

Application for conversion and exercising an option



Policy number

Advisor instructions:

Use this application if applying for:

- conversion, group conversion or exercising an option (without an increase in coverage) of all eligible Sun Life Financial life insurance products offered by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, or
- conversion or exercising an option (without an increase in coverage)
 - on critical illness insurance, the only benefits being added are Return of premium on death (ROPD), Return of premium on cancellation (ROPC) or Return of premium on cancellation or expiry (ROPC/E), or
 - on life insurance, the only benefits being added are Plus premium, Child term (CTB) or Guaranteed return of premium death benefit.

You may also apply for non-smoking status on this new application for any of the above transactions.

Use the Application for life and/or critical illness insurance, instead of this application, if applying for:

- conversion or exercising an option with an increase in coverage (amount of insurance applied for exceeds the amount available for conversion/exercising option), or
- conversion or exercising an option (without an increase in coverage) and adding a benefit that was not on the original policy (This does not apply to adding ROPD, ROPC, ROPC/E, Plus premium or CTB.).

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

Policies issued before January 1, 2017 are considered grandfathered and will remain so unless certain changes are made.

These may include:

- Any application that requires underwriting, or
- Any conversion, including term to term conversions.

These do not include exercising a guaranteed insurability option if original policy was issued prior to January 1, 2017.

Ensure the Important information you should know page, containing the Sun Life Financial Privacy Statement of Canada **is given to the proposed insured.**

Notes:

- If there are more than 2 people to be insured under this policy number, complete a second form and attach it to this application.
- Advisors must refer to our illustration software to determine if a signed illustration is required for this application.

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

- The international tax residency self-certification for FATCA and 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.

In this application, *I, you, your, Person 1* and *Person 2* refer to the proposed insured(s) and the applicant(s). *We, us, our* and *the company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

At the start of each section, we've stated who *I, you* and *your* refer to in that section.

AAPPE



General information

In this section, *you, your, Person 1* and *Person 2*, refer to the proposed insured and/or the applicant(s).

a) Information about Person 1 (proposed insured)

First name	Middle initial	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Former surname (if any)	City of birth	Country of birth		
Residential address (street number and name)				Apartment or suite
City	Province/State	Country	Postal/Zip code	
Phone number		Business phone number		

Proof of age (Complete only if not provided on the original application.)

Document (indicate type)	Requirement
<input type="checkbox"/> Canadian, U.S.A., U.K. or Bermuda driver's licence <input type="checkbox"/> Change to Canadian, U.S.A., U.K. or Bermuda birth certificate <input type="checkbox"/> Canadian citizenship <input type="checkbox"/> Indian status card <input type="checkbox"/> Register of civil status in Quebec <input type="checkbox"/> Provincial identification card <input type="checkbox"/> Military card	Registration number
<input type="checkbox"/> Current valid Canadian passport <input type="checkbox"/> Current valid passport (other country) <input type="checkbox"/> Current Nexus card	Expiry date (dd-mm-yyyy)
<input type="checkbox"/> Baptismal certificate <input type="checkbox"/> Hospital certificate of birth	Issue date (dd-mm-yyyy)
<input type="checkbox"/> Provincial ID health insurance card (if date of birth is indicated) Includes: RAMQ, Medicare and BC medical care card (may say MSP card)	Expiry date (dd-mm-yyyy) or Registration number
<input type="checkbox"/> Permanent resident card	Expiry date (dd-mm-yyyy) or ID number

Is the proposed insured also an applicant? Yes No

If you are also an applicant, are you applying for universal or permanent life insurance? Yes No

If **'yes'**, what is your Social Insurance Number? **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? Yes No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN)

CRS - If **'yes'**, 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
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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 applicant want to retain age? Yes No **Note:** Age may be retained up to 90 days.

Information about Person 2 (proposed insured)

First name	Middle initial	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Former surname (if any)	City of birth	Country of birth		
Residential address (street number and name)				Apartment or suite

General information			
City	Province/State	Country	Postal/Zip code
Phone number		Business phone number	

Proof of age (Complete only if not provided on the original application.)

Document (indicate type)	Requirement
<input type="checkbox"/> Canadian, U.S.A., U.K. or Bermuda driver's licence <input type="checkbox"/> Change to Canadian, U.S.A., U.K. or Bermuda birth certificate <input type="checkbox"/> Canadian citizenship <input type="checkbox"/> Indian status card <input type="checkbox"/> Register of civil status in Quebec <input type="checkbox"/> Provincial identification card <input type="checkbox"/> Military card	Registration number
<input type="checkbox"/> Current valid Canadian passport <input type="checkbox"/> Current valid passport (other country) <input type="checkbox"/> Current Nexus card	Expiry date (dd-mm-yyyy)
<input type="checkbox"/> Baptismal certificate <input type="checkbox"/> Hospital certificate of birth	Issue date (dd-mm-yyyy)
<input type="checkbox"/> Provincial ID health insurance card (if date of birth is indicated) Includes: RAMQ, Medicare and BC medical care card (may say MSP card)	Expiry date (dd-mm-yyyy) or Registration number
<input type="checkbox"/> Permanent resident card	Expiry date (dd-mm-yyyy) or ID number

Is the proposed insured also an applicant? Yes No

If you are also an applicant, are you applying for universal or permanent life insurance? Yes No

If 'yes', what is your Social Insurance Number? **Note:** Required for tax reporting for life insurance.

FATCA - If 'yes', are you a U.S. resident for tax purposes (which includes a U.S. citizen)? Yes No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN)

CRS - If 'yes', 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
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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 applicant want to retain age? Yes No **Note:** Age may be retained up to 90 days.

Is there an applicant who is not a proposed insured? Yes No If 'no' proceed to c).

b) Information about the applicant(s) who are not a proposed insured

i) Individual (not a corporation, trust or other entity) applicant information

Complete the following for all Individual (not a corporation, trust or other entity) applicants.

Applicant's first name	Middle initial	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Occupation	Residential address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code	
Relationship to the proposed insured				

Are you applying for universal or permanent life insurance? Yes No

General information

If **'yes'**, what is your Social Insurance Number? **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? Yes No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN)

CRS - If **'yes'**, 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
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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 _____

Applicant's first name	Middle initial	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Occupation	Residential address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code	
Relationship to the proposed insured				

Are you applying for universal or permanent life insurance? Yes No

If **'yes'**, what is your Social Insurance Number? **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? Yes No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN)

CRS - If **'yes'**, 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
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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 _____

ii) Corporation, trust or other entity applicant information

Complete the following for all corporation, trust or other entity applicants.

