Application for reinstatement of life or critical illness insurance

Sun Life Financial

Use this form to apply to reinstate a policy of any amount when the number of days from the premium due date is 62 to 180 days. If the number of days is more than 180 days, use the Application for policy change, reinstatement and/or reconsideration of rating (E110/E245) and have the proposed insured provide medical evidence based on the appropriate age and amount chart.

Application to reinstate policy number

In this application, *I, you, your, Person 1* and *Person 2* refer to the proposed insured(s) and/or the applicant(s). Person 2 may be the second proposed insured, the insured spouse and/or the joint insured as indicated in the original policy to be reinstated. *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, your*, *Person 1* and *Person 2* refer to in that section.

1 General information

Person 1's first name	Middle initial	Last name	Applicant's first name	Middle initial	Last name
Person 2's first name	**Middle initial**	**Last name**	**Applicant's first name**	**Middle initial**	**Last name**

2 Outstanding payments

In this section, *your* refers to the applicant(s).

All outstanding payments must be collected before the policy can be reinstated.

Amount paid with application $ _____ **Note: We do not accept cash payments.**

Your policy will be reinstated with the same payment option that was last used for this policy. If this option was Pre-authorized chequing (PAC), the new withdrawal date for regular monthly payments will be the same as the last withdrawal date used on this policy.

If the method of payment is PAC, we will issue a special PAC cheque to pay any outstanding payments not submitted with the application.

3 Personal information for the proposed insureds

In this section, *you, your, Person 1* and *Person 2* refer to the proposed insured(s). The questions must be answered by the proposed insured(s). If any proposed insured is a minor, the minor's parent or legal guardian must provide the information on their behalf.

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.

3.1 Medical advisor/clinic information

Person 1	a) Do you have a usual medical advisor or clinic? ☐ Yes ☐ No	If '**yes**', name of usual medical or health care advisor or medical clinic		
	Address	City	Province	
	Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
	Answer b) if '**yes**' to a). b) In the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy)		
	Answer c) if '**no**' to a). c) In the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy)		
	If '**yes**', name and address of doctor consulted			

RINSTATE

Please submit only 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.

Application to reinstate policy number

3 Personal information for the proposed insureds (continued)

Person 2	a) Do you have a usual medical advisor or clinic? ☐ Yes ☐ No	If '**yes**', name of usual medical or health care advisor or medical clinic.		
	Address	City	Province	
	Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
	Answer b) if '**yes**' to a). b) In the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy)		
	Answer c) if '**no**' to a). c) In the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No	If '**yes**', date of most recent exam or checkup (dd-mm-yyyy)		
	If '**yes**', name and address of doctor consulted.			

3.2 Smoking and tobacco use

Note: Questions in 3.2 do not need to be answered for proposed insureds under the age of 16.

	Person 1	Person 2
In the **last 5 years**, have you smoked or used cigarettes, cigarillos, small or large cigars, pipes, betelnut, chewing tobacco, nicotine gum or patches, nicotine or tobacco in any other form?	☐ Yes ☐ No	☐ Yes ☐ No

Proposed insured	Product(s)	Amount(s) and frequency of use	Date(s) last used (dd-mm-yyyy)
Person 1			
Person 2			

3.3 Drug and alcohol use

Note: Questions in 3.3 do not need to be answered for proposed insureds under the age of 16.

In the **last 5 years**, have you:

	Person 1	Person 2
a) used marijuana or hashish, cocaine, LSD, ecstasy or other psychoactive drugs, heroin, fentanyl or other narcotics, anabolic steroids or other performance enhancing drugs?	☐ Yes ☐ No	☐ Yes ☐ No

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

Proposed insured	Product(s) (Indicate all that apply.)	Amount(s) and frequency of use	Date(s) last used (dd-mm-yyyy)
Person 1	☐ marijuana or hashish mixed with tobacco ☐ marijuana or hashish without tobacco ☐ other:		
Person 2	☐ marijuana or hashish mixed with tobacco ☐ marijuana or hashish without tobacco ☐ other:		

b) been charged with or convicted of an alcohol or drug related driving offence or refusing a breathalyzer test?	☐ Yes ☐ No	☐ Yes ☐ No
c) received treatment or been told to reduce use or frequency of use, seek treatment, counselling or medical advice due to your use of drugs or alcohol?	☐ Yes ☐ No	☐ Yes ☐ No

Application to reinstate policy number

3 Personal information for the proposed insureds (continued)

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

Proposed insured	Details
Person 1	
Person 2	

3.4 Other information

Note: Question in 3.4 does not need to be answered for proposed insureds **under the age of 10.**

In the **last 5 years**, have you been charged with, convicted of or imprisioned for any criminal offence; or are you currently on probation, parole or statutory release?

