Application for life and/or critical illness insurance

Sun Life 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.

Life's brighter under the sun

Sun Life

810-2799-01-21

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HOW TO SEND US THE APPLICATION

- ☐ Tear off the *Thank you for applying with Sun Life* page and give it to the owner.
- ☐ If they've applied for temporary insurance, tear off the *Certificate for temporary insurance* page and give a copy to all the owners.
- ☐ Send us all pages of this completed application through your MGA or National Account, and attach:
  - ☐ Any required **additional forms, including replacement forms, completed and signed.**
  - ☐ If applying for *Sun Par Protector II*, *Sun Par Accumulator II*, *Sun Par Accelerator*, *SunUniversalLife II* or *SunUniversalLife Pro*, **a signed illustration.**
  - ☐ If applying for temporary insurance, a cheque or payment authorization for the **initial payment.**

Questions?

If you have questions about this application, please call us at **1-877-SUN-LIFE** (1-877-786-5433).

Important information

Use this application for any of the following:

- up to the first two people applying for life insurance, and up to five children under the child term benefit (CTB), or
- one person applying for critical illness insurance,
- all conversions and options exercised with an increase in coverage, or
- all policy replacements.

If more people are to be insured under the same policy, complete an application form for the additional people, and list them in question 1.5 in this application.

DO NOT use this application for:

- any conversions or options exercised with no coverage increase. Instead complete **Form 260**, *Application for conversion and exercising an option*,
- changes in smoking status with no other policy changes. Instead complete **Form 18**, *Declaration of smoking status (for changes to existing policies only)*, and
- changes in smoking status with a coverage inscrease. Instead complete **Form 110**, *Application for policy change, reinstatement and/or reconsideration of rating*.

Options for gathering the client's medical information

You have the following options:

1. You can ask your client all of the questions in this application.
2. You can request a tele-interview and skip asking most of the *Lifestyle* questions and all of the *Medical* questions.
3. If a paramedical is required, you may skip asking all of the *Medical* questions.
4. If a non-medical is required, do not order a paramedical. A non-medical can be replaced by a tele-interview only.

Discuss this with your client at the start of the application and indicate your preference in question 17.5.

For faster processing

- Please print clearly using blue or black ink.
- To speed up APS ordering, complete Section 10.1 Medical Information: Physician or health care professional.

Application for life and/or critical illness insurance

Sun Life

Policy number (for H.O. use only)

In this application, ***insured***, ***owner***, ***you*** and ***your*** refer either to the proposed insureds or the proposed owners. At the start of each section we've stated who ***you*** and ***your*** refer to in that section.

Note: If any proposed insured is a minor, the minor's parent or legal guardian must provide the information on their behalf.

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

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

- The international tax residency self-certification for FATCA/CRS questions in this application should be answered only by an individual owner (including a sole proprietor)/proposed insured. Non-individual (corporate or other entity) information must be completed on **Form 4545**, *International tax classification for an entity*.
- 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 completed **Form 4573**, *International tax self-certification for Individuals*. 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.

1 General policy information

In this section, *you* and *your* refer to all owners of the policy.

1.1 What type of insurance are you applying for? Check one or both boxes:

☐ Life insurance ☐ Critical illness insurance

1.2 What type of policy will this be? Check one box:

☐ New policy ☐ Replacement of an existing policy ☐ Conversion of an existing policy with an increase in coverage

☐ Exercising a policy option with an increase in coverage

1.3 How many people are being insured (*excluding* children being insured under child term benefit)?

Adults	Children

1.4 Are you insuring any children under a child term benefit? ☐ Yes ☐ No

1.5 If more than two people are being insured for life insurance, have you completed another application for the other insureds? ☐ Yes ☐ No

If ***Yes***, and this is the first application you're completing, provide the names of the additional people insured on an additional application. If this is the additional application, do not fill in any names below.

