Child term benefit (CTB) $

☐ Plus premium benefit (PPB) $

Payment options for PPB:

Scheduled (regular monthly or annual payments): ☐ Monthly $

☐ Annual $

☐ Long term care conversion option (Juvenile policy only)

3 Policy changes and reconsiderations of ratings/extras or class (continued)

b) Changing an existing benefit or smoking status

- ☐ Increase death/basic insurance benefit or level amount at risk/plus policy fund to: $
- ☐ Exercising guaranteed insurability benefit to add to existing policy (no evidence required if this is the only change being applied for) $
- ☐ Death benefit option change
  - ☐ Change universal life
    - ☐ level death benefit to level amount at risk/plus policy fund, with a death benefit of $
    - ☐ level amount at risk/plus policy fund to level death benefit, with a death benefit of $
  - ☐ Level insurance amount
  - ☐ Indexed insurance amount (check one.)
    - ☐ at % per year (specify between 1% and 8% in multiples of 0.25%)
    - ☐ at the annual rate of Canada's Consumer Price Index (to a maximum of 8% per year)
  - ☐ Insurance amount plus your policy fund value
    For multi-life coverage, the policy fund value will be paid as a proportion of each insurance amount to the total, unless you tell us your policy fund value is to be paid with the ☐ first ***or*** ☐ last settlement of basic insurance benefit under the policy.
  - ☐ Fund builder
    Fund builder is a variation of the Insurance amount plus fund option.
    Starting with the _____ policy anniversary, the Insurance amount will be reduced annually to the lowest level that maintains your policy's tax-exempt status.
    Stop annual reductions when the insurance amount reaches $
- ☐ Change dividend option (Choose one.)
  - ☐ Paid-up additional insurance (PUA) (New or change from Premium reduction option (PRO))
  - ☐ PUA to PRO
  - ☐ Annual premium reduction
  - ☐ Cash payment
  - ☐ Dividends on deposit
- ☐ Change to non-smoker

c) Reconsideration of rating/extra or class

- ☐ Reconsideration of rating/extra
- ☐ Reconsideration of class on preferred class products or class **Note:** Routine age and amount evidence is required based on current age nearest.

d) Reconsideration of exclusion

- ☐ Non-medical **Note:** Complete and attach the appropriate questionnaire
- ☐ Medical **Note:** Complete sections 9 - 13.

e) Cost of insurance

Change cost of insurance: ☐ Level ☐ Yearly renewable ☐ Limited pay 20

f) Adding a life (under base coverage)

- ☐ Adding a new life $

Proposed insured's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

3 Policy changes and reconsiderations of ratings/exclusions/extras or class (continued)

g) Other

Complete if you are applying to add or change any other benefits not already indicated indicated in this application.

Type of transaction	Type of policy	Benefit name	Amount (added or changed to)
☐ Add ☐ Change			$
☐ Add ☐ Change			$
☐ Add ☐ Change			$

3.2 Decreasing or deleting benefits

a) Decreasing

☐ Decrease death/basic insurance benefit to this amount $

☐ Decrease reserve/policy fund on universal life (level death benefit)

Amount of cheque: $

Note: If we decline your request based on the evidence provided, then we'll reduce the principal death benefit by the withdrawal amount, we will make this change when the withdrawal is made.

b) Other

Complete if you are applying to decrease or delete any other benefits not already indicated in this application.

Type of transaction	Type of policy	Benefit name	Amount after decrease
☐ Decrease ☐ Delete			$
☐ Decrease ☐ Delete			$
☐ Decrease ☐ Delete			$

3.3 Investment changes on existing policies

Note: If you also require an Investment change on an existing policy, the Investment account change and allocation form (E154W) must be completed and submitted along with this application.

4 Additional evidence required

Complete the following if:

- increasing the amount at risk/plus policy fund
- changing dividend option from PRO to PUA, or
- adding PPB after the second policy anniversary (refer to the Making changes to Plus premium benefit chart for availability).

Notes:

- For all other situations where evidence of insurability is required, complete sections 8 - 14 as applicable.
- The questions must be answered by the proposed insured. If the proposed insured is under age 16 (18 in Quebec), the questions must be answered by the proposed insured's parent or legal guardian.

1) Has the proposed insured **ever** been treated for or had any symptoms or indication of:
   a) heart attack or any other heart disease or disorder, stroke/TIA, cancer or any other growth(s) or malignancy, diabetes or kidney, lung or liver disease or disorder? ☐ Yes ☐ No
   b) AIDS, HIV infection or any other disease or disorder of the immune system? ☐ Yes ☐ No
2) Is the proposed insured aware of any symptoms for which they have not yet consulted a physician or received treatment? ☐ Yes ☐ No
3) Has the proposed insured **ever** had any medical conditions, not already mentioned, for which they have been or are being investigated, under observation or treated for, or for which they are currently awaiting investigation or test results? **(Do not tell us about genetic testing or genetic test results.)** ☐ Yes ☐ No
4) Has the proposed insured **ever** had any applications for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? ☐ Yes ☐ No

4 Additional evidence required (continued)

Give details for all '**yes**' answers to questions 1 - 4 in the box below.

Question number	Details

5 Beneficiary

In this section, *you* and *your* refer to the proposed owner.

Note: For Early death benefit (EDB) election on Joint last--to-die with the Insurance amount plus policy fund, complete the form *Early death benefit beneficiary election or change* (E272).

Beneficiary for this new/additional coverage.

a) Primary beneficiaries (Share of benefits must add up to 100%.)

Notes:

- In Quebec, the share of the predeceasing beneficiary will pass on to the surviving beneficiary(ies) of the same level only if you have designated beneficiaries to receive death benefits in equal shares. In cases of unequal shares, the predeceased beneficiary's share will revert to you or your estate.
- In Quebec, if you name your legal spouse (by marriage or civil union) as the beneficiary, this designation will be irrevocable unless you check the Revocable box in the beneficiary designation sections in a) and b).

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation	% share of benefits to be paid	
				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		Total 100%

b) Contingent beneficiaries (Share of benefits must add up to 100%.)

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation	% share of benefits to be paid	
				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		Total 100%

c) Trustee for a minor beneficiary (Complete when a minor beneficiary has been named in beneficiary designations a) or b).)

In all provinces other than Quebec, if you designate minor children as beneficiaries, you should also name a trustee to receive funds on their behalf.

In Quebec, any amount payable to a minor beneficiary during their minority will be paid to the parent(s) or legal guardian of the minor child.

I appoint _____ as a trustee to receive any payments on behalf of any named beneficiary, during their minority. The trustee may apply such payments solely for the support, maintenance, education and benefit of such beneficiary at the discretion of the trustee.

6 Acknowledgement of variability

In this section, *I* refers to the proposed owner.

I acknowledge there are many variables that can affect an insurance policy's performance, including the following (where applicable):

- the type of and future investment performance of the Investment account option(s) selected
- the future investment performance of the participating account
- future dividend scales
- the timing and amount of future payments to and withdrawals from the policy
- the cost of insurance
- mortality and morbidity rates, lapse rates and expenses
- policy loans, and
- future federal income tax rules and provincial income and premium taxes.

More specifically, I understand interest rates, future dividend scales, and the performance of securities markets in particular can fluctuate significantly and that even a small change in any one of these variables could have a dramatic negative or positive impact on the policy's non-guaranteed benefits and values. I understand that past performance does not predict nor is it a good indicator of future results.

I acknowledge that any illustrations shown to me in connection with the sale of the policy will not become part of the policy and were provided solely to show me how policy values may change over time based on different sets of assumptions.

I understand that, unless indicated as "Guaranteed", the benefits and values in an illustration are not guaranteed, are hypothetical only and are based on assumptions that are certain to change. I realize they are neither an estimate nor a guarantee of future policy performance.

I understand actual results will differ upward or downward from those illustrated, because they are highly dependent upon a number of variables (including those listed above) and that even a small change in any one of these variables could have a dramatic negative or positive impact on the non-guaranteed figures shown in an illustration.