Name of corporation, trust or entity				
Title of person to whom all notices and correspondence about this policy are to be sent				
Mailing address (street number and name)				Apartment or suite
City	Province/State	Country	Postal code/Zip	

Are you applying for universal or permanent life insurance? Yes No

If **'yes'**, forms [4831 \(Identity verification and third party determination for entity owners\)](#) and [4545 \(International tax classification for an entity\)](#) must be completed for this applicant.

Policy number

General information			
Name of corporation, trust or entity			
Title of person to whom all notices and correspondence about this policy are to be sent			
Mailing address (street number and name)			Apartment or suite
City	Province/State	Country	Postal code/Zip

Are you applying for universal or permanent life insurance? Yes No

If 'yes', forms [4831 \(Identity verification and third party determination for entity owners\)](#) and [4545 \(International tax classification for an entity\)](#) must be completed for this applicant.

c) Information about contingent owner(s)

Note: You should name a contingent owner if:

- there is only one applicant and the policy will continue after that owner's death (where the applicant is not the proposed insured person), or
- there is more than one applicant.

Is there a contingent owner? Yes No If 'no', proceed to the Beneficiary information section.

Multiple owners outside Quebec

If this policy is owned by more than one person and an owner dies, their interest will pass in equal shares to the surviving owners unless a contingent owner is named for them. If, on the death of any owner, that deceased owner's interest is to pass to a named contingent owner, then the name of the contingent owner must be completed in the space provided below next to the applicable owner's name.

Multiple owners in Quebec

Survivorship provisions do not apply in Quebec. If one of the owners die, their interest in the policy will pass to the contingent owner named below. The surviving owner will continue to own their interest in the policy. Indicate the name of the applicant and their contingent owner in the space provided below.

Applicant (owner)	Contingent owner	Relationship to the applicant (owner)
Applicant (owner)	Contingent owner	Relationship to the applicant (owner)
Applicant (owner)	Contingent owner	Relationship to the applicant (owner)

Beneficiary information

In this section, *you* and *your* refer to the applicant(s). If not completed, the beneficiary will be the applicant or the estate of the applicant.

Notes:

- For **SunUniversalLife II** and **SunUniversalLife Pro** joint last-to-die with the Insurance amount plus policy fund option, complete the [Early death benefit beneficiary election and/or change \(E272\)](#) form.
- 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 that designation.

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

Note: 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 the cases of unequal shares, the predeceased beneficiary's share will revert to you or your estate.

Are you applying for critical illness insurance? Yes No If 'yes', proceed to c).

Beneficiary informationDo you want to name a primary beneficiary(ies) for Person 1? Yes No

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
			%

Do you want to name a primary beneficiary(ies) for Person 2? Yes No

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
			%

b) Contingent beneficiaries (Share of benefits must add up to 100%.)Do you want to name a contingent beneficiary(ies) for Person 1? Yes No

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
			%

Do you want to name a contingent beneficiary(ies) for Person 2? Yes No

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable % shared of benefits to be paid
			%

Beneficiary information**c) Critical illness insurance designations****Note:** If you designate a payee, you will not receive the **critical illness** benefit payment.

i) Critical illness benefit payee beneficiary

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
				%

ii) Return of premium on death beneficiary

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
				%

iii) Return of premium on cancellation or expiry beneficiary

Note: If not completed, we pay any Return of premium on cancellation or expiry benefit to the applicant or the estate of the applicant.

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	% shared of benefits to be paid
				%

d) Trustee for a minor beneficiary (Complete when a minor beneficiary has been named in beneficiary designations a) - c).)Have you named a minor beneficiary anywhere in a) – c) and want to name a trustee for that beneficiary? Yes No**Notes:**

- 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) Primary beneficiaries: I appoint

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ii) Contingent beneficiaries: I appoint

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iii) Critical illness benefit payee beneficiary: I appoint

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Beneficiary information

iv) Return of premium on death beneficiary: I appoint

[Empty text box for beneficiary name]

as a trustee to receive any payments on behalf of any named minor 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.

Transaction type and plan details

In this section, *you* and *your* refer to the applicant(s).

Notes:

- Question 1 must be answered by the applicant(s).
- Questions 2 and 3 must be answered by the applicant(s) and the proposed insured(s) if other than applicant. If a proposed insured is under age 16 (18 in Quebec), the question must be answered by their parent or legal guardian.
- Questions 2 and 3 are only to be answered if applying for a conversion or exercising an option. Do not answer if applying for a group conversion.

1. What type of transaction are you applying for? Conversion Group conversion Exercising option
2. On the original policy, was there a Waiver of Premium/Risk, Disability Waiver or Owner Waiver - Disability benefit on either the insured person or owner? Yes No

If "yes" complete question 3.

3. Is the proposed insured or the applicant currently disabled or have they made a claim or are intending to make a claim to a disability benefit on any policy being converted or from which an option is being exercised? Yes No

Complete for conversions only:

Notes:

- Changes to policies issued prior to 2017 may result in the loss of grandfathering which may result in a negative tax consequence.
- All conversions must meet current product minimums and are subject to the terms and conditions of the policy being converted and our administrative rules.
- If converting more than 1 policy, the conversion will result in only 1 new policy being produced.

Policy number	<input type="checkbox"/> Full conversion	<input type="checkbox"/> Partial conversion	Amount not being converted is to:	<input type="checkbox"/> remain in force	<input type="checkbox"/> be cancelled
Policy number	<input type="checkbox"/> Full conversion	<input type="checkbox"/> Partial conversion	Amount not being converted is to:	<input type="checkbox"/> remain in force	<input type="checkbox"/> be cancelled
Policy number	<input type="checkbox"/> Full conversion	<input type="checkbox"/> Partial conversion	Amount not being converted is to:	<input type="checkbox"/> remain in force	<input type="checkbox"/> be cancelled

a) Conversion of:

- Term plan
- Critical illness (term only)
- Critical illness attached term (on proposed insured or additional insured person)
- Term insurance on additional insured person
- Universal life coverage
- Spousal term
- Other

Transaction type and plan details

b) Convert to:

Sun Par Protector II \$ or Sun Par Accumulator II \$

10 pay 20 pay Life pay (to age 100)

Indicate: Single life Joint first-to-die Joint last-to-die
 premiums payable to first death (Available on Life pay only.)
 premiums payable to last death

Note: The Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II section must also be completed.

Sun Par Accelerator \$ (Base insurance amount + Enhanced amount)

Indicate: Single life Joint first-to-die Joint last-to-die (Premiums payable to second death.)

Request to receive mailing

Upon issuance of the policy, you will have the right to attend and to vote in person or by proxy at the meetings of the voting policyholders of Sun Life Assurance Company of Canada.

Do you want to receive notice of these meetings and related information? Yes No

If not completed, we will assume response as 'yes'.