First name	Middle initial	Last name	Date of birth (dd–mm–yyyy)

AAPPE

Policy number (for H.O. use only)

1 General policy information (continued)

1.6 a) What is the purpose and intended use of this insurance? Check all that apply:

☐ Income replacement ☐ Creditor protection ☐ Tax or estate planning ☐ Key person insurance ☐ Buy-sell agreement
☐ Estate protection ☐ Mortgage protection ☐ Charitable donation ☐ Asset protection ☐ Business protection
☐ Other – provide details:

b) Provide details for any sales concept or sales strategy not referenced in 1.6 a).

c) If the owner is a business, complete the following:

First name(s) of business owner(s)	Last name(s)	Name of the business	% of business owned	Total amount of business insurance already in force with all companies	Total amount of new business insurance currently pending or contemplated with all companies
			%	$	$
			%	$	$
			%	$	$
			%	$	$

Annual sales	Net after tax income	Fair market value
$	$	$

1.7 Will there be an illustration attached with this application? ☐ Yes ☐ No

Note: A signed illustration is required on all ***Sun Par Protector II, Sun Par Accumulator II, Sun Par Accelerator, SunUniversalLife II*** and ***SunUniversalLife Pro*** applications.

1.8 What language would you like your policy and future correspondence in? Check one box:

☐ English ☐ French

2 The people to be insured

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

Insured 1

2.1 Name and contact information of Insured 1

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	Middle initial	Last name

Former last name (if any)	Date of birth (dd-mm-yyyy)	Gender ☐ M ☐ F	If you're also an owner applying for universal or permanent life insurance, please provide your Social Insurance Number.

Home phone	Cell phone	Work phone	Extension
			X

Your residential address (street number and name – PO Box and General Delivery addresses not acceptable)	Apartment or suite number

City	Province	Country	Postal code

Your citizenship and residency status

	Country of birth	City of birth
2.2 Where were you born?		

2.3 What's your citizenship or residency status? Check one box:

☐ Canadian citizen – skip to question 2.6. ☐ Permanent resident or landed immigrant. ☐ Other

Policy number (for H.O. use only)

2 The people to be insured (continued)

2.4 If you answered *Permanent resident* or *landed immigrant*, or *Other*, how long have you lived in Canada?

Years, and	Months

2.5 If you're not a Canadian citizen or permanent resident, complete the following:

☐ You have applied for permanent resident status. ☐ You haven't applied for permanent resident status. **Please explain below:**

Important information
Complete questions 2.6 and 2.7 **ONLY** if Insured 1 is also an owner and applying for universal or permanent life insurance.

2.6 Are you a U.S. citizen or resident for tax purposes (FATCA)?

☐ Yes – provide details below. ☐ No

Your U.S. Taxpayer Identification Number (TIN)

2.7 Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes (CRS)?

☐ Yes – provide details below. ☐ No – skip to question 2.8.

Your jurisdiction of tax residence	Your Taxpayer Identification Number (TIN)

If you do not have a Taxpayer Identification Number, check a box to give the reason:

☐ You've applied for one but haven't received it yet.

☐ Your jurisdiction of tax residence doesn't issue TINs.

☐ Other – provide details:

Insured 2

2.8 Name and contact information of Insured 2

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	Middle initial	Last name

Former last name (if any)	Date of birth (dd-mm-yyyy)	Gender ☐ M ☐ F	If you're also an owner applying for universal or permanent life insurance, please provide your Social Insurance Number.

Home phone	Cell phone	Work phone	Extension
			X

If the address is the same as Insured 1, you do not need to complete the address below.

Your residential address (street number and name – PO Box and General Delivery addresses not acceptable)	Apartment or suite number

City	Province	Country	Postal code

Your citizenship and residency status

2.9 Where were you born?

Country of birth	City of birth

2.10 What's your citizenship or residency status? Check one box:

☐ Canadian citizen – skip to question 2.13. ☐ Permanent resident or landed immigrant. ☐ Other

2.11 If you answered *Permanent resident* or *landed immigrant*, or *Other*, how long have you lived in Canada?

Years, and	Months

Policy number (for H.O. use only)

2 The people to be insured (continued)

2.12 If you're not a Canadian citizen or permanent resident, complete the following:

☐ You have applied for permanent resident status. ☐ You haven't applied for permanent resident status. **Please explain below:**

Important information
Complete questions 2.13 and 2.14 **ONLY** if Insured 2 is also an owner and applying for universal or permanent life insurance. If not, skip to question 2.15.