7 Identity verification, third party determination and politically exposed persons (PEP)/head of an international organization (HIO)

Completion of this section is mandatory if:

- this application is for universal or permanent life insurance, and
- any proposed owner **is an individual.**

Notes:

- In this section, *you* and *your* refer to the proposed owner(s), which includes sole proprietors.
- The questions must be answered by the proposed owner(s) of this application.
- If any proposed owner **is not an individual** (*ie Corporation or other entity*), forms 4381 (*Identity verification and third party determination for entity owners*) and 4545 (*International tax classification for an entity*) must be completed for that proposed owner.
- Form 4355 (*Non face-to-face identity verification by agent or mandatory, third party determination and politically exposed persons (PEP)*) must be completed for any proposed owner who:
  - **is a Canadian resident but is not present at the time this application is being completed**, or
  - **does not reside in Canada**.

Always verify the identity of clients and find out whether any third parties are involved. This helps Sun Life Financial to manage risk and to comply with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and other relevant legislation/regulations.

If additional space is required for any part of this section, complete form 4830 for each proposed owner.

If you have completed form 4830, indicate how many have been completed for this application: ☐

Identity verification

Proposed owner 1's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Detailed occupation/pre-retired occupation/principal business

Residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.	Apartment or suite

City	Province/State	Country	Postal/Zip code

Identification method - Complete one of the below methods (a or b). Record all the information; do not attach photocopies.

☐ a) Photo identification:

View an original, valid and current Canadian passport, driver's licence or document issued by a Canadian federal, provincial or territorial government for that individual. A foreign photo identification document is acceptable if it is equivalent to an acceptable Canadian photo identification document.

Type of document	Document number	Document expiry date (dd-mm-yyyy)	Province of issue	Country of issue	Date of verification (dd-mm-yyyy)

☐ b) Dual process:

View 2 original, valid and current documents from 2 different independent and reliable sources. Must collect all information from 2 out of the 3 options listed below;

1. Name and address.
2. Name and date of birth.
3. Name and proof of Canadian deposit account, or Canadian loan account.

Note: Some examples of acceptable reliable sources would be: federal, provincial, territorial and municipal levels of government, crown corporations, financial entities or utility providers. Detailed information is required (i.e. CIBC/Union Gas/BC marriage certificate).

Source 1	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)

7 Identity verification, third party determination and politically exposed persons (PEP)/head of an international organization (HIO) (continued)

Proposed owner's 2 first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Detailed occupation/pre-retired occupation/principal business

Residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.	Apartment or suite

City	Province/State	Country	Postal/Zip code

Identification method - Complete one of the below methods (a or b). Record all the information; do not attach photocopies.

☐ a) Photo identification:

View an original, valid and current Canadian passport, driver's licence or document issued by a Canadian federal, provincial or territorial government for that individual. A foreign photo identification document is acceptable if it is equivalent to an acceptable Canadian photo identification document.

Type of document	Document number	Document expiry date (dd-mm-yyyy)	Province of issue	Country of issue	Date of verification (dd-mm-yyyy)

☐ b) Dual process:

View 2 original, valid and current documents from 2 different independent and reliable sources. Must collect all information from 2 out of the 3 options listed below;

1. Name and address.
2. Name and date of birth.
3. Name and proof of Canadian deposit account, or Canadian loan account.

Note: Some examples of acceptable reliable sources would be: federal, provincial, territorial and municipal levels of government, crown corporations, financial entities or utility providers. Detailed information is required (i.e. CIBC/Union Gas/BC marriage certificate).

Source 1	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)

7.1 Third party determination

Types of a third party include but are not limited to:

• Payor • Attorney (Power of Attorney) or Mandatary • Collateral Assignee/Hypothecary Creditor

Is the contract to be paid for by a third party or used by or on behalf of a third party? ☐ Yes ☐ No

If '**yes**', what is the type of third party? ☐ Individual ☐ Entity ☐ Both

Name (If individual, indicate first name, middle initial and last name)	If individual, date of birth (dd-mm-yyyy)

Type of third party	Relationship to proposed owner	Detailed occupation/pre-retired occupation/principal business

Address/residential address (street number and name) **Note:** PO Box and General Delivery addresses are not acceptable.	Apartment or Suite

City	Province/State	Country	Postal/Zip code

If an entity, registration number	Province/State of registration	Country of registration

7 Identity verification, third party determination and politically exposed persons (PEP)/head of an international organization (HIO) (continued)

Name (If individual, indicate first name, middle initial and last name)			If individual, date of birth (dd-mm-yyyy)
Type of third party	Relationship to proposed owner	Detailed occupation/pre-retired occupation/principal business	
Address/residential address (street number and name) **Note:** PO Box and General Delivery addresses are not acceptable.			Apartment or Suite
City	Province/State	Country	Postal/Zip code
If an entity, registration number	Province/State of registration	Country of registration	

If unable to obtain any required information for any third party, record the measures taken and why you were unsuccessful below:

7.2 Politically exposed persons (PEP)/Head of international organization (HIO)

To the best of every proposed owner's knowledge, has any proposed owner, their family members or close associates, held any of the positions indicated in a), b) or c) below? Indicate **Yes** or **No** in a), b) and c) below.

Record all that apply in the charts below.

Notes:

- Family member means spouse, civil union spouse or common-law partner, children/step children, siblings/half siblings/step siblings of any proposed owner, biological/adoptive/step parent of any proposed owner, biological/adoptive/step parent of spouse, civil union spouse or common-law partner.
- Close associate is someone who is closely associated with any proposed owner for personal or business reasons. Examples of circumstances that may lead to the determination that someone is closely associated with any proposed owner include, but are not limited to:
  - Transactions that occur between a PEP or an HIO and any proposed owner;
  - Business activities between a PEP or an HIO and any proposed owner;
  - Media coverage linking a PEP or an HIO and any proposed owner; or
  - A personal relationship such as a romantic relationship or close friendship between a PEP or an HIO and any proposed owner.

a) Politically exposed foreign persons (PEFP) - (living or deceased, current or ever held) ..... ☐ Yes ☐ No

1. member of the executive council of government
2. president (head) of a state-owned company
3. president (head) of a state-owned bank
4. deputy minister (or equivalent rank) in government
5. ambassador
6. counsellor of an ambassador
7. attaché
8. leader (or president) of a political party represented in a legislature
9. head of state
10. head of government
11. head of a government agency
12. judge of a supreme court, constitutional court or other court of last resort
13. military officer with a rank of general or above
14. member of a legislature

Proposed owner's first name	Middle initial	Last name	
First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner's first name	Middle initial	Last name	
First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

7 Identity verification, third party determination and politically exposed persons (PEP)/head of an international organization (HIO) (continued)

b) Politically exposed domestic persons (PEDP) - (living or deceased, current or in the last 5 years) ..... ☐ Yes ☐ No

1. governor general
2. lieutenant governor
3. member of the Senate
4. member of the house of commons
5. member of a legislature
6. deputy minister (or equivalent rank) in government
7. ambassador
8. counsellor of an ambassador
9. attaché
10. military officer with a rank of general or above
11. president of a corporation that is wholly owned directly by Her Majesty in right of Canada or a province
12. head of a government agency
13. judge of an appellate court in a province
14. judge of the federal court of appeal
15. judge of the supreme court of Canada
16. leader (or president) of a political party represented in a legislature
17. holder of any prescribed office or position
18. mayor

Proposed owner's first name	Middle initial	Last name	
First name (PEDP) If not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner's first name	Middle initial	Last name	
First name (PEDP) If not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

c) Head of an international organization (HIO) - (currently held) ..... ☐ Yes ☐ No

An individual is an HIO if the individual is the head of an international organization or the head of an institution established by an international organization. An international organization is an organization set up by the governments of more than one country and established by means of a formally signed agreement between those governments.