Non-participating permanent life \$

10 pay 15 pay 20 pay Life pay (to age 100)

Indicate: Single life Joint first-to-die Joint last-to-die
 premiums payable to first death (Available on Life pay only.)
 premiums payable to last death

SunUniversalLife II \$

Indicate: Single life Joint first-to-die Joint last-to-die
 COI payable to first death
 COI payable to second death

Note: The Additional information required if converting or exercising option to SunUniversalLife II section must also be completed.

SunUniversalLife Pro \$

Indicate: Single life Joint first-to-die Joint last-to-die
 COI payable to first death
 COI payable to second death

Note: The Additional information required if converting or exercising option to SunUniversalLife Pro section must also be completed.

SunUniversalLife (Bermuda only) \$

Indicate: Single life Joint first-to-die Joint last-to-die

Note: The Additional information required if converting or exercising option to SunUniversalLife (Bermuda only) section must also be completed.

Sun Lifetime Alternative (Only available if converting from Sun 1 Year Term or Sun Term to 65.) \$

Transaction type and plan details

Term (Only available on term conversions.)

\$

20 year 30 year

Indicate:

Single life

Joint first-to-die

Multi-life

(Complete for person 2)

\$

20 year 30 year

Sun Critical Illness Insurance

\$

Term 75

or Lifetime

Guaranteed payment period

Guaranteed payment period

15 years

To age 75

10 years

15 years

To age 100

Existing universal life policy

Policy number

Amount of increase
\$

Other

c) Benefit details:

i) On new policy

Carry over these benefit(s) (describe):

If carrying over CTB, provide the name(s) and date(s) of birth of children covered under the CTB.

Child	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Are you reducing the CTB benefit amount? Yes No

If 'yes', indicate the new CTB amount.

\$

Add the following benefit(s):

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

CTB

\$

ROPD

ROPC (Lifetime only.)

ROPC/E (Term 75 only.)

Adult

Child

Adult

Child

15 years

Advanced

15 years

Advanced

age 65

age 35

age 65

age 35

age 75

age 75

Guaranteed return of premium death benefit (Available on 15 or 20 pay non-participating permanent life only.)

ii) On original policy

Cancel these benefit(s) (describe):

Transaction type and plan details

d) Statement of smoking status

Note: In the following question, *you* refers to the applicant(s).

	Person 1	Person 2
Are you applying for non-smoker rates on this new application?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', does the existing policy have non-smoker rates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'no', you must answer the Smoking declaration questions in the Additional evidence section.

Complete for group conversions only:

- Notes:**
- All conversions must meet current product minimums and are subject to the terms and conditions of that policy and our administrative rules.
 - Include a copy of the client's termination notice with this application.

a) Convert to:

- Sun Lifetime Alternative
 - Carry over Accidental death benefit from original group policy
- Sun One year term
- Sun Term to 65

Group policy number	Certificate number
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Group company name	Eligible amount \$	Amount being converted \$
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Date (dd-mm-yyyy)

Date the group insurance was terminated, the last day worked or the benefit's expiry date:

Is this a group spousal conversion? Yes No If 'yes', complete the following spousal information:

First name	Last name	SIN (required for tax reporting for life insurance)	Date of birth (dd-mm-yyyy)
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The spouse must also sign the Acknowledgement and agreement section of this application.

b) Statement of smoking status

In the **last 12 months**, has the proposed insured 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

Complete for exercising options only:

Note: All options must meet current product minimums and are subject to the terms and conditions of that policy and our administrative rules.

a) New plan:

Sun Par Protector II \$ or Sun Par Accumulator II \$

10 pay 20 pay Life Pay (to age 100)

Note: The Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II section must also be completed.

Sun Par Accelerator \$ (Base insurance amount + Enhanced amount)

Request to receive mailing

Upon issuance of the policy, you will have the right to attend and to vote in person or by proxy at the meetings of the voting policyholders of Sun Life Assurance Company of Canada.

Do you want to receive notice of these meetings and related information? Yes No

If not completed, we will assume response as 'yes'.

Non-participating permanent life \$

10 pay 15 pay 20 pay Life pay (to age 100)

Policy number

Transaction type and plan details

SunUniversalLife II \$

Note: The Additional information required if converting or exercising option to SunUniversalLife II section must also be completed.

SunUniversalLife Pro \$

Note: The Additional information required if converting or exercising option to SunUniversalLife Pro section must also be completed.

SunUniversalLife (Bermuda only) \$

Note: The Additional information required if converting or exercising option to SunUniversalLife (Bermuda only) section must also be completed.

Term \$

10 year 10 year with renewal protection 15 year 20 year 30 year

Other

b) Option being exercised:

Guaranteed insurability

Age Date of marriage

(dd-mm-yyyy)

Child's date of birth

(dd-mm-yyyy)

Date of legal adoption

(dd-mm-yyyy)

Other

Child term

In the **last 12 months**, has the proposed insured 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

Business value protection

Note: Complete and attach a [Financial questionnaire \(E96\)](#) and 2 years of financial statements on the business named on the application for the new policy.

Partner protection (Only available on term plans.)

First name of deceased	Last name	Amount of coverage on the deceased (Basic insurance amount)
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>

Indicate policy number:

Policy number exercising option from

i) On new policy

Carry over these benefit(s) (describe):

Add the following benefit:

CTB

\$

Guaranteed return of premium death benefit (Available on 15 or 20 pay non-participating permanent life only.)

Transaction type and plan details

ii) On original policy

Cancel these benefit(s) (describe):

c) Statement of smoking status (Do not complete if exercising a Child term option.)

Note: In the following question, *you* refers to the applicant(s).

Person 1

Are you applying for non-smoker rates on this new application?

Yes No

If 'yes', does the existing policy have non-smoker rates?

Yes No

If 'no', you must answer the Smoking declaration questions in the Additional evidence section.

Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II

i) Dividend options (If not completed, default will be PUA.)

Paid-up additional insurance (PUA) **Note:** If adding PUA and it exceeds the maximum insurance amount, the Additional evidence section must also be completed.

Annual premium reduction (Only available if premiums are payable on an annual basis.)

Cash payment

Dividends on deposit

Enhanced insurance **Note:** If adding enhanced insurance and it exceeds the maximum insurance amount, the Additional evidence section must also be completed.

Basic amount	Enhanced amount	Total (Basic + Enhanced)
\$	\$	\$

Do you want to add the Plus premium benefit (PPB)? Yes No

ii) Plus premium benefit (PPB) (Not available on 10 pay. Only available if PUA or Enhanced insurance selected in i) Dividend options.)

Note: If adding PPB, the Additional evidence section must also be completed.

Payment option for PPB

Scheduled (regular monthly or annual payments): Monthly \$ Annual \$

iii) Premium offset (If not completed, we will assume response as 'yes'.)