	Person 1		**Person 2**	
	☐ Yes	☐ No	☐ Yes	☐ No

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

Proposed insured	**Date(s) of offence(s) (dd-mm-yyyy)**	**Type of offence(s)**	**Details**
Person 1			
Person 2			

3.5 Residence and travel

In the **next 12 months**, do you intend to:

	Person 1		**Person 2**	
a) **travel** outside of **Canada** or the **United States**?	☐ Yes	☐ No	☐ Yes	☐ No
b) **reside** outside of **Canada**?	☐ Yes	☐ No	☐ Yes	☐ No

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

Proposed insured	**Countries and cities**	**Length and purpose of stay in each**	**Past date(s) of travel (dd-mm-yyyy)**	**Future date(s) of travel (dd-mm-yyyy)**
Person 1				
Person 2				

4 Family history questionnaire for the proposed insureds

In this section, *you, your, Person 1* and *Person 2* refer to the proposed insured(s). The questions must be answered by the proposed insured(s). If any proposed insured is a minor, the minor's parent or legal guardian must provide the information on their behalf.

Note: Questions in 4 do not need to be completed for proposed insureds **over the age of 65**. **Do not tell us about genetic testing or genetic test results.**

	Person 1		**Person 2**	
a) Have any of your parents, brothers or sisters been diagnosed **before age 65** with heart disease, stroke/TIA, cancer (including leukemia, lymphoma and Hodgkin's disease), diabetes or Parkinson's disease?	☐ Yes	☐ No	☐ Yes	☐ No
b) Have any of your parents, brothers or sisters **ever** been diagnosed with Huntington's disease, polycystic kidney disease (PKD), multiple sclerosis (MS), muscular dystrophy, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or any other hereditary disease or disorder?	☐ Yes	☐ No	☐ Yes	☐ No

Application to reinstate policy number

4 Family history questionnaire for the proposed insureds (continued)

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

Proposed insured	Details	Condition (if cancer include type)	Age at onset	Age if living	Age at death
Person 1					
Person 2					

5 Height and weight

In this section, *Person 1* and *Person 2* refer to the proposed insured(s).

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

Proposed insured	Height	Weight	In the last 12 months, has there been a weight loss of more than 4.5 kg (10 lbs)?
Person 1	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ Yes ☐ No If '**yes**', provide details including amount of weight loss and cause of the weight loss.
Person 2	☐ ft/in ☐ cm	☐ lb ☐ kg	☐ Yes ☐ No If '**yes**', provide details including amount of weight loss and cause of the weight loss.

6 Personal medical history for the proposed insureds

In this section, *you, your, Person 1* and *Person 2* refer to the proposed insured(s). The questions must be answered by the proposed insured(s). If any proposed insured is a minor, the minor's parent or legal guardian must provide the information on their behalf.

In the **last 5 years**, have you:	Person 1	Person 2
1. a) been treated for or had any indication of heart attack or any other heart disease or disorder, high blood pressure, stroke or transient ischemic attack (TIA), cancer or any other growth(s) or malignancy, diabetes or kidney, lung or liver disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b) been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?	☐ Yes ☐ No	☐ Yes ☐ No
c) been admitted or been told to be admitted to a hospital or other medical facility, or had surgery performed or recommended?	☐ Yes ☐ No	☐ Yes ☐ No
d) 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
2. Are you:		
a) presently disabled or otherwise prevented from performing your usual activities or regular duties of your occupation?	☐ Yes ☐ No	☐ Yes ☐ No
b) aware of any symptoms for which you have not yet consulted a physician or received treatment or for which you are currently awaiting investigation or test results?	☐ Yes ☐ No	☐ Yes ☐ No

Application to reinstate policy number

6 Personal medical history for the proposed insureds (continued)

If '**yes**' to any question in # 1 - 2, provide details below.