Examples of international organizations include, but are not limited to:

- North Atlantic Treaty Organization (NATO)
- Organization for Economic Co-operation and Development (OECD)
- International Monetary Fund (IMF)
- World Bank Group
- World Health Organization (WHO)
- La Francophonie

Proposed owner's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Source of payment and purpose of product

7.3 Provide the source of payment for this application (Select all that apply.)

- ☐ salary or earned income
- ☐ existing investment account
- ☐ proceeds from death benefits or estate
- ☐ social benefits
- ☐ other (give details below)
- ☐ proposed owner's savings
- ☐ pension income
- ☐ sale of property
- ☐ borrowed funds
- ☐ business income
- ☐ gifted funds
- ☐ inherited funds

7.4 What is the purpose and intended use of the product applied for? (Select one only.)

- ☐ income replacement
- ☐ mortgage protection
- ☐ creditor protection
- ☐ asset protection
- ☐ estate protection
- ☐ business protection
- ☐ charitable donation
- ☐ tax or estate planning
- ☐ other (give details below)

8 Temporary insurance (Not available on reinstatements or reconsideration of ratings.)

In this section, *you,* in questions 1 - 3, refers to the proposed insured.

Notes:

- The questions in section 8 must be answered by the proposed insured. If the proposed insured is under 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.
- If questions 1, 2 or 3 are answered '**yes**' or not answered, there is no temporary insurance coverage. **Review the Certificate of temporary insurance with your clients so they understand the terms, conditions and exclusions that apply to temporary insurance.**

First name	Middle initial	Last name

1) Within the **last 12 months**, have you consulted a doctor for chest pain, any known or suspected heart attack, stroke, cancer or HIV/AIDS? ☐ Yes ☐ No

2) Have you **ever** applied for life, critical illness, or health insurance and been refused coverage or been offered coverage that is modified in any way? ☐ Yes ☐ No

3) Within the **last 60 days**, have you been admitted or advised to be admitted to a hospital or clinic as an in-patient **(excluding pregnancy or childbirth)**, or have you been advised to have any tests or surgery not yet done? ☐ Yes ☐ No

9 Personal information

In this section, *you* and *your* refer to the proposed insured.

Note: The questions in section 9 must be answered by the proposed insured. If the proposed insured is under 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.

It's important you provide complete and true information for us to assess your application. If you're not sure whether some information is relevant, provide it anyway. If you fail to provide all relevant information that you know about, future claims could be denied and any policy we've issued declared void. Do not tell us about genetic testing or genetic test results.

Consent to use your existing evidence

1 a) In the **last 9 months**, have you completed an application for life or critical illness insurance with Sun Life Financial? ☐ Yes ☐ No

If '**yes**', indicate the policy number. Policy number

If '**no**', proceed to 9.1.

b) For this change being applied for, should we use your answers and statements provided to us in writing or orally from the policy listed above? ☐ Yes ☐ No

If '**no**', proceed to 9.1.

c) Do you confirm there has been no change in health, occupation or other circumstances that would require a change to any of your answers or statements from the policy listed above? ☐ Yes ☐ No

If '**no**', proceed to 9.1.

d) Do you confirm your previous answers and statements from the policy listed above have been reviewed carefully and they are complete and true? ☐ Yes ☐ No

If '**yes**', indicate the evidence you reviewed (Indicate all that apply.): ☐ Application ☐ Tele-interview ☐ Paramedical ☐ Other _____

If '**no**', proceed to 9.1.

- If '**yes**' to all 1 a) through d), proceed to section 14.
- This consent will form part of your insurance application and any misrepresentation may result in Sun Life Financial declining any application(s) or terminating any existing policy(ies).
- If any further evidence of insurability is needed, you will be notified by your advisor.

9.1 Smoking and tobacco use

Note: Question 9.1 does not need to be answered for proposed insureds under the age of 16.

In the **last 5 years**, have you smoked or used cigarettes, cigarillos, small or large cigars, pipes, betelnut, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ☐ Yes ☐ No

If '**yes**', provide details.

Product(s)	**Amount(s) and frequency of use**	**Date(s) last used (dd-mm-yyyy)**

9 Personal information (continued)

9.2 Insurance history and replacement/disclosure statements and/or Life Insurance Replacement Declarations

a) Do you have any existing life and/or critical illness insurance in force on your life? ☐ Yes ☐ No

If '**yes**', complete the following.

Date(s) issued (mm-yyyy)	Plan type(s)	Amount(s) (including benefits)	Company name(s)	Replacing	Business or personal
	☐ Life ☐ CII			☐ Yes ☐ No	☐ Business ☐ Personal

b) Comparison disclosure statement and/or Life Insurance Replacement Declaration is required by regulation for a life insurance application that will replace an existing policy or application.

Is this application intended to replace or reduce the benefits of any existing insurance policy or a pending insurance application of any company (other than by conversion)? ☐ Yes ☐ No

Notes:

- If '**yes**', complete and attach the required applicable replacement disclosure form.
- For critical illness insurance applications, a replacement form is required for Quebec applications only.
- If more than one policy is being replaced, a separate replacement disclosure form is required for each policy being replaced.

c) Do you have any applications for life, disability, critical illness or long term care insurance **currently** pending or contemplated? ☐ Yes ☐ No

If '**yes**', provide details below.

Company name(s)	Plan type(s)	Amount(s) applied for	Total amount of new insurance to be put into effect with all companies

d) Have you **ever** had any applications for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? ☐ Yes ☐ No

If '**yes**', indicate when, which company and why in the box below.

9.3 Employment information

Note: Question 9.3 does not need to be answered for proposed insureds under the age of 16.

a) What is your occupation?

b) What are your occupational duties?

c) What is your employer's name and address?

9.4 Financial information

Note: Questions in 9.4 do not need to be answered for proposed insureds under the age of 16.

a) What is your annual earned income, including salary, commissions and bonuses? $

b) What is your annual unearned income from other sources, including pensions, dividends, interest and income from real estate? $

c) What is your personal Canadian net worth? $

d) What is your personal foreign net worth? $

9 Personal information (continued)

e) In the **last 5 years**, have you declared or been petitioned into personal or corporate bankruptcy? ..... ☐ Yes ☐ No
If '**yes**', provide details below.

Date discharged (dd-mm-yyyy)	Circumstances of bankruptcy

f) If a proposed insured is financially dependant on their spouse, provide the following information on the income earner, if not already indicated in this application.

Spouse's annual income	Amount of life insurance in force on the spouse	Amount of CII in force on the spouse
$	$	$

9.5 Drug and alcohol use

Note: Questions in 9.5 do not need to be answered for proposed insureds under the age of 16.

a) In the **last 10 years**, have you used marijuana or hashish, cocaine, LSD, ecstasy or other psychoactive drugs, heroin, fentanyl or other narcotics, anabolic steroids or other performance enhancing drugs? ..... ☐ Yes ☐ No
If '**yes**', complete the following:

Product(s)	Amount(s) and frequency of use	Date last used (dd-mm-yyyy)
☐ marijuana or hashish mixed with tobacco		
☐ marijuana or hashish without tobacco		
☐ other _____		
☐ other _____		

b) Do you currently drink alcohol? ..... ☐ Yes ☐ No
If '**yes**', provide details below.

Product(s) Indicate all that apply	Amount(s) consumed and frequency of use		
☐ Beer ☐ Wine ☐ Liquor	Beer: Number of bottles: _____ per ☐ day ☐ week or ☐ month	Wine: Number of glasses: _____ per ☐ day ☐ week or ☐ month	Liquor: Number of oz: _____ Number of ml: _____ per ☐ day ☐ week or ☐ month

c) Have you **ever** received treatment or been told to reduce use or frequency of use, seek treatment, counselling or medical advice due to your use of drugs or alcohol? ..... ☐ Yes ☐ No
If '**yes**', complete and attach the appropriate *Alcohol usage* (E26) and/or *Drug questionnaire* (E12).

9.6 Driving history

Note: Questions in 9.6 do not need to be answered for proposed insureds under the age of 16.