Do you want us to notify you if and when the policy you applied for may become eligible for premium offset? Yes No

Premium offset is an administrative feature (not a contractual right under the policy) that may allow you to use dividends and accumulated value within the policy to help pay future premiums if certain conditions are met. The premium offset date is not guaranteed. It may occur sooner or later, or not at all, depending on future dividend scale changes. If and when the policy goes on premium offset, at some point you may have to resume out-of-pocket premium payments.

iv) Request to receive mailing (If not completed, we will assume response as 'yes'.)

Upon issuance of the policy, you will have the right to attend and to vote in person or by proxy at the meetings of the voting policyholders of Sun Life Assurance Company of Canada.

Do you want to receive notice of these meetings and related information? Yes No

If not completed, we will assume response as 'yes'.

Additional information required if converting or exercising option to SunUniversalLife II

Note: If an investment mix change is required on an existing universal life policy, complete a Investment account change and allocation form.

i) Death benefit options (If not completed, default will be Insurance amount plus policy fund.)

Choose one of the following:

Insurance amount plus policy fund

Level insurance amount

ii) Cost of insurance (If not completed, default will be Level.)

Level Yearly to 85 Yearly to 70 Level for 10 years Level for 15 years Level for 20 years

Policy number

Transaction type and plan details

- Daily interest account
- Guaranteed interest account – 1 year

Additional information required if converting or exercising option to SunUniversalLife Pro

Note: If an investment mix change is required on an existing universal life policy, complete a Investment account change and allocation form.

i) Death benefit options (If not completed, default will be Insurance amount plus policy fund.)

Choose one of the following:

- Insurance amount plus policy fund
- Level insurance amount

ii) Cost of insurance (If not completed, default will be Level.)

- Level
- Yearly to 85
- Yearly to 100

iii) Investment account options (If not completed, default will be Daily interest account 100%.)

You must allocate your payments to any of the following Investment account options. Your choices must be in multiples of 5% and they must add up to 100%. Each of your investment account options must have a minimum amount of \$100.00.

If you have selected an Investment account option which is no longer available but is not reflected in this application, we will allocate your selection to the Daily interest account (DIA). We'll tell you what options are then available for you to make an alternative selection. You can tell us which option you want to use in place of the option that's no longer available.

Interest rate accounts	Percentage
Daily interest account	%
Guaranteed interest account (GIA) 10 year	%
Sun Life Diversified Account Pro	%
Total	%

Your GIA earnings will automatically compound until the account matures.

On maturity, your GIA - 10 year account balances will automatically transfer to the Activity account unless you check this box:

- Rollover to a new account of the same term

In what order do you want your investment account withdrawals and transfers processed? If not specified, your withdrawal order will be Proportional. (Check one.)

Proportional:

- Proportional from all investment accounts, based on account value at time of withdrawal.

or

Alternate order:

Funds are withdrawn in the following order:

- DIA
- GIA (taken first from layers closest to maturity)
- Sun Life Diversified Account Pro

iv) Maintaining your policy's tax-exempt status

Note:

Check one of the boxes below. (**Note:** If not completed, default is Increase insurance amount as required [to a maximum of 8%] but reverse the increase when this can be done without losing tax-exempt status [note the cost of insurance will be changed accordingly].)

- Retain insurance amount
- Increase insurance amount as required (to a maximum of 8%) but reverse the increase when this can be done without losing tax-exempt status (note the cost of insurance will be changed accordingly).
- Increase insurance amount as required (to a maximum of 8% and the cost of insurance will be increased accordingly), but do not reverse the increase.

Note: A DIA service account will be established for any excess funds.

Additional information required if converting or exercising option to SunUniversalLife (Bermuda only)

Note: If an investment mix change is required on an existing universal life policy, complete a Universal Life Client service request form.

i) Death benefit options (If not completed, default will be Insurance amount plus your policy fund.)

Choose one of the following:

- Level insurance amount
- Indexed insurance amount
- Insurance amount plus your policy fund value

Transaction type and plan details

For multiple life coverage, the fund value will be paid as a proportion of each insurance amount to the total, unless you tell us your fund value is to be paid with the first **or** last settlement of basic benefits under the policy.

ii) **Cost of insurance (If not completed, default will be Guaranteed level rates.)**

Guaranteed yearly term **or** Guaranteed level term

iii) **Investment bonus (If not completed, we will assume response as 'no'.)** Yes No

iv) **Investment account options (If not completed, default will be Daily interest account 100%).**

You must allocate your payments to any of the following Investment account options. Your choices must be in multiples of 5% and they must add up to 100%. Each of your investment accounts must also have a minimum amount of \$100.00.

If you have selected an Investment account option which is no longer available but is not reflected in this application, we will allocate your selection to the Daily interest account (DIA). We'll tell you what options are then available for you to make an alternative selection. You can tell us which option you want to use in place of the option that's no longer available.

Interest rate accounts	Percentage
Daily interest account	%
Guaranteed interest accounts (GIAs)	
1 year	%
3 year	%
5 year	%
10 year	%
20 year	%
Sub total	%

Accounts based on indices	Percentage
American Equity	%
Canadian Bond	%
Canadian Equity	%
Foreign Equity	%

+ Sub total %
 = 100% %

Your GIA earnings will automatically compound until the account matures.

On maturity, your GIA account balances will automatically transfer to the Activity account unless you check this box:

Rollover to a new account of the same term

In what order do you want your investment account withdrawals and transfers processed? If not specified, your withdrawal order will be Standard. (A change to this section is not available after the policy is issued. Check one.)

Standard order:

- Activity account
- Daily interest account
- Accounts based on the performance of indices
- Accounts based on the performance of managed funds
- GIAs (nearest to maturity)

or **Alternate order:**

- Activity account
- Daily interest account
- GIAs (nearest to maturity)

Acknowledgement of variability

I refers to the applicant(s).

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.

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

Completion of this section is mandatory if:

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

Notes:

- In this section, *you* and *your* refer to the applicant(s), which includes sole proprietors.
- The questions must be answered by the applicant(s).

If any applicant is **not an individual** (ie Corporation or other entity), forms 4831 (Identity verification and third party determination for entity owners) and 4545 (International tax classification for an entity) must be completed for that applicant.

Additional 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 applicant 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 applicant.

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

**Identity verification
Applicant 1 (Information on an individual applicant)**

Applicant'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 information; do not attach copies.

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 <input type="checkbox"/> Name <input type="checkbox"/> Date of birth <input type="checkbox"/> Address <input type="checkbox"/> Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used <input type="checkbox"/> Name <input type="checkbox"/> Date of birth <input type="checkbox"/> Address <input type="checkbox"/> Financial account	Date of verification (dd-mm-yyyy)

PIVERIDE



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

Identity verification

Applicant 2 (Information on an individual applicant)

Applicant'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 information; do not attach copies.