2.13 Are you a U.S. citizen or resident for tax purposes (FATCA)?

☐ Yes – provide details below. ☐ No

Your U.S. Taxpayer Identification Number (TIN)

2.14 Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes (CRS)?

☐ Yes – provide details below. ☐ No – skip to question 2.15.

Your jurisdiction of tax residence	Your Taxpayer Identification Number (TIN)

If you do not have a Taxpayer Identification Number, check a box to give the reason:

☐ You've applied for one but haven't received it yet.

☐ Your jurisdiction of tax residence doesn't issue TINs.

☐ Other – provide details:

If a child is being insured under the main policy – if none, skip to Section 3.

Important information
Complete the following if Insured 1 is under the age of 16 (in Quebec, under the age of 18). **Do not complete for children to be covered under a child term benefit.**

If any insured is a child

2.15 What is the relationship of the owners to the child? Check all that apply:

☐ Parent ☐ Legal guardian ☐ Grandparent ☐ Other – provide details:

2.16 Who does the child live with?

☐ Owner 1 ☐ Owner 2 ☐ Grandparent ☐ Someone else – provide details below:

First name of the person this child lives with	Middle initial	Last name	Relationship to this child

Residential address (street number and name)	Apartment or suite number

City	Province	Country	Postal code

2.17 Who will be answering medical questions for this child?

Note: This person must be the child's parent or legal guardian and have full knowledge of their medical history. They must also be present at the time this application is being completed.

☐ Owner 1 – also a parent or legal guardian ☐ Owner 2 – who is also a parent or legal guardian

☐ Parent or legal guardian who is not also an owner – provide details below:

This person must also sign in Section 16, Agreements and signatures.

First name of person answering questions	Last name	Relationship to this child

Policy number (for H.O. use only)

3 Owner information

In this section, *you* and *your* refer to all owners of the policy. Note: Sole proprietors are to provide information under the Individual sub sections and not under Corporation, trust or other entity sub sections.

Owner 1

3.1 Who will be Owner 1? Check one box:

☐ Insured 1 – skip to question 3.1 b). ☐ Insured 2 – skip to question 3.1 b). ☐ The individual named in 3.1 a).

☐ The corporation, trust or entity named below in in 3.1 c).

a) Individual

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	Middle initial	Last name	
Former last name (if any)		Date of birth (dd-mm-yyyy)	Gender ☐ M ☐ F
If you're applying for universal or permanent life insurance, please provide your Social Insurance Number.		Relationship to the insured	
Home phone	Cell phone	Work phone	Extension
			X
Residential address (street number and name – PO Box and General Delivery addresses not acceptable)			Apartment or suite number
City	Province	Country	Postal code

b) What is your detailed occupation, pre-retirement occupation or principal business?

Detailed occupation/pre-retirement occupation/principal business (ensure specific details are provided)
If currently employed or self-employed, provide name and address of employer or business.

c) Corporation, trust or other entity

Important information
For all non-individual owners, additional forms may be required.

Name			
Title of person to whom all notices, statements and correspondence about this policy are to be sent			
Address (street number and name – PO Box and General Delivery addresses not acceptable)			Apartment or suite number
City	Province	Country	Postal code

Owner 2

3.2 Who will be Owner 2? Check one box:

☐ Insured 1 – skip to question 3.2 b). ☐ Insured 2 – skip to question 3.2 b). ☐ The individual named in 3.2 a).

☐ The corporation, trust or entity named below in in 3.2 c).