Have you been charged with or convicted of:

a) in the **last 10 years**, an alcohol or drug related driving offence or refusing a breathalyzer test? ..... ☐ Yes ☐ No

b) in the **last 3 years**, any other driving offences **(Exclude tickets for parking and failure to provide insurance or ownership cards.)**? ..... ☐ Yes ☐ No

Note: If '**yes**' to a) or b), provide details below. For speeding convictions, include the number of kilometres per hour over the speed limit.

Date(s) of offence(s) (dd-mm-yyyy)	Type(s) of offence(s)	Details

9 Personal information (continued)

9.7 Foreign residence/travel

a) In the **last 12 months**, have you **travelled** or **resided** outside of Canada? ☐ Yes ☐ No
(Exclude travel or residence of less than 6 months in the United States.)

If '**yes**', provide details below.

Countries and cities	Length of stay in each	Purpose of stay in each	Date(s) of travel (mm-yyyy)

b) In the **next 12 months**, do you intend to **travel** or **reside** outside of Canada? ☐ Yes ☐ No
(Exclude travel or residence of less than 6 months in the United States.)

If '**yes**', provide details below.

Countries and cities	Length of stay in each	Purpose of stay in each	Date(s) of travel (mm-yyyy)

9.8 Other information

Note: Questions in 9.8 do not need to be answered for proposed insureds under the age of 10.

a) In the **last 12 months**, have you flown in an aircraft as a pilot, crew member or flight attendant, or do you intend to do so in the **next 12 months**? ☐ Yes ☐ No

If '**yes**', complete and attach an *Aviation questionnaire* (E4).

b) In the **last 12 months**, have you participated in motorized racing, underwater diving, mountain climbing, skydiving, hang gliding, heli-skiing, backcountry or out of bounds skiing/snowboarding/snowmobiling or any other dangerous activity, or do you intend to do so in the **next 12 months**? ☐ Yes ☐ No

If '**yes**', complete and attach the appropriate questionnaire.

c) In the **last 10 years**, have you been charged with, convicted of or imprisoned for any criminal offence; or are you currently on probation, parole or statutory release? ☐ Yes ☐ No

If '**yes**', provide details below.

Details

9.9 Individual insurance for a child

Note: Complete the following section if the proposed insured is under the age of 16 and applying for individual life (excluding CTB).

a)

Relationship of proposed owner to the proposed insured	
Does the proposed insured live with the proposed owner? ☐ Yes ☐ No	If '**no**', with whom and where does the proposed insured live (name, city/town)?
Does the proposed owner have full knowledge of the proposed insured's medical history? ☐ Yes ☐ No If '**no**', provide name and relationship of person who is providing the required personal and medical information on this child. This person must also sign on page 28.	

b) What is the total amount of existing and applied for life, critical illness, disability and long term care insurance and the annual earned income on one of the parents?

Life	Critical illness	Disability	Long term care	Annual earned income
$	$	$	$	$

c) What is the total amount of existing and applied for life, critical illness, disability and long term care insurance and the annual earned income on the other parent?

Life	Critical illness	Disability	Long term care	Annual earned income
$	$	$	$	$

9 Personal information (continued)

d) What is the Canadian net worth of the parents? $

e) What is the foreign net worth of the parents? $

f) Does the proposed insured have any siblings age 15 or less? ☐ Yes ☐ No
If '**no**', proceed to section 10.

i) If '**yes**', for all insurable siblings age 15 or less, is there a similar amount of life and/or critical illness insurance in force, currently pending or contemplated? ☐ Yes ☐ No

ii) If '**no**' to i) **and applying for life insurance coverage**, provide the sibling's amount of insurance and reason for the difference in the box below.

iii) If '**no**' to i) **and applying for critical illness insurance coverage**, provide the sibling's amount of insurance and reason for the difference in the box below.

10 Medical advisor/clinic information

Name and address of usual medical advisor or medical clinic.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured. If the proposed insured is under 16 (18 in Quebec), signed and dated by the proposed insured's parent or legal guardian.

a) Do you have a usual medical advisor or clinic? ☐ Yes ☐ No	If '**yes**', name of usual medical or health care advisor or medical clinic.		
Address		City	Province
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
Answer b) if '**yes**' to a). b) In the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No			If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).
Answer c) if '**no**' to a). c) In the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No			If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).
If '**yes**', name and address of doctor consulted.			

11 Family history

In this section, *you* and *your* refer to the proposed insured.

The questions in this section must be answered by the proposed insured. If the proposed insured is under 16 (18 in Quebec), the questions must be answered by the proposed insured's parent or legal guardian.

Note: Questions in 11 do not need to be completed for proposed insureds **over the age of 65**. **Do not tell us about genetic testing or genetic test results.**

a) Have any of your parents, brothers or sisters been diagnosed **before age 65** with heart disease, stroke/TIA, cancer (including leukemia, lymphoma and Hodgkin's disease), diabetes or Parkinson's disease? ☐ Yes ☐ No

11 Family history (continued)

b) Have any of your parents, brothers or sisters **ever** been diagnosed with Huntington's disease, polycystic kidney disease (PKD), multiple sclerosis (MS), muscular dystrophy, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or any other hereditary disease or disorder? .. ☐ Yes ☐ No

If '**yes**' to a) or b), complete the following chart.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured or proposed owner.

Relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

12 Height and weight

12.1 Proposed insureds over the age of 10

Note: If more space is required, use a separate sheet signed and dated by the proposed insured.

Height	Weight	In the last 12 months, has there been a weight loss of more than 4.5 kg (10 lbs)?
☐ ft/in ☐ cm	☐ lb ☐ kg	☐ Yes ☐ No If '**yes**', provide details including amount of weight lost and cause of the weight loss.

12.2 Children age 1 to 10

a) In the **last 2 years**, have you been told by a doctor or health practitioner that your height, weight or physical development were not meeting normal developmental milestones? ..... ☐ Yes ☐ No

b) In the **last 2 years**, have you been told by a doctor or health practitioner to gain or lose weight or to follow a diet? ..... ☐ Yes ☐ No

c) In the **last 12 months**, have you had a weight loss of more than 4.5 kg (10 lbs)? ..... ☐ Yes ☐ No

If '**yes**' to a), b) or c), indicate your current measured height ☐ ft/in ☐ cm and weight ☐ lb ☐ kg.

Provide details including diagnosis and doctor's recommendations. If there has been any weight loss in the **last 12 months**, indicate amount of weight loss and cause of the weight loss.

12.3 Children under the age of 1

a) Was the birth premature by more than 4 weeks or is there any indication of failure to thrive or gain weight? ..... ☐ Yes ☐ No

b) Have you been told by a doctor or health practitioner that your height, weight or physical development were not meeting normal milestones? ..... ☐ Yes ☐ No

If '**yes**' to a) or b), indicate your birth weight ☐ lb ☐ kg, and your current measured height ☐ ft/in ☐ cm and weight ☐ lb ☐ kg.

Provide details including current status and any other relevant information.

13 Personal medical history

13.1 Medical information

In this section, *you* and *your* refer to the proposed insured. The questions must be answered by the proposed insured. If a proposed insured is under age 16 (18 in Quebec), the questions must be answered by the proposed insured's parent or legal guardian.

a) Heart and circulatory system

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No

- high blood pressure
- high cholesterol
- angina
- chest pain
- heart attack
- coronary artery disease (CAD)
- transient ischemic attack (TIA)
- stroke or cerebrovascular accident (CVA)
- heart murmur
- irregular pulse
- blood clot(s)
- peripheral vascular disease (poor circulation)
- aneurysm
- any other disease or disorder of the heart or blood vessels

If '**yes**' has been answered to any condition in a), provide details below. List each condition along with all related treatments, dates, durations, results, names and addresses of doctors, hospitals and clinics consulted.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured.

Details

b) Abnormal growths or malignancy

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No

- cancer
- leukemia
- lymphoma
- melanoma
- dysplastic nevus (atypical mole)
- basal cell carcinoma
- tumour
- cyst(s)
- polyp(s)
- any other growths or malignancy

If '**yes**' has been answered to any condition in b), provide details below. List each condition along with all related treatments, dates, durations, results, names and addresses of doctors, hospitals and clinics consulted.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured.

