

Application for Sun Retirement Health Assist

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

Policy number (For H.O. use only)

Notes:

- Before completing this application, please review the questions in section 8 to determine if an application should be submitted.
- Ensure the required signed illustration is attached to this application.

1 Applicant (To be completed only if applicant is different than the proposed insured.)

Mr. Mrs. Miss Ms. Other

First name	Middle initial	Last name	
Former last name (if applicable)			Date of birth (dd-mm-yyyy) <input type="checkbox"/> Male <input type="checkbox"/> Female
Is the applicant an owner, planholder, insured person or annuitant on any other plan with the company? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', indicate one policy or account number: <input type="text"/>			

2 Mailing information for the applicant (Must be completed on all applications.)

Do you want your policy to be in: English Français

How will this policy be delivered: directly to you (n/a by the advisor, to you Advisor/LTCl specialist, please specify:

Financial centre no.

Applicant's mailing address (number and street)		Apartment or suite
City	Province	Postal code

3 Proposed insured

Mr. Mrs. Miss Ms. Other

First name	Middle initial	Last name	
Former last name (if applicable)			Date of birth (dd-mm-yyyy) <input type="checkbox"/> Male <input type="checkbox"/> Female
Is the proposed insured an owner, planholder, insured person or annuitant on any other plan with the company? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', indicate one policy or account number: <input type="text"/>			
Does the proposed insured want to backdate to retain age? <input type="checkbox"/> Yes <input type="checkbox"/> No Note: Age may be retained up to 90 days.			

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3 Proposed insured (continued)

Proof of age

Document (indicate type)	Requirement
<input type="checkbox"/> Canadian, USA or UK driver's license <input type="checkbox"/> Canadian, USA or UK 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 than Canada <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

4 Mailing information for the proposed insured (Complete only if different from address in number 2.)

Proposed insured's address (number and street)		Apartment or suite
City	Province	Postal code

5 Phone information for proposed insured

Please provide at least one phone number where we can contact the proposed insured.

Type of phone <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Other	Proposed insured's telephone number	Extension	Best time to call <input type="checkbox"/> am <input type="checkbox"/> pm
Type of phone <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Cell <input type="checkbox"/> Other	Proposed insured's telephone number	Extension	Best time to call <input type="checkbox"/> am <input type="checkbox"/> pm

6 Transaction type

1. Was this application completed in Quebec? Yes No
 If 'yes', is this application intended to replace or reduce the benefits of any existing insurance policy or a pending insurance application of any company? Yes No
 If 'yes' and Quebec, please submit the Notice of replacement of insurance of persons contract form.

2. Is this application to replace an existing Sun or Clarica long term care insurance policy? Yes No

If 'yes', indicate the ORIGINAL weekly benefit amount \$

Is the original base plan to stay in force? Yes No

Indicate amount to be replaced \$

Provide the policy number of the long term care insurance policy that is to be changed or terminated by this application.

Clarica Sun

Notes:

- The policy listed above will be changed or terminated on the date that any insurance applied for in this application becomes effective.
- This transaction will result in changes to or termination of the old policies identified and the issue of a new policy. This may result in the loss of one or more benefits or changes to the policy terms and conditions including any waiting period or benefit period.
- Any credits from the changed or terminated policy will be applied to the withdrawable premium fund for the proposed application.

7 Plan information

Note: The benefit period is unlimited.

A. Weekly benefit amount

\$

(Must be between \$500 - \$2,300)

B. Waiting period

365 days (1 year) 730 days (2 years)

C. Additional options

Return of premium on death

Note: The beneficiary will be the:

- applicant or the estate of the applicant, or
- the beneficiary named by the applicant in the special instruction section of this application.

8 Personal history of the proposed insured

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

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

8.1 Personal history questions

1. Are you a Canadian citizen or permanent resident? Yes No
Note: If 'no', you are ineligible. Please do not proceed with this application.

2. Height: cm ft & in Weight: kg lbs
Note: Advisors/LTCl specialists should refer to the underwriting guide to determine if build is eligible.

Note: For questions 3 - 5, any 'yes' answer makes you ineligible. Please do not proceed with this application.

3. Have you been told to use or do you use a wheelchair, walker, motorized scooter, multi-pronged cane, oxygen or dialysis? Yes No
 4. Are you currently receiving a disability income benefit or have you ever received a lump sum settlement? Yes No
 5. Do you need the assistance or supervision of another person for bathing, dressing, toileting, transferring (such as moving to or from a bed or chair), continence or feeding? Yes No

Note: For question 6, answering 'yes' to 6 a) or b), or to any of the numeric subset question in c) - e) makes you ineligible. Please do not proceed with this application.