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 <input type="checkbox"/> Name <input type="checkbox"/> Date of birth <input type="checkbox"/> Address <input type="checkbox"/> Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used <input type="checkbox"/> Name <input type="checkbox"/> Date of birth <input type="checkbox"/> Address <input type="checkbox"/> Financial account	Date of verification (dd-mm-yyyy)

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, first name, middle initial, last name.)			If individual, date of birth (dd-mm-yyyy)	
Type of third party	Relationship to applicant	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	

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

Name (If individual, first name, middle initial, last name.)			If individual, date of birth (dd-mm-yyyy)
Type of third party	Relationship to applicant	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 the required information for any person above, record the measures taken and why you were unsuccessful below:

--

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

To the best of every applicant's knowledge, has any applicant, their family members or close associates held any of the positions indicated in a), b) and c) below? Indicate **Yes** or **No** beside 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 applicant, biological/adoptive/step parent of any applicant, biological/adoptive/step parent of spouse, civil union spouse or common-law partner.
- Close associate is someone who is closely associated with any applicant for personal or business reasons. Examples of circumstances that may lead to the determination that someone is closely associated with any applicant include, but are not limited to:
 - Transactions that occur between a PEP or an HIO and any applicant;
 - Business activities between a PEP or an HIO and any applicant;
 - Media coverage linking a PEP or an HIO and any applicant; or
 - A personal relationship such as a romantic relationship or close friendship between a PEP or an HIO and any applicant.

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

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

Applicant's first name		Middle initial	Last name
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name		Middle initial	Last name
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

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

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

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

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

Applicant's first name		Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name		Relationship to applicant (PEDP)
Country where position held	Organization or institution		Position held (indicate all applicable numbers from list)	

Applicant's first name		Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name		Relationship to applicant (PEDP)
Country where position held	Organization or institution		Position held (indicate all applicable numbers from list)	

Applicant's first name		Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name		Relationship to applicant (PEDP)
Country where position held	Organization or institution		Position held (indicate all applicable numbers from list)	

Applicant's first name		Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name		Relationship to applicant (PEDP)
Country where position held	Organization or institution		Position held (indicate all applicable numbers from list)	

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

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

Applicant's first name		Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name		Relationship to applicant (HIO)
Country where position held	Organization or institution		Position held	

Applicant's first name		Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name		Relationship to applicant (HIO)
Country where position held	Organization or institution		Position held	

Applicant's first name		Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name		Relationship to applicant (HIO)
Country where position held	Organization or institution		Position held	

Applicant's first name		Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name		Relationship to applicant (HIO)
Country where position held	Organization or institution		Position held	

Source of payment and purpose of product

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

- | | | |
|---|--|---|
| <input type="checkbox"/> salary or earned income | <input type="checkbox"/> applicant's savings | <input type="checkbox"/> gifted funds |
| <input type="checkbox"/> existing investment account | <input type="checkbox"/> pension income | <input type="checkbox"/> inherited funds |
| <input type="checkbox"/> proceeds from death benefits or estate | <input type="checkbox"/> sale of property | <input type="checkbox"/> borrowed funds |
| <input type="checkbox"/> social benefits | <input type="checkbox"/> business income | <input type="checkbox"/> other (give details below) |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> income replacement | <input type="checkbox"/> mortgage protection | <input type="checkbox"/> creditor protection |
| <input type="checkbox"/> asset protection | <input type="checkbox"/> estate protection | <input type="checkbox"/> business protection |
| <input type="checkbox"/> charitable donation | <input type="checkbox"/> tax or estate planning | <input type="checkbox"/> other (give details below) |

Person 1

Evidence no. (for H.O. use only)

E#

Person 2

Evidence no. (for H.O. use only)

E#

Additional evidence

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.

Note: In a), *you* refers to the applicant(s).

a) **Are you:**

Note: In this section *you* refers to the applicant(s).

- 1) adding ROPD to a Sun Critical Illness Insurance product? Yes No
- 2) adding paid-up additional insurance or enhanced insurance that exceeds the maximum insurance amounts? Yes No
- 3) adding paid-up additional insurance or enhanced insurance, where the original policy(converting policy) exceeds the maximum insurance amounts? Yes No
- 4) adding a Guaranteed return of premium on death benefit on Non-participating permanent life product? Yes No
- 5) adding the Plus premium benefit, regardless of face amount? Yes No
- 6) adding a Child term benefit? Yes No

b) **Information about proposed insured(s)**

Notes: • In this section *you* refers to the proposed insured(s).

- This section must be answered for any 'yes' answers above by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian who has full knowledge of the proposed insured's personal or medical history.
- If more space is required, use a separate sheet signed and dated by the proposed insured.

1) Have you **ever** been treated for or had any symptoms or indication of:

- i) 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

Person 1

Person 2

Yes No

Yes No

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

If 'yes', provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

- ii) AIDS, HIV infection or any other disease or disorder of the immune system

Yes No

Yes No

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

If 'yes', provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

- 2) Are you aware of any symptoms for which you have not yet consulted a physician or received treatment?

Yes No

Yes No

Provide details including symptoms, date of onset and any other relevant information.

If 'yes', provide details including symptoms, date of onset and any other relevant information.

Person 1 details

EAPPE

Policy number



Additional evidence

Person 2 details

- 3) 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? **(Do not tell us about genetic testing or genetic test results.)** Yes No Yes No

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

If **'yes'**, provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

- 4) 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 Yes No

Provide details including date of application, plan type, decision and reason, and name of company.

If **'yes'**, provide details including date of application, plan type, decision and reason, and name of company.

Person 1 details

Person 2 details

- c) **Smoking declaration** (To be completed if converting or exercising an option (not CTB) and applying for a change to non-smoker rates on the new policy.)

Notes: • In the following questions, *you* refers to the proposed insured(s).

- The following questions must be answered by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian **who has full knowledge of the proposed insured's personal or medical history**.
- If you have answered the Statement of smoking status question in the Transaction type and plan details section as **'yes'**, the following questions must also be answered.

1. a) When was the last time you used tobacco or nicotine products in any form (e.g. cigars, cigarettes, pipes, chewing tobacco, nicotine patches or nicotine gum)? Complete the chart below.

Proposed insured	Daily	Occasionally (socially)	Used within the last 5 years	Last used more than 5 years ago	Never smoked or used tobacco or nicotine products
Person 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Date last used (dd-mm-yyyy): _____	<input type="checkbox"/>	<input type="checkbox"/>
Person 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Date last used (dd-mm-yyyy): _____	<input type="checkbox"/>	<input type="checkbox"/>

- b) If you selected **Occasionally**, provide details.