Details

c) Glands and/or endocrine system

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No

- diabetes
- gestational diabetes
- abnormal blood sugar
- goitre
- hyperthyroidism
- hypothyroidism
- lymph or gland disease or disorder
- any other thyroid, pituitary or endocrine disease or disorder

If '**yes**' has been answered to any condition in c), provide details below.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured.

Details

d) Blood

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No

- anemia
- hemophilia
- any other blood or bleeding disease or disorder

If '**yes**' provide details in section 13.3.

13 Personal medical history (continued)

e) Gastrointestinal system

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- hepatitis (including hepatitis carrier state)
- cirrhosis
- jaundice
- Crohn's disease
- ulcerative colitis
- irritable bowel syndrome
- diverticulitis
- persistent diarrhea
- rectal or intestinal bleeding
- ulcer (peptic or gastric)
- pancreatitis
- any other disease or disorder of the bowel, esophagus, stomach, pancreas or liver

If '**yes**' provide details in section 13.3.

f) Eyes, ears, nose, throat and mouth

Have you **ever** been treated for or had any symptoms or indication of (**excluding routine check-ups where no follow-up is required, such as tonsillectomy, adenoidectomy, sinusitis or any other disorder requiring eye glasses, contact lenses or ear tubes**): ☐ Yes ☐ No

- blindness
- permanent or temporary loss of vision in either eye
- glaucoma
- optic neuritis
- deafness
- impaired hearing
- labyrinthitis
- any other disease or disorder of the eye, ears, nose, throat or mouth

If '**yes**' provide details in section 13.3.

g) Respiratory system

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- asthma
- chronic obstructive pulmonary disease (COPD)
- emphysema
- chronic or recurrent bronchitis
- sleep apnea
- sarcoidosis
- cystic fibrosis
- tuberculosis
- persistent cough
- hoarseness
- shortness of breath or difficulty breathing
- any other respiratory disease or disorder

If '**yes**' provide details in section 13.3.

h) Mental health

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- chronic anxiety
- depression
- burnout
- chronic fatigue syndrome
- attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
- eating disorder
- schizophrenia
- attempted suicide
- any other psychological, emotional or nervous disease or disorder

If '**yes**' provide details in section 13.3.

i) Skin and connective tissue

Have you **ever** been treated for or had any symptoms or indication of (**excluding poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema**): ☐ Yes ☐ No

- lupus
- scleroderma
- any other skin or connective tissue disease or disorder

If '**yes**' provide details in section 13.3.

j) Genitourinary system

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- abnormal prostate specific antigen (PSA)
- prostatitis or any other prostate disease or disorder
- breast lump(s) or cyst(s)
- abnormal mammogram
- abnormal pap smear
- hysterectomy
- disease or disorder of the ovary or uterus
- sexually transmitted disease
- disease or disorder of the genital organs
- kidney stone(s)
- nephritis
- urinary tract infection
- sugar, blood or protein in the urine
- any other kidney or bladder disease or disorder

If '**yes**' provide details in section 13.3.

k) Musculoskeletal system

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- arthritis
- fibromyalgia
- muscular dystrophy
- paralysis
- numbness or weakness of an arm or leg
- any other disease or disorder of the muscles, joints, limbs, back or bones

If '**yes**' provide details in section 13.3.

13 Personal medical history (continued)

l) Nervous system

Have you **ever** been treated for or had any symptoms or indication of: ☐ Yes ☐ No

- autism
- cerebral palsy
- Down syndrome
- developmental delay
- epilepsy or seizure(s)
- multiple sclerosis (MS)
- loss of balance, consciousness, sensation or speech
- coma
- concussion
- severe headache(s) or migraine(s)
- dizziness
- fainting
- Parkinson's disease
- Huntington's disease
- tremor
- Alzheimer's disease
- dementia or cognitive impairment
- amyotrophic lateral sclerosis (ALS)
- any other disease or disorder of the brain or nervous system

If '**yes**' provide details in section 13.3.

13.2 Medical tests and consultations

a) **Have** you **ever** been tested for or has anyone **ever** recommended that you should be tested for exposure to the HIV(AIDS) virus? ☐ Yes ☐ No

b) **Have** you **ever** been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system? ☐ Yes ☐ No

c) In the **last 5 years**, have you had any medical or diagnostic tests, such as ECG, scans, MRI, ultrasounds, biopsies, blood or urine tests? (**Exclude any tests you've already told us about in this application. Do not tell us about genetic testing or genetic testing results.**) ☐ Yes ☐ No

d) Are you pregnant? ☐ Yes ☐ No

If '**yes**', indicate which trimester and pre-pregnancy weight:

☐ 1st (1-3 months)

☐ 2nd (4-6 months)

☐ 3rd (7-9 months)

Pre-pregnancy weight ☐ lb ☐ kg

e) **Other than for conditions already disclosed**, in the **last 5 years**, have you had an illness or injury which prevented you from performing your usual activities or the regular duties of your occupation for a period **exceeding 2 weeks**? ☐ Yes ☐ No

f) Do you have any symptoms for which you have not yet consulted a physician or received treatment? (**Exclude common cold, flu or seasonal allergy symptoms.**) ☐ Yes ☐ No

g) **Other than for conditions already disclosed**, has a doctor or other health care advisor requested any tests or made any referrals that have not yet been completed, or are you currently awaiting test results? (**Do not tell us about genetic testing or genetic testing results.**) ☐ Yes ☐ No

h) **Other than for conditions already disclosed**, in the **last 5 years**, have you been admitted to a hospital or made any other medical facility for 24 hours or more? (**Exclude miscarriage, vasectomy, tubal ligation, appendectomy, hernia repair, child birth, cosmetic surgery or gall bladder surgery.**) ☐ Yes ☐ No

i) **Other than for conditions already disclosed**, have you been prescribed or are you taking any prescription medications? ☐ Yes ☐ No

If '**yes**' to any question in a) - i), provide details in section 13.3.

13.3 Details

If '**yes**' to any conditions in 13.1 d) - l), and 13.2, provide details below. List each condition along with all related treatments, dates, durations, results, names and addresses of doctors, hospitals and clinics consulted.

Note: If more space is required, use a separate sheet signed and dated by the proposed insured.

Question number(s)	Details

14 Child(ren) to be insured under a child term benefit

Note: Complete this section only if you are applying for a child term benefit.

In this section, *you* refers to the proposed insured.

The proposed insured may cover their biological, adopted or step-children under a child term benefit. Provide the following information for **each** child to be insured under this benefit.

Child	First name	Middle initial	Last name	Relationship to proposed insured	Sex	Date of birth (dd-mm-yyyy)
1				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
2				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
3				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
4				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
5				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	

Do all of the listed children live with you? ..... ☐ Yes ☐ No

If '**no**', complete the following.

Child 1	First name of person the child lives with	Middle initial	Last name		Relationship to child	
	Residential address (street number and name)		Apartment or suite	City	Province	Postal code
Child 2	First name of person the child lives with	Middle initial	Last name		Relationship to child	
	Residential address (street number and name)		Apartment or suite	City	Province	Postal code
Child 3	First name of person the child lives with	Middle initial	Last name		Relationship to child	
	Residential address (street number and name)		Apartment or suite	City	Province	Postal code
Child 4	First name of person the child lives with	Middle initial	Last name		Relationship to child	
	Residential address (street number and name)		Apartment or suite	City	Province	Postal code
Child 5	First name of person the child lives with	Middle initial	Last name		Relationship to child	
	Residential address (street number and name)		Apartment or suite	City	Province	Postal code

Do you have full knowledge of each child's medical history? ..... ☐ Yes ☐ No

If '**no**', is the person who has the most knowledge of the medical history of the children present? ..... ☐ Yes ☐ No

Note: If not present, this benefit may not be applied for at this time.