Proposed insured	**Details**
Person 1	
Person 2	

7 Complete for children to be covered under Child term or Children's insurance benefit

In this section, any insured child refers to any children originally covered under the Child term or Children's insurance benefit on the policy to be reinstated.

In the **last 2 years**, has any insured child consulted a physician or other health practitioner? ☐ Yes ☐ No
If '**yes**', provide details below.

Child 1	Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
	Details			
Child 2	Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
	Details			
Child 3	Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
	Details			
Child 4	Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
	Details			
Child 5	Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
	Details			

Application to reinstate policy number

8 Complete for applicant if there is any disability waiver benefit/coverage on the applicant

The applicant who was covered under this benefit/coverage, must answer the questions in this section and must sign section 10. If more than one applicant has been indicated on page 1, provide the name of the applicant who was covered under this benefit.

Applicant's first name	Middle initial	Last name

	Person 1		Person 2	
1. In the **last 5 years**, has the applicant:				
a) been treated for or had any indication of heart attack or any other heart disease or disorder, high blood pressure, stroke or transient ischemic attack (TIA), cancer or any other growth(s) or malignancy, diabetes or abnormal blood sugar or any other kidney, lung or liver disease or disorder?	☐ Yes	☐ No	☐ Yes	☐ No
b) been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?	☐ Yes	☐ No	☐ Yes	☐ No
c) been admitted or been told to be admitted to a hospital or other medical facility, or had surgery performed or recommended?	☐ Yes	☐ No	☐ Yes	☐ No
d) 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
2. Is the applicant presently disabled or otherwise prevented from performing their usual activities or regular duties of their occupation?	☐ Yes	☐ No	☐ Yes	☐ No

If '**yes**' to any of the above, provide details below. List each condition along with all related treatments, dates, durations, results, names and addresses of doctors, hospitals and clinics consulted.

Question number(s)	**Details**

9 Acknowledgement of variability

In this section, *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.

Application to reinstate policy number

10 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).

10.1 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. Relationship to proposed insured:

Person 1	☐ Advisor ☐ Other Indicate:	Applicant 1	☐ Advisor ☐ Other Indicate:
Person 2	☐ Advisor ☐ Other Indicate:	Applicant 2	☐ Advisor ☐ Other Indicate:

6. In what language where the questions translated?

Proposed insured 1		Applicant 1	
Proposed insured 2		Applicant 2	

10.2 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(s) and/or applicant(s) indicated above in sub-section 10.1, 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

Application to reinstate policy number

11 Declaration and authorization

Acknowledgement and agreement:

The applicant(s) confirm they've received, read and agree to:

- the Sun Life Financial Privacy Statement for Canada, and
- the guide to critical illness definitions, if critical illness insurance was applied for.

Declaration:

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

- they were present when their portion of this application with the Sun Life Assurance Company of Canada (company) was completed,
- they reviewed all their answers and statements recorded in 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,
- 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 have read and agree to the Acknowledgement of variability, if applicable,
- they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under the "Products and services" section of the website at *www.sunlife.ca* or by calling our toll-free Customer Care Centre at 1-800-786-5433.
- they understand the company is not responsible for the validity of any beneficiary appointments, and
- they agree to the pre-authorized chequing (PAC) authorization, if they are the PAC Payor(s).

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

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

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

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

Please submit only 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.

Application to reinstate policy number

12 Advisor declaration

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 confirm that:

- I have reviewed with each applicant, proposed insured and 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 facts material to the insurance applied for,
- I am licensed in the province in which the application was completed and this signature page was signed, and
- I saw every person sign this application.

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.

Advisor's first name	Middle initial	Last name	Advisor number/code

Date (dd-mm-yyyy)	Advisor's signature X
Date (dd-mm-yyyy)	Supervisor's signature X

For Financial centre use only

Date (dd-mm-yyyy)	Amount paid for reinstatement for premiums due $ ☐ Payment reported

Please submit only 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

Application to reinstate 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 the 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).

ADMIN1E