6. Have you **ever** been told to have any tests or investigations, been diagnosed with or treated for:
- a) multiple sclerosis (MS), Parkinson's disease, Huntington's disease or muscular dystrophy Yes No
 b) Alzheimer's disease, dementia, chronic memory loss, transient ischemic attack (TIA), mini-stroke, stroke or cerebrovascular accident (CVA) Yes No
 c) diabetes Yes No
 If 'yes', you must answer (i - iv)
 i) Do you use more than 40 units of insulin daily? Yes No
 ii) Have you **ever** been diagnosed with, treated for or been told to have any tests or investigations for angina, chest pain or heart attack? Yes No
 iii) Have you had a coronary artery bypass graft (CABG) or angioplasty? Yes No
 iv) Have you **ever** had any diabetic complications such as numbness of any arm, leg or foot, ongoing protein in the urine, kidney disease, circulatory disease, leg ulcers or retinopathy (which required treatment)? Yes No
 d) systemic lupus erythematosus Yes No
 If 'yes', were you diagnosed before age 50? Yes No
 e) osteoarthritis, rheumatoid/inflammatory arthritis, osteoporosis, spine or disc disorder? Yes No
 If 'yes', you must answer (i - iii)
 i) Have you **ever** had more than one fall, more than one fracture or more than one joint replacement? Yes No
 ii) Do you use four or more medications to treat condition? Yes No
 iii) Do you have any physical limitation to your normal day to day activities? Yes No

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8 Personal history of the proposed insured (continued)

Note: For question 7, answering 'yes' to any of the numeric sub set questions makes you ineligible. Please do not proceed with this application.

7. Do you currently use cigarettes, cigarillos, small or large cigars, pipes, marijuana or hashish, betelnut, chewing tobacco, nicotine gum or patches, nicotine or tobacco in any other form? Yes No

If 'yes', you must answer (i - iv).

Have you **ever** been diagnosed with, treated for or been told to have any tests or investigations for:

- i) chronic respiratory disorder, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis (exclude mild to moderate asthma) Yes No
- ii) transient ischemic attack (TIA), mini-stroke, stroke or cerebrovascular accident (CVA) Yes No
- iii) limited ability to walk or climb stairs Yes No
- iv) leg ulcers Yes No

8.2 Personal information questions

1. Do you have any long term care insurance in force with any company? Yes No
If 'yes', complete the following chart.

Insurance company	Insurance date (dd-mm-yyyy)	Weekly benefit amount	Being replaced
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Do you have any applications for long term care insurance currently pending or contemplated? Yes No
If 'yes', provide details indicating company names, plan types, amounts applied for and total amount of new insurance to be put into effect.

Company name	Plan type	Amount applied for	Total amount of new insurance intended to place with all companies
		\$	\$
		\$	\$
		\$	\$
		\$	\$

3. Have you **ever** applied for long term care insurance with Sun Life Financial or any other company and been declined? Yes No
If 'yes', provide details.

8 Personal history of the proposed insured (continued)

4. Name and address of usual medical advisor or clinic.

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

9 Payments

1. 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 Pre-authorized chequing (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 section 2 below has been selected.

a) Payment options available on applications submitted by a Sun Life Financial advisor or Sun Life Financial LTCI specialist

Pre-authorized chequing (PAC) Yes No If 'yes', please complete section 2.

Notes:

- If all payors do not agree to all of the terms of the PAC authorization in section 2, PAC may not be used.
- We will withdraw all payments, including the initial payment, from the account shown in section 2.

Annual Yes No If 'yes', submit the total annual payment to the advisor/LTCI specialist at the time the application is completed. Make the cheque payable to Sun Life Assurance Company of Canada.

\$ Amount paid to advisor/LTCI specialist with application.

b) Payment options available on applications submitted by a third party advisor (Do not submit any payment with the application.)

Payment on delivery

Indicate how 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 section 2 below
- PAC withdrawal based on PAC information provided in section 2 below, or
- PAC withdrawal with PAC information/payment instructions to be provided on delivery

2. Pre-authorized chequing (PAC) authorization

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

All PAC payors agree:

- Sun Life Assurance Company of Canada 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 will 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 section 12 as a PAC payor,
- the company may not assign this authorization to another company or person in order to permit them to debit the PAC payor's account for these payments (e.g. where there has been a change in control of the company) without providing at least 10 days prior written notice, and
- to waive the requirement that the company notify them of:
 - this authorization before the first payment is processed
 - any subsequent payments, and
 - any changes to the amount or date of the payment initiated by them or the company.



9 Payments (continued)

a) Withdraw funds to pay the initial payment Yes No If 'yes', complete b) or c).

Notes (n/a if third party advisor):

- We will immediately withdraw 1/12th of the annual payment as the initial payment.
- If 'no', submit the total initial payment to the advisor at the time the application is completed.

b) Start a new PAC Yes No

(If 'yes' complete d) and e). Regular PAC withdrawals for this policy will start one month from the policy date, unless otherwise indicated in d).)

c) Add to existing PAC that is paying for policy Yes No

(Regular PAC withdrawals for this policy will be withdrawn on the same day each month as the existing PAC for the policy number listed above, unless otherwise indicated in d).)

d) The company 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 authorization on page 10. For a joint account requiring more than one signature to withdraw funds, all the account holders must sign the authorization on page 10.

We will withdraw the initial payment immediately.