If '**yes**', provide the name and relationship of the person answering the questions on behalf of the children.

Name of person answering questions	Relationship to the children

Has any application for insurance on any of the children **ever** been declined, rated or modified in any way? ..... ☐ Yes ☐ No

14 Child(ren) to be insured under a child term benefit (continued)

1. Has any child **ever** been treated for or had any symptoms or indication of:
   a) heart murmur or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
   b) cancer, leukemia or any other growths or malignancy? ☐ Yes ☐ No
   c) diabetes or any other thyroid or endocrine disease or disorder? ☐ Yes ☐ No
   d) hemophilia, bleeding disorder or any other blood disease or disorder? ☐ Yes ☐ No
   e) Crohn's disease, ulcerative colitis, hepatitis or any other disease or disorder of the bowel, stomach or liver? ☐ Yes ☐ No
   f) asthma, cystic fibrosis, tuberculosis or any other respiratory disease or disorder? ☐ Yes ☐ No
   g) depression, anxiety, attention deficit disorder or any other psychological, emotional or nervous disease or disorder? ☐ Yes ☐ No
   h) disease or disorder of the kidney or urinary tract? ☐ Yes ☐ No
   i) muscular dystrophy, multiple sclerosis or any other neurological disease or disorder? ☐ Yes ☐ No
   j) Down syndrome, developmental delay, autism, cerebral palsy or any other congenital disease or disorder? ☐ Yes ☐ No
   k) epilepsy, seizure or any other disease or disorder of the brain? ☐ Yes ☐ No
2. Has any child **ever** been tested for exposure to the HIV (AIDS) virus? ☐ Yes ☐ No
3. Are there any medical conditions, not already mentioned, for which any child had or is awaiting investigation, treatment or is under observation? (**Exclude routine check-ups where no follow-up is required, colds, flu, tonsillectomy, adenoidectomy, appendectomy, hernia repair and tubes in ears. Do not tell us about genetic testing or genetic test results.**) ☐ Yes ☐ No

If '**yes**' to any questions in 1 - 3, provide details below.

	Question number(s)	**Details**
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		

14 Child(ren) to be insured under a child term benefit (continued)

The following questions must be answered by the proposed insured when adding CTB to an existing policy.

4. Are you currently claiming on your disability benefit? ☐ Yes ☐ No
5. Have you **ever** been treated for or had any symptoms or indication of:
   a) heart attack or any other heart disease or disorder, stroke/TIA, cancer or any other growth(s) or malignancy, diabetes or kidney, lung or liver disease or disorder? ☐ Yes ☐ No
   b) AIDS, HIV infection or any other disease or disorder of the immune system? ☐ Yes ☐ No
6. Are you aware of any symptoms for which you have not yet consulted a physician or received treatment? ☐ Yes ☐ No
7. Have you **ever** had any medical conditions, not already mentioned, for which you have been or are being investigated, under observation or treated for, or for which you are currently awaiting investigation or test results? ☐ Yes ☐ No
8. Have you **ever** had any applications for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? ☐ Yes ☐ No

If '**yes**', to any questions in 4 - 8, provide details below.

15 Authorization to disclose information to your advisor

In this section, *you* and *your* refer to the proposed insured.

Purpose

If you check '**yes**' below, you give us permission to disclose your personal information to your advisor, who may use it to discuss insurance options with you.

We don't need this authorization to review and make a decision about your application.

Sharing of information

The information we may share with your advisor could include:

- medical testing and laboratory results
- other confidential personal information about illness, including mental illness, infectious diseases, other medical conditions or use of medications
- other information about your health discovered as we assess your application but that you may not know about when you apply
- drug and alcohol use and rehabilitation
- employment history and personal finances
- any record of criminal activity, and
- other facts about your life and how they affect our decision to insure you.

We may choose not to share information about you that we have obtained from a physician or medical facility where that information was not disclosed to us as part of the application process.

Authorization

By checking '**yes**' below, you authorize the company to share information about you:

- which was collected for underwriting this application, and
- only to the advisor indicated in the box below.

Advisor's first name	Middle initial	Last name	Advisor code

By checking '**yes**' below, you also understand that:

- even though you have indicated '**yes**' below, we have the right to withhold highly sensitive personal information from your advisor
- you may cancel this authorization at any time by calling us at 1-877-SUN-LIFE (1-877-786-5433), and
- this authorization remains valid until 30 days after the later of the day we:
  (a) amend your existing policy (including reconsideration of a rating), as applied for
  (b) reinstate the existing lapsed policy indicated in this application, or
  (c) mail you a notice telling you that we have declined your application.

Does the proposed insured agree to the disclosure of their information? ☐ Yes ☐ No (If not indicated, answer is '**no**'.)

16 Payments

Notes:

- We do not accept cash payments.
- Complete this section if payment(s) are to be taken directly from the payor's bank account.
- Attach a cheque marked void with this application.

Banking information

Supply the following information:

Account holder's first name	Last name	Account holder's first name	Last name
Name of financial institution			
Address of financial institution (street number and name)			
City		Province	Postal code
Transit number	Account number		

Terms and conditions for pre-authorized chequing (PAC)

Note: All PAC payors must agree to the following terms in order to use the PAC payment option.

All PAC payors agree:

- Sun Life Assurance Company of Canada (company) may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from their bank account indicated in this application for insurance,
- all pre-authorized debits be processed as personal under the Payments Canada rules (this means having 90 calendar days from the date any payment is processed to claim reimbursement for any unauthorized payment),
- the withdrawal amount is considered variable under the Payments Canada rules,
- any notices to be sent to them under this agreement may be sent to the proposed owner/owner's most recent address that the company has on record at the time a notice is sent,
- the company may charge a fee and may cancel the PAC for any withdrawal that is not honoured,
- all persons, whose signatures are required to sign on the bank account indicated below, have signed section 19 as a PAC payor,
- the company may not assign this authorization to another company or person, in order to permit them to debit the PAC payor's account for these payments (e.g. where there has been a change in control of the company), without providing at least 10 days prior written notice, and
- to waive the requirement that the company notify them of:
  - this authorization before the first payment is processed
  - any subsequent payments, and
  - any changes to the amount or date of the payment initiated by them or the company.

Regular withdrawals will start one month from the date the application was signed or on _____ (dd-mm-yyyy).

The payor may cancel this authorization at any time, subject to providing the company with 10 days notice. Payors should contact their financial institution about their rights regarding cancellation. A sample cancellation form is available at *www.payments.ca*.

Payors have certain recourse rights if any debit does not comply with this agreement. For example, payors have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAC Agreement. To obtain more information on recourse rights, payors should contact their financial institution or visit *www.payments.ca*.

Contact us at any time at:

Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5
1-877-SUN-LIFE (1-877-786-5433)
Fax 1-866-487-4745
www.sunlife.ca

17 Special instructions

18 Translation agreement and declaration

Was this application translated for any proposed insured and/or proposed owner in a language other than English?

☐ Yes ☐ No

If '**yes**', you must complete the sub sections below.

Note: The translator must be 18 years of age or older and may not be:

- a beneficiary,
- a proposed owner, or
- any other person who has an interest in the policy (excluding the advisor).

18.1 Proposed insured and/or proposed owner agreement

In this section, *you* and *your* refer to the proposed insured and/or proposed owner.

1. Who was this application translated for in a language other than English? ☐ Proposed insured ☐ Proposed owner

2. Do you agree that your answers to the questions asked and translated for you are complete and true, and do you understand they form part of the application?

Proposed insured ☐ Yes ☐ No	Proposed owner ☐ Yes ☐ No

Note: If '**no**', we are unable to continue with your application at this time. The application must not be submitted.

3. Do you agree that this application was fully explained to you in your preferred language, and do you understand the content provided by the translator?

Proposed insured ☐ Yes ☐ No	Proposed owner ☐ Yes ☐ No

Note: If '**no**', we are unable to continue with your application at this time. The application must not be submitted.