Proposed insured	Products (check all that apply)	Dates last used (dd-mm-yyyy)	# used in last 12 months for large cigars only
Person 1	<input type="checkbox"/> Large cigars <input type="checkbox"/> Other tobacco and nicotine products	Large cigars: _____ Other: _____	Large cigars only: _____
Person 2	<input type="checkbox"/> Large cigars <input type="checkbox"/> Other tobacco and nicotine products	Large cigars: _____ Other: _____	Large cigars only: _____

2. **Person 1:** Height _____ cm ft & in Weight _____ kg lb

Person 2: Height _____ cm ft & in Weight _____ kg lb

3. In the last 12 months, have you had a weight loss of more than 4.5kg or 10lbs? **Person 1** Yes No **Person 2** Yes No

Person 1: If 'yes' complete the chart below.

Amount of change: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	Reason for change: <input type="checkbox"/> diet <input type="checkbox"/> exercise <input type="checkbox"/> surgery <input type="checkbox"/> other
---	--

If 'other', provide details below.

Additional evidence

Person 2: If 'yes' complete the chart below.

Amount of change: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	Reason for change: <input type="checkbox"/> diet <input type="checkbox"/> exercise <input type="checkbox"/> surgery <input type="checkbox"/> other
If 'other', provide details below.	

4. a) In the last 5 years, have you used marijuana or hashish? Yes No Yes No
 If 'yes' to a), indicate which of the following best describes you average frequency of use.

Proposed insured	Daily	Weekly	Monthly	Less than once per month	Date last used (dd-mm-yyyy)
Person 1	<input type="checkbox"/> # per day: _____ Amount per use in grams: _____	<input type="checkbox"/> # per week: _____ Amount per use in grams: _____	<input type="checkbox"/> # per month: _____ Amount per use in grams: _____	<input type="checkbox"/>	<input type="checkbox"/> _____
Person 2	<input type="checkbox"/> # per day: _____ Amount per use in grams: _____	<input type="checkbox"/> # per week: _____ Amount per use in grams: _____	<input type="checkbox"/> # per month: _____ Amount per use in grams: _____	<input type="checkbox"/>	<input type="checkbox"/> _____

- b) If 'yes' to a), do you mix the marijuana or hashish with tobacco? Yes No Yes No
 c) If 'yes' to a), do you use it for medicinal purposes? Yes No Yes No
 d) If 'yes' to c), did a physician prescribe it? Yes No Yes No
 If 'yes', is this your usual physician or health care professional? Yes No Yes No
 e) If 'yes' to d), what condition is being treated? Yes No Yes No

- f) In the last 10 years, have you used any drugs or narcotics that weren't prescribed to you (such as cocaine, LSD, ecstasy, heroin, fentanyl, anabolic steroids or amphetamines)? Yes No Yes No
 If 'yes' provide details.

Proposed insured	Drug or narcotic	Amounts and frequency of use	Date last used (dd-mm-yyyy)
Person 1			
Person 2			

- g) Have you ever been treated, counselled or gone to meetings for alcohol or drug abuse? Yes No Yes No
 If 'yes', complete and attach the appropriate [Alcohol usage questionnaire \(E26\)](#) and/or [Drug questionnaire \(E12\)](#).
 h) If 'no' to g), has a doctor or health care professional ever recommended you get treatment or counselling or limit the amount alcohol or drugs you use? Yes No Yes No
 If 'yes', complete and attach the appropriate [Alcohol usage questionnaire \(E26\)](#) and/or [Drug questionnaire \(E12\)](#).

5. Have you ever been treated for or had any symptoms or indication of:
- i) AIDS or HIV infection Yes No Yes No
 - ii) chest pain, high blood pressure, irregular pulse or heart disease or disorder Yes No Yes No
 - iii) stroke or cerebrovascular accident (CVA), aneurysm, transient ischemic attack (TIA) or paralysis Yes No Yes No
 - iv) asthma, persistent cough or any other lung disease or disorder Yes No Yes No
 - v) diabetes, abnormal blood sugar or kidney disease or disorder Yes No Yes No
 - vi) cancer, tumour or any other growth or malignancy Yes No Yes No
 - vii) ulcer (peptic or gastric), ulcerative colitis or Crohn's disease Yes No Yes No
 - viii) hepatitis (including hepatitis carrier state) or any other liver disease or disorder Yes No Yes No
 - ix) any other medical history not previously mentioned Yes No Yes No

Additional evidence

Give details for all 'yes' answers in question 5.

Proposed insured	Question number	Date (mm-yyyy)	Indicate all related treatments, durations, dates, tests and results. Include names and addresses of all attending physicians, medical facilities and hospitals.
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			
<input type="checkbox"/> Person 1 <input type="checkbox"/> Person 2			

6. Provide additional details for any question in this section.

Person 1
Person 2

7. Do you have a usual medical advisor or medical clinic?

Yes No Yes No

Person 1

a) If 'yes' to question 7, name of usual medical or health care professional or medical clinic.			
Address (street number and name)		City	
		Province/State	
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
b) If 'yes' to question 7, in the last 5 years , did you see this doctor or clinic for a routine physical exam or checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'yes', date of most recent exam or checkup (dd-mm-yyyy).	
c) If 'no' to question 7, in the last 5 years , did you see any doctor or clinic for a routine physical exam or checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'yes', date of most recent exam or checkup (dd-mm-yyyy).	
If 'yes', to c), name and address of doctor consulted.			

Person 2

a) If 'yes' to question 7, name of usual medical or health care professional or medical clinic.			
Address (street number and name)		City	
		Province/State	
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
b) If 'yes' to question 7, in the last 5 years , did you see this doctor or clinic for a routine physical exam or checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'yes', date of most recent exam or checkup (dd-mm-yyyy).	
c) If 'no' to question 7, in the last 5 years , did you see any doctor or clinic for a routine physical exam or checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'yes', date of most recent exam or checkup (dd-mm-yyyy).	
If 'yes', to c), name and address of doctor consulted.			

Additional evidence

d) **Family history** (To be completed if converting to critical illness and applying for change to non-smoker rates on new policy.)

Note: In the following question, *you* refers to the applicant(s).

1. Are you applying for a conversion to critical illness insurance? Yes No

If 'yes', complete the following.

Notes:

- In the following questions, *you* refers to the proposed insured(s).
- These questions must be answered by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian who has full knowledge of the proposed insured's personal or medical history.
- The following questions do not need to be completed for proposed insured(s) over the age of 65. **Do not tell us about genetic testing or genetic test results.**

2. 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

3. 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 2) or 3), complete the following chart.

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

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

Notes:

- In this section, *you* refers to the proposed insured.
- The proposed insured's biological, adopted or step-children may be covered under a child term benefit.