Regular PAC withdrawals will start one month from the policy date or on _____ (dd-mm-yyyy).

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

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

Contact us at any time at:

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

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

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

10 Special instructions

11 Translation agreement and declaration

Was this application translated for any proposed insured and/or applicant in a language other than English?
 If 'yes', you must complete the sub sections below.

Yes No

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).

11.1 Proposed insured and/or applicant agreement

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

- Who was this application translated for in a language other than English?
 Proposed insured Applicant
- Do you agree that your answers to the questions asked and translated for you are complete and true, and do you understand they form part of the application?
 Proposed insured: Yes No Applicant: Yes No

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

- Do you agree that this application was fully explained to you in your preferred language, and do you understand the content provided by the translator?
 Proposed insured: Yes No Applicant: 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. Relationship to proposed insured:

Proposed insured	<input type="checkbox"/> Advisor <input type="checkbox"/> Other	Applicant	<input type="checkbox"/> Advisor <input type="checkbox"/> Other
Indicate:	_____	Indicate:	_____

6. In what language were the questions translated?

Proposed insured		Applicant	
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11.2 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 and/or applicant indicated above in sub-section 11.1, you:

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

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

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

12 Acknowledgement and agreement

Acknowledgement and agreement: The applicant confirms they've received, read and agree to:

- the brochure called "A clear connection: Your relationship with Sun Life Financial" (only applicable if a Sun Life Financial advisor completed this application with you), and
- the brochure called "Caring for the long term – Our relationship with you" (only applicable if a Sun Life Financial LTCI specialist completed this application with you)
- the Information about your application for Sun Retirement Health Assist.

The applicant and proposed insured (if other than applicant) confirm they've received, read and agree to the Sun Life Financial Privacy Statement for Canada.

Declaration

The applicant, proposed insured and pre-authorized chequing (PAC) payors confirm:

- they were present when their portion of this application with the 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 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), and
- PAC payors, by signing below, agree to the terms of the PAC authorization, as set out in section 9.

Authorization of the proposed insured

The proposed insured authorizes:

- 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 about me, 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 my 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 my life, and for any infectious or communicable disease, to the Medical Office of Health where required by law.

Location signed	Date (dd-mm-yyyy)	Signature
Province:	Signed on:	Applicant (indicate title of signing officers if applicable) X
Province:	Signed on:	Proposed insured (if other than applicant) X
Province:	Signed on:	PAC payor (if other than applicant or proposed insured) X
Province:	Signed on:	PAC payor (if other than applicant or proposed insured) X

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

13 Advisor/LTCL specialist's report

Payment information

Payment made with this application \$	Future payment frequency <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly
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Advisor/LTCL specialist's information

Note: Shares must be a minimum of 10%.

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

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

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

Advisor/LTCL specialist's declaration and notice of disclosure (Must be signed by advisor/LTCL specialist only.)

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

- I have disclosed to the 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 the 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 the 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 the 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 section 14), I the advisor/LTCL specialist, also confirm that:

- I have reviewed with the applicant, proposed insured and each PAC payor, all of their information in this application and, to the best of my knowledge, this information is complete and true and has all the facts material to the insurance applied for;
- I have provided them with a copy of the brochure called "A clear connection: Your relationship with Sun Life Financial" and discussed it with them (only applicable if a Sun Life Financial advisor completed this application);
- I have provided them with a copy of the brochure called "Caring for the long term – our relationship with you" and discussed it with them (only applicable if a Sun Life Financial LTCL specialist completed this application); and
- I saw every person sign this application.

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

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

Policy number

Did a licensed administrative assistant complete the application? Yes No

I, the licensed administrative assistant, confirm that:

- I have reviewed with the applicant, proposed insured and each PAC payor, all of their information in this application and, to the best of my knowledge, this information is complete and 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
Licensed administrative assistant's signature X		Date (dd-mm-yyyy)

Information about your application for Sun Retirement Health Assist

Policy number

When you can expect to receive your policy or refund

You should receive your policy, or any payment refund, within 90 days of the date the application is completed. If you do not, please call our Customer Care Centre toll-free at 1-877-SUN-LIFE (1-877-786-5433).

You are considered to have received your policy 5 days after it is mailed to the address shown on your application from our office, or on the date the your advisor or the LTCI specialist delivers it to you.

If you change your mind about the policy, you may send us a written request to cancel it within the earlier of:

- 10 days of receiving it from us, or
- 60 days after the policy is issued.

Refund of payments

Any payments paid will be refunded without interest if:

- your application is not approved, or
- you withdraw your application.

Receipt for application payment (complete for all applications)

Received from _____ on

Date (dd-mm-yyyy)

\$

OR

authorization to take first payment by pre-authorized chequing and the required banking information

Advisor/LTCI specialist's signature

X

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Important information you should know

Policy number

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

Sun Life Financial Privacy Statement for Canada

Respecting your privacy

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

Access to your information

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

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

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

MIB, Inc.
330 University Avenue
Suite 501
Toronto, ON 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