4. Name of person who provided the translation:

Translator's first name	Middle initial	Last name

5. Translator's relationship to person translation was provided for:

Proposed insured	☐ Advisor ☐ Other Indicate:	Proposed owner	☐ Advisor ☐ Other Indicate:

6. In what language were the questions translated?

Proposed insured	Proposed owner

18.2 Translator's declaration/signature (if other than advisor)

In this sub-section, *you* refers to the translator.

By signing below, you declare that for any proposed insured and/or proposed owner indicated above in sub-section 18.1, you:

- faithfully and truly translated this application and the answers provided to you,
- read over the entire contents of this application and the answers provided to you were recorded, and
- explained the information and everyone understood the contents of this application and provided all requested information.

You also declare that you do not have any interest in this application and are age 18 or older.

Province signed	Date (dd-mm-yyyy)	Translator's signature
		X

19 Acknowledgement and agreement

Acknowledgement and agreement:

The proposed owners confirm they've received, read and agree to:

- the Certificate of temporary insurance, when applicable, and
- the Guide to critical illness definitions, if critical illness insurance was applied for.

The proposed owners and proposed insureds (if other than proposed owner) confirm they've received, read and agree to the Sun Life Financial Privacy Statement for Canada (found on the Important information you should know page).

Declaration:

The proposed owners, proposed insureds and pre-authorized chequing (PAC) payors confirm:

- they were present when their portion of this application with the Sun Life Assurance Company of Canada (company) was completed,
- they reviewed all their answers and statements recorded in this application,
- that all the information they supplied in connection with this application is complete and true, and was provided by them to the advisor (or some other person authorized by the company) for underwriting, administration of insurance and claims paying purposes,
- they understand that if they do not completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements) the company may void the policy,
- they agree that their personal, medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada (found on the page entitled Important information you should know),
- they have read and agree to the Acknowledgement of variability, if applicable,
- they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under the "Products and services" section of the website at *www.sunlife.ca* or by calling our toll-free Customer Care Centre at 1-877-SUN-LIFE (1-877-786-5433),
- they acknowledge that by signing below they:
  - are aware that changes made to policies issued prior to 2017 may result in a loss of grandfathering protection, which may have negative tax consequences, and
  - had an opportunity to discuss this with their financial, legal and tax advisors and understand the tax consequences that policy changes may cause.
- they understand the company is not responsible for the validity of any beneficiary appointments, and
- PAC payors, by signing below, agree to the terms of the PAC authorization, as set out in section 16.

The proposed insured confirms the information described in section 15 may be shared with their advisor if they answered '**yes**' in that section.

Authorization of all proposed insureds:

The proposed insureds (parent or legal guardian, if proposed insured is under age 16 (18 in Quebec)) authorize:

- any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigation agencies, MIB Inc. or other organization, institution or person, including the members of the Sun Life Financial group of companies, which includes this company, that have records or knowledge of any proposed insured, to give only that information necessary for underwriting, administration of insurance and claims paying purposes to the company, its representatives and its reinsurers,
- the performance of such examinations, electrocardiograms, blood profiles, and tests for HIV (AIDS) antibody and hepatitis, if needed to underwrite this application, and
- the company to release only the necessary personal information obtained during the underwriting process to their personal physician, to MIB, Inc., to the company's reinsurers, to any insurance company, if an application has been made to that company for an insurance policy on their life, and for any infectious or communicable disease, to the Medical Officer of Health where required by law.

Province signed	Date (dd-mm-yyyy)	Signature
	Signed on:	Proposed owner (indicate title of signing officers if applicable) X
	Signed on:	Proposed owner (indicate title of signing officers if applicable) X
	Signed on:	Proposed insured (if other than proposed owner or if under age 16 (18 in Quebec), signature of parent or guardian) X
	Signed on:	Proposed insured (if other than proposed owner) X
	Signed on:	PAC payor (if other than proposed owner or proposed insured) X
	Signed on:	PAC payor (if other than proposed owner or proposed insured) X

A copy of this authorization is as valid as the original.

20 Advisor's report

In this section, *you* and *your* refer to the advisor who is selling the policy.

Attach a business card.

About the proposed insured

Did you meet the proposed insured?	☐ Yes ☐ No	How long have you known the proposed insured?

Purpose of insurance:

☐ Stock repurchase ☐ Buy-sell agreement ☐ Creditor protection ☐ Income replacement

☐ Key person insurance ☐ Tax or estate planning ☐ Concept ☐ Deferred compensation

☐ Other, provide details in the box below

Indicate which underwriting requirements you have arranged for and/or will be submitting. (Select all that apply.)

Proposed insured additional evidence being submitted:

☐ None ☐ Paramedical ☐ Vitals ☐ Urine specimen ☐ Other (specify) _____

Provide name of insurance company we are to obtain medical evidence from

Provide name of service provider you have ordered the medical evidence from

Additional comments or special instructions

Business finances of the proposed insured

If coverage is for business-related needs, tell us about the business finances.

Percentage of business owned by the proposed insured %	Are other partners or owners also applying? If '**yes**', give details on each partner. ☐ Yes. Amount of insurance $ ☐ No. Give details		
Net worth of the business $			
Fair market value of the business $	Net after-tax business income	Last fiscal year $	Previous fiscal year $

Advisor information

Note: Shares must be a minimum of 10%.

Is commission being shared? ☐ Yes ☐ No. If '**yes**', provide details.

First name of lead service advisor sharing commission	Last name	Code	Share %	Office
First name of advisor sharing commission	Last name	Code	Share %	Office

Indicate distribution partner name (MGA or NA) as well as your own company or advisor address in the box below.

20 Advisor's report (continued)

Advisor declaration and notice of disclosure (Must be signed by advisor only.)

With the understanding that Sun Life Financial will rely on all the information collected to process this application to conduct consumer due diligence and to satisfy applicable regulatory requirements, I, the advisor, confirm that:

- all of the identification details provided in this application match the original identification documents shown to me;
- reasonable effort was exercised to determine if each proposed owner is acting on behalf of a third party;
- the dual purpose method for identity verification is not the preferred method. If I have used it in this application, I have only done so because the proposed owner/sole proprietor does not possess the required photo identification. I have ensured that the 2 documents viewed are originals from reliable and independent sources;
- I have disclosed to each proposed owner that I am an independent advisor that has a contract to sell products issued by Sun Life Assurance Company of Canada, and I have also identified any other companies I represent;
- I have disclosed to each proposed owner that I will receive compensation in the form of commissions or salary for the sale of life and health insurance products;
- I have disclosed to each proposed owner that I may also receive additional compensation in the form of bonuses or non-monetary benefits such as travel incentives or attendance at conferences;
- I have disclosed to each proposed owner any conflicts of interest that I may have with respect to this transaction; and
- I am licensed in the province in which this application was completed and this signature page was signed.

If indicated in the Translation agreement and declaration section that I acted as a translator, by signing below, I declare that for any proposed insured(s) and/or proposed owner(s) indicated in that section, I:

- faithfully and truly translated this application and the answers provided to me,
- read over the entire contents of this application and the answers provided to me were recorded; and
- explained the information and everyone understood the contents of this application and provided all requested information.

If applicable (see section 21) I, the advisor, also confirm that:

- I have reviewed the details provided in this application with each proposed owner/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the client in a face-to-face meeting (unless form 4355 has been completed); and
- I saw every person sign this application.

If there are reasonable grounds to suspect that there is an undisclosed third party, PEP or HIO involved with this application, email details to *money.laundering@sunlife.com*.

Advisor's first name		Middle initial	Last name
Office	Advisor code	Email address	
Date (dd-mm-yyyy)	Advisor's signature X		
Date (dd-mm-yyyy)	Supervisor's signature X		

21 Licensed administrative assistant's declaration (To be completed if a licensed administrative assistant completed the application.)

Did a licensed administrative assistant complete the application **(excluding section 7)**? ☐ Yes ☐ No

I, the licensed administrative assistant, confirm that:

- I have reviewed the details provided in this application with each proposed owner/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the client in a face-to-face meeting (unless form 4355 has been completed); and
- I saw every person sign this application.