If there is more than 1 proposed insured, who's child(ren) are being insured? Person 1 Person 2

Does the proposed insured currently have any children? Yes No

If 'yes', complete the following.

Notes:

- If more than 3 children are to be insured, print off an additional copy of the CTB pages and submit those pages with this application.
- The information below must be provided by the Person who's children are being insured.

Information about Child 1 to be insured

Child's first name	Middle initial	Last name
Relationship to proposed insured <input type="checkbox"/> Child <input type="checkbox"/> Step child <input type="checkbox"/> Adopted child		<input type="checkbox"/> Male <input type="checkbox"/> Female
		Date of birth (dd-mm-yyyy)

Policy number

Child(ren) to be insured under a child term benefitDoes this child live with you? Yes NoIf 'yes', who does this child live with? Person 1 Person 2

If 'no', complete the following.

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/State	Postal/Zip code

Do you have full knowledge of this child's medical history? Yes NoIf 'no', is the person who has the most knowledge of the medical history for this child present? Yes No**Note:** If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children
---	------------------------------

Information about Child 2 to be insured

Child's first name	Middle initial	Last name
Relationship to proposed insured <input type="checkbox"/> Child <input type="checkbox"/> Step child <input type="checkbox"/> Adopted child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)

Does this child live with you? Yes NoIf 'yes', who does this child live with? Person 1 Person 2

If 'no', complete the following.

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/State	Postal/Zip code

Do you have full knowledge of this child's medical history? Yes NoIf 'no', is the person who has the most knowledge of the medical history for this child present? Yes No**Note:** If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children
---	------------------------------

Information about Child 3 to be insured

Child's first name	Middle initial	Last name
Relationship to proposed insured <input type="checkbox"/> Child <input type="checkbox"/> Step child <input type="checkbox"/> Adopted child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)

Does this child live with you? Yes NoIf 'yes', who does this child live with? Person 1 Person 2

If 'no', complete the following.

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/State	Postal/Zip code

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

Do you have full knowledge of this child's medical history? Yes No

If 'no', is the person who has the most knowledge of the medical history for this child present? Yes No

Note: If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children
---	------------------------------

Note: Provide details for each child answering 'yes' to any question in numbers 1 - 4. If any child is age 16 (18 in Quebec) or over, they must answer the following questions and sign the Acknowledgement and agreement section of this application.

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

Child to be insured	Details
Child to be insured	Details
Child to be insured	Details

2. 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

Child to be insured	Details
Child to be insured	Details
Child to be insured	Details

b) cancer, leukemia or any other growths or malignancy Yes No

Child to be insured	Details
Child to be insured	Details
Child to be insured	Details

c) diabetes or any other thyroid or endocrine disease or disorder Yes No

Child to be insured	Details
Child to be insured	Details
Child to be insured	Details

d) hemophilia, bleeding disorder or any other blood disease or disorder Yes No

Child to be insured	Details
Child to be insured	Details
Child to be insured	Details

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

e) Crohn's disease, ulcerative colitis, hepatitis or any other disease or disorder of the bowel, stomach or liver Yes No

Child to be insured	Details
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Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

f) asthma, cystic fibrosis, tuberculosis or any other respiratory disease or disorder Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

g) depression, anxiety, attention deficit disorder or any other psychological, emotional or nervous disease or disorder Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

h) disease or disorder of the kidney or urinary tract Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

i) muscular dystrophy, multiple sclerosis or any other neurological disease or disorder Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

j) Down syndrome, developmental delay, autism, cerebral palsy or any other congenital disease or disorder Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

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

k) epilepsy, seizure or any other disease or disorder of the brain

Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

3. Has any child **ever** been tested for exposure to the HIV (AIDS) virus?

Yes No

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

4. 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

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Child to be insured	Details
---------------------	---------

Authorization to disclose information to your advisor

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

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
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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) issue a new insurance policy, or
 - (b) mail you a notice telling you that we have declined your application.

Does Person 1 agree to the disclosure of their information? Yes No (If not indicated, answer is 'no'.)

Does Person 2 agree to the disclosure of their information? Yes No (If not indicated, answer is 'no'.)



Payments

Method of payment information

Notes:

- We do not accept cash payments.
- If a method of payment is not selected, we will proceed on a Payment on delivery basis and we assume PAC with payment instructions will be provided on delivery.
- Payments will not be taken from the payor’s account until the policy is in effect unless initial payment in the Pre-authorized chequing (PAC) authorization section has been selected.

What is the method of payment?

- Annual: If selected, submit the total annual payment to the advisor at the time the application is completed. Make cheque payable to Sun Life Assurance Company of Canada.
- Payment on delivery: If selected, the Payment on delivery and Pre-authorized chequing (PAC) authorization (if applicable) must also be completed.
- Pre-authorized chequing (PAC): If selected, the Pre-authorized chequing (PAC) authorization section must also be completed.
- Future periodic payment (only applicable for universal life applications): If selected, the Future periodic payment section must also be completed.
- Bermuda only

Frequency: Quarterly Annual **Note:** If not indicated, default will be Annual.
 Currency: Bermuda funds U.S.A. funds **Note:** If not indicated, default will be Bermuda funds.

Future periodic payment amount \$

Payment on delivery

Indicate how the initial payment will be made:

- cheque on delivery for full annual payment
- cheque on delivery for initial monthly payment with subsequent payments based on PAC information provided in the Pre-authorized chequing (PAC) authorization section
- PAC withdrawal based on PAC information provided in the Pre-authorized chequing (PAC) authorization section, or
- PAC withdrawal with PAC information/payment instructions to be provided on delivery

Pre-authorized chequing (PAC) authorization

Are all PAC payors also a proposed insured and/or applicant? Yes No If 'no' provide the PAC payor name(s).

PAC payor's first name	Middle initial	Last name
PAC payor's first name	Middle initial	Last name

Notes:

- All PAC payors must agree to the following terms to use the PAC payment option.
 - We will withdraw all payments, including the initial payment, from the account indicated.
- 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 applicant/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 the Acknowledgement and agreement section 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

Payments

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.**

a) Do the payors want us to withdraw funds to pay the initial payment? Yes No

If **'yes'**, there could be a premium credit transferred to the new application to help pay the initial payment if this is a full conversion. If there is a premium credit, would you still like us to withdraw the initial payment? Yes No

If **'no'**, ensure the total initial payment has been submitted to the advisor upon completion of this application.

b) Does the payor want to add to an existing PAC? Yes No

If **'yes'**, what is the policy number the existing PAC is paying for?

Policy number

If **'yes'**, regular PAC withdrawals for this policy will be withdrawn on the same day each month for the policy number indicated unless a different day is indicated here:

Monthly withdrawal day for this application

c) Does the payor want to start a new PAC? Yes No If **'yes'**, complete d).

d) Sun Life Assurance Company of Canada will withdraw funds to pay all payments, including the initial payment if selected, on this policy each month from the bank account shown on the sample cheque attached or any account designated.

