

Application to redeem locked-in money due to shortened life expectancy



Prior to completing this form, the owner should consider obtaining independent advice concerning the effect of this application on his/her rights.

Jurisdiction of locked-in account*
Account* number

1 Owner information

Owner's first name	Last name	Date of birth (dd-mm-yyyy) - -	
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number - -

2 Attestation

I am the owner of the account* identified above and attest that, on the date I sign this application, I request to redeem, on the basis of my disability or condition, all or part of the value of my account* as applicable.

How much do you want to redeem?
(check only one of the boxes below)

- All amounts under my account* (withholding tax will apply)
- The amount of \$ _____ before withholding taxes, which is less than the balance of the account*

I attest that all of the information contained in this application is true, complete and correct. I understand that this application, once made, is irrevocable and that Sun Life Financial Trust Inc., Sun Life Assurance Company of Canada, Sun Life Financial Investment Services (Canada) Inc., and any of their affiliates cannot be held liable should my circumstances change in the future. I understand that pursuant to this request, a Market Value Adjustment may apply, if applicable to my account*.

I further understand that it is a criminal offence for anyone to knowingly make a false declaration and/or make or use a false document.

Signature of owner X	Date (dd-mm-yyyy) - -
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Some provincial pension legislation requires that if you have a spouse as defined by applicable legislation, a spousal rights waiver or spousal consent form may be required for this request.

Once both your attestation and the physician's statement have been completed, please send your application to the appropriate Sun Life Financial entity as indicated on the back of this form.

* "account" may also refer to "contract" or "policy"

Physician's statement

I am a physician licensed to practice medicine in a jurisdiction in Canada.

In my opinion, _____ (name of applicant) has a disability or condition that is likely to considerably shorten his or her life expectancy.

In my opinion, the disability/condition of the individual above is likely to shorten their life to a period of less than two years. **(Required for Manitoba and Ontario)**

Physician's first name (please print)		Last name	
Address (street number and name)			Apartment or suite
City		Province	Postal code
Physician's signature X			Date (dd-mm-yyyy) — —

Sun Life Financial Investment
Services (Canada) Inc.
227 King St South
PO Box 1601 STN Waterloo
Waterloo ON N2J 4C5
**(Sun Life Financial nominee
name accounts)**

Sun Life Assurance
Company of Canada
227 King St South
PO Box 1601 STN Waterloo
Waterloo ON N2J 4C5
**(Sun Life Financial
accumulation annuity
products)**

Sun Life Financial
Trust Inc.
227 King St South
PO Box 1601 STN Waterloo
Waterloo ON N2J 4C5
**(Sun Life Financial
GIC products)**