Licensed administrative assistant's first name		Middle initial	Last name
Date (dd-mm-yyyy)	Licensed administrative assistant's signature X		

Please submit only one copy of this document to Sun Life through your MGA or National Account.

Certificate of temporary insurance

(Not available on reinstatements or reconsideration of ratings.)

Policy number

We, us, our and *the company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Please read the following to understand the coverage under the Certificate of temporary insurance.

Sun Life Assurance Company of Canada and you, the proposed owner, agree to the following:

What is this certificate?

This certificate provides immediate insurance coverage until it ends as described below.

This means if a proposed insured dies or suffers a covered critical illness during our underwriting process, we'll pay the benefit amount we would have paid if we had issued the policy being applied for, subject to the conditions and exclusions set out below.

When does this certificate come into effect?

This certificate comes into effect on the date the proposed insured signs section 19 of this application if:

a) the temporary insurance questions in the application have been truthfully answered *no*
b) all other required questions in the application have been truthfully and completely answered, and
c) a payment of at least 1/12th of the annual premium for your base plan and any additional benefits has been made with the application.

A decision to accept or decline your application for insurance may take up to 90 days.
The beneficiary for temporary insurance is the person or persons named as beneficiary in your application.

When does temporary insurance end?

The temporary insurance automatically ends on the earliest of:

a) the instant the insurance applied for comes into effect
b) the date we decline your application for insurance, following which we will mail a notice of the decline to the address given in the application
c) the 90th day following the date the application for insurance was signed
d) the date the proposed owner asks us to cancel the application
e) the date the proposed owner declines our offer of insurance, or
f) the 30th day following the date the application for insurance was signed and we have not received the required Identity verification and third party determination information with this application.

If the temporary insurance ends for reasons b), c), d) e) or f), we'll refund any amount you've paid us while your application was being processed.

When can you expect to receive your policy, or your refund if we decline the application?

You should receive your policy, or any payment refund if your application is declined, within 90 days of completing your application. If you don't, please contact your advisor.

Conditions and exclusions

This certificate forms part of your application for insurance. Insurance coverage is subject to certain conditions and exclusions, which depend on the type of insurance you requested.

Reduction of death benefit or coverage

If you've asked us to cancel a Sun Life Financial policy on this application and a proposed insured dies or suffers a covered critical illness while we're underwriting this application, we will:

a) pay any death or critical illness insurance benefit amount payable on the policy you've asked us to cancel, and
b) reduce any amount payable under this certificate by the amount payable under the policy you've asked us to cancel.

The following conditions and exclusions apply to life insurance:

1. Amount we pay under this certificate (Conditions)

If any of the proposed life insureds are age 71 or older, then the total amount of any death benefit payable under this certificate is the lesser of $100,000 and the total amount of any death benefit (including any accidental death benefit) applied for under this application and any other pending life insurance applications with the company.

If the proposed life insureds are all under age 71, then the total amount of any death benefit payable under this certificate is the lesser of $1,000,000 and the total amount of any death benefit (including any accidental death benefit) applied for under this application and any other pending life insurance applications with the company.

Please complete, detach and leave with the proposed owner if the temporary insurance conditions are met.

2. When we won't pay benefits under this certificate (Exclusions)

We won't pay a death benefit under this certificate if:

a) a proposed insured takes their own life, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
b) a proposed insured or proposed owner misrepresents or fails to disclose any fact within their knowledge that is material to the risk
c) a proposed insured dies before reaching the age of 15 days, or
d) on the date the application for insurance was signed, a proposed insured named on the application:
   i) due to illness or injury, was prevented from performing their usual activities or occupation for a period **exceeding 2 weeks**
   ii) had cancer within the **last 12 months**
   iii) had suffered a stroke or a heart attack within the **last 12 months**, or
   iv) was confined to a hospital, nursing home, sanitarium, psychiatric facility, or any other health-related facility in the **last 45 days**.

The following conditions and exclusions apply to critical illness insurance:

1. Amount we pay under this certificate (Conditions)

If the proposed insured is age 17 or under, the total amount payable under this certificate is the lesser of $250,000 and the total amount of critical illness insurance applied for under this application and any other pending critical illness insurance applications with the company.

If the proposed insured is between the ages of 18 and 65, the total amount payable under this certificate is the lesser of $500,000 and the total amount of critical illness insurance applied for under this application and any other pending critical illness insurance applications with the company.

2. When we won't pay benefits under this certificate (Exclusions)

This certificate covers only the illnesses and medical conditions defined in the applied for critical illness insurance policy.

We won't pay benefits for any illness or condition not specifically mentioned in that policy.

We won't pay the critical illness insurance benefit under this certificate if:

a) the proposed insured person is over age 65
b) on the date the application for insurance was signed, the proposed insured:
   i) had previously been diagnosed with a covered critical illness or had any signs or symptoms of a covered critical illness, medical consultations, investigations, tests, treatment or counselling that led to a diagnosis of a covered critical illness
   ii) had any signs or symptoms of a chronic kidney, liver or lung disease, medical consultations, investigations, tests, treatment or counselling that led to a diagnosis of chronic kidney, liver or lung disease within the **last 24 months**
   iii) due to illness or injury, was prevented from performing their usual activities or occupation for a period **exceeding 2 weeks**, or
   iv) was confined to a hospital, nursing home, sanitarium, psychiatric facility, or any other health-related facility in the **last 45 days**
c) the proposed insured suffers a covered critical illness which is directly or indirectly associated with:
   i) attempting to take their own life or causing themselves bodily injury, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
   ii) committing or attempting to commit a criminal offence
   iii) intentionally taking any drug other than as prescribed by a licensed medical practitioner and in accordance with the instructions given
   iv) intentionally taking any intoxicant, narcotic, poisonous substance, or
   v) was operating a vehicle while their blood alcohol level was more than 80 milligrams of alcohol per 100 milliliters of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle was in motion.
d) the proposed insured had or has signs or symptoms associated with:
   i) cancer or benign brain tumour, or
   ii) Parkinson's disease or any specified atypical parkinsonian disorders
e) the proposed owner or proposed insured misrepresents or fails to disclose any fact within their knowledge that is material to the risk, or
f) the proposed insured does not survive for 30 days following the date of diagnosis of a covered critical illness.

How your universal life funds will be invested

Any money paid with this application will be invested in the Investment account options selected, subject to applicable minimums, on the date we have received all requirements and they are satisfactory to us.

All cheques must be payable to Sun Life Assurance Company of Canada.

Receipt – Received from:

First name	Middle initial	Last name	Amount paid for initial payment for this application (Indicate 'Nil', if no payment.)	Date (dd-mm-yyyy)
			$	

Banking information provided and PAC agreement signed to take initial payment by pre-authorized chequing? ☐ Yes ☐ No

Advisor's signature
X

Important information you should know

Sun Life Financial

Policy number

Note: This page is to be detached and given to the proposed insured. Do not submit with the application.

Sun Life Financial Privacy Statement for Canada

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Access to your information

We or our reinsurers may also submit a brief report of our findings to MIB, Inc. (MIB), a non-profit organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

MIB receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the company's privacy and securities practices, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at *privacy@mib.com*.

To learn more about MIB, Inc., you may visit the website at *www.mib.com*, call 416-597-0590 or write to:

MIB, Inc.
330 University Avenue
Suite 501
Toronto, Ontario M5G 1R7

You may ask to see your personal information on file with MIB, Inc. and correct anything that is inaccurate or incomplete.

About Sun Life Financial

As a leading international financial services organization, we're proud to offer a diverse range of wealth accumulation and protection products and services. Tracing our roots back to 1865, Sun Life Financial has operations in key markets around the world. But most importantly, we're in business to help people achieve and maintain the peace of mind that comes from having sound financial solutions in place.

If you'd like more information about Sun Life Financial, please visit our website at *www.sunlife.ca* or call 1-877-SUN-LIFE (1-877-786-5433).