All persons whose signatures are required to sign on this account must sign the Acknowledgement and authorization section. For a joint account requiring more than one signature to withdraw funds, all the account holders must sign the Acknowledgement and authorization section.

We will withdraw the initial payment immediately.

(dd-mm-yyyy)

Regular PAC withdrawals will start one month from the policy date or on

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

Payments

Attach a sample cheque marked void OR complete the following: (Only accounts with chequing privileges may be used.)

Account holder name 1		Account holder name 2	
Name of financial institution			
Address of financial institution (street number and name)			
City		Province	Postal code
Branch/Transit number	Bank/Institution number	Account number	

This sample cheque shows the information that you need to provide.

Notes:

Branch/Transit numbers are normally 4-5 digits

Bank/Institution numbers are always 3 digits long:

BMO 001

Scotiabank 002

RBC 003

TD 004

CIBC 010

Account numbers can be up to 12 digits long

012

RANDY DOE
123 ANY STREET
CITY, PROVINCE, A1B 2C3

DATE: Y Y Y Y M M D D
Y Y Y Y M M D D

PAY TO THE ORDER OF: _____ \$ _____

_____ / 100 DOLLARS

YOUR FINANCIAL INSTITUTION
789 ANY STREET
CITY, PROVINCE, W7Y 8Z9

MEMO _____ MP _____

⑈012⑈ ⑆01234⑈001 1234 56⑈7⑈

⑈012⑈ ⑆01234⑈001 1234 56⑈7⑈

Cheque # Branch/Transit # Bank/Institution # Account #

Special instructions

Translation agreement and declaration

Was this application translated for any proposed insured(s) and/or applicant(s) 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,
- an applicant, or
- any other person who has an interest in the policy (excluding the advisor).

a) Proposed insured(s) and/or applicant(s) agreement

In this section, *you* and *your* refer to the proposed insured(s) and/or applicant(s).

1. Who was this application translated for in a language other than English?

Person 1 Person 2 Applicant 1 Applicant 2

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?

Person 1: Yes No Person 2: Yes No Applicant 1: Yes No Applicant 2: 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?

Person 1: Yes No Person 2: Yes No Applicant 1: Yes No Applicant 2: 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:

Person 1	<input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate _____	Person 2	<input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate _____
Applicant 1	<input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate _____	Applicant 2	<input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate _____

6. In what language were the questions translated?

Person 1		Person 2	
Applicant 1		Applicant 2	

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

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

By signing below, you declare that for any proposed insured(s) and/or applicant(s) indicated above in sub-section a), 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
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Acknowledgement and agreement

Acknowledgement and agreement

The applicants confirm they've received, read and agree to the Guide to critical illness definitions, if critical illness insurance was applied for. The applicants and proposed insureds (if other than applicant) confirm they've received, read and agree to the Sun Life Financial Privacy Statement for Canada.

Declaration

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

- they were present when their portion of this application with Sun Life Assurance Company of Canada (company) was completed,
- they reviewed all of their answers and statements recorded in the 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(ies),
- they agree that their personal, medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada,
- they agree that their personal information may be shared with or disclosed to our distribution partners such as managing general agencies or national accounts, market intermediaries and their employees and agents for the purposes identified in the Sun Life Financial Privacy Statement for Canada;
- they 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 the Payments section.

The proposed insured(s) confirm the information described in the Authorization to disclose information to your advisor section, may be shared with their advisor if they checked '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 Office of Health where required by law.

Signed in	Signed on (dd-mm-yyyy)	Applicant (indicate title of signing officers if applicable) X
Signed in	Signed on (dd-mm-yyyy)	Applicant (indicate title of signing officers if applicable) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (if other than applicant) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (if other than applicant or if under 16 [18 in Quebec] signature of parent or guardian) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (spouse covered under spousal group conversion) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured to be covered under CTB (if over 16 [18 in Quebec]) X
Signed in	Signed on (dd-mm-yyyy)	PAC payor (if other than applicant or proposed insured) X
Signed in	Signed on (dd-mm-yyyy)	PAC payor (if other than applicant or proposed insured) X

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

© Sun Life Assurance Company of Canada, 2019.

Policy number

Advisor report

Payment information

Payment made with this application \$	Future payment frequency <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly (Bermuda only)	Amount of future periodic payments \$
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Mailing information

Is the mailing address different from the residential address? Yes No

Address (street number and name)			
City	Province/State	Country	Postal/Zip code

Advisor information

Note: Shares must be a minimum of 10%.

Is commission being shared? Yes No

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

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

Are you related to the people to be insured and/or applicant(s)? Yes No

- Related means:
- a) a family member such as a spouse, parent, grandparent, sibling, child, grandchild or in-law
 - b) a corporation where you or a family member, individually or together own 50% or more of any class of shares of the corporation
 - c) where your business is incorporated, any director, officer, employee or agent and any parent, subsidiary or affiliated corporation
 - d) a trust arrangement where you have a relationship to the trust, the trustee or a trust beneficiary, or you are a settler, trustee or trust beneficiary of the trust.

If 'yes' provide details

About the proposed insured(s)

Person 1

Did you meet with the proposed insured in person? Yes No

If 'no' provide details

How long have you known the proposed insured?

Person 2

Did you meet with the proposed insured in person? Yes No

If 'no' provide details

How long have you known the proposed insured?

AGTSTMTE

Policy number



Advisor report

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 customer due diligence and to satisfy applicable regulatory requirements, I, the advisor, confirm that:

- reasonable effort was exercised to determine if each applicant is acting on behalf of a third party;
- all of the identification details provided in this application match the original identification documents shown to me;
- 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 applicant/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 applicant 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 applicant 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 applicant 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 applicant 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 applicant(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 the Licensed administrative assistant's declaration section). I the advisor, also confirm that:

- I have reviewed the details provided in this application with each applicant/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);
- it has all the facts material to the insurance applied for; 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	E-mail address
Date (dd-mm-yyyy)	Advisor's signature X		
Date (dd-mm-yyyy)	Supervisor's signature X		

Licensed administrative assistant's declaration

Did a licensed administrative assistant complete the application (excluding the Identity verification section)? Yes No

I, the licensed administrative assistant, confirm that:

- I have reviewed the details provided in this application with each applicant/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;
- it has all the facts material to the insurance applied for; 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		

Note: Please only submit one copy of this document.

- Career Sales Force advisors: Original or fax toll-free to 1-866-487-4745.
- All others: Through your MGA or National Account.

Important information you should know



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).

ADMINIE

Policy number