Policy number (for H.O. use only)

3 Owner information (continued)

a) Individual

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	Middle initial	Last name	
Former last name (if any)		Date of birth (dd-mm-yyyy)	Gender ☐ M ☐ F
If you're applying for universal or permanent life insurance, please provide your Social Insurance Number.	Relationship to the insured		
Home phone	Cell phone	Work phone	Extension X
Residential address (street number and name – PO Box and General Delivery addresses not acceptable)			Apartment or suite number
City	Province	Country	Postal code

b) What is your detailed occupation, pre-retirement occupation or principal business?

Detailed occupation/pre-retirement occupation/principal business (ensure specific details are provided)
If currently employed or self-employed, provide name and address of employer or business.

c) Corporation, trust or other entity

Important information
You may not indicate a non-individual owner if one has been indicated under Owner 1.
For all non-individual owners, additional forms may be required.

Name			
Title of person to whom all notices, statements and correspondence about this policy are to be sent			
Address (street number and name – PO Box and General Delivery addresses not acceptable)			Apartment or suite number
City	Province	Country	Postal code

Mailing information to you

3.3 Which address should we use to mail you notices and policy statements? Check one box:

☐ Address of Owner 1 ☐ Address of Owner 2 ☐ Address of Insured 1 ☐ Address of Insured 2 ☐ Another address – provide details below:

Name of person to whom all notices, statements and correspondence about this policy are to be sent		Title (if applicable)	
Mailing address (street number and name)			Apartment or suite number
City	Province	Country	Postal code

Policy number (for H.O. use only)

3 Owner information (continued)

If you'd like to name a contingent owner

Important information

If there's one owner

A contingent owner will take over ownership of the policy if the owner dies and an insured person is still alive. Otherwise, the ownership interest will pass to the owner's estate.

If there's more than one owner (outside of Quebec)

If an owner dies, their ownership interest will pass in equal shares to the surviving owners. However, if the owner has named a contingent owner, their interest will pass to the contingent owner.

If there's more than one owner (in Quebec)

If an owner dies, their ownership interest will pass to the contingent owner they've named, or if no contingent owner has been named, the ownership interest will pass to the owner's estate. The other surviving owner will continue to own their interest in the policy.

3.4 Do you want to name a contingent owner?

☐ Yes – provide details below. ☐ No – skip to question 3.5.

	First name of contingent owner	Last name	Relationship to owner
Owner 1			
Owner 2			

Important information

Complete question 3.5 **ONLY** if:

- you're applying for **universal** or **permanent life insurance**,
- you're **age 65 or older**, and
- the death benefit is more than **$1 million**.

If you're planning to transfer ownership of the policy

3.5 Are you buying this policy with the intention of transferring ownership to someone else?

☐ Yes – provide details below. ☐ No

Important information

Complete questions 3.6 and 3.7 **ONLY** if:

- any owner is not also an insured, and
- you are applying for **universal** or **permanent life insurance**.

Individual owners: The international tax residency self-certification for FATCA / CRS questions 3.6 and 3.7 must be answered by all **individual owners** (including sole proprietors).

Non-individual owners: Corporations or other entities must complete **Form 4545**, *International tax classification for an entity* instead.

Your residency for tax purposes

3.6 Are you a U.S. citizen or resident for tax purposes (FATCA)?

Owner 1	Owner 2
☐ Yes – provide details below: ☐ No	☐ Yes – provide details below: ☐ No
Your U.S. Taxpayer Identification Number (TIN)	Your U.S. Taxpayer Identification Number (TIN)

Policy number (for H.O. use only)

3 Owner information (continued)

3.7 Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes (CRS)?

Owner 1	Owner 2
☐ Yes – provide details below: ☐ No	☐ Yes – provide details below: ☐ No
Your jurisdiction of tax residence	Your jurisdiction of tax residence
Your Taxpayer Identification Number (TIN)	Your Taxpayer Identification Number (TIN)
If you do not have a Taxpayer Identification Number, check a box to give the reason: ☐ You've applied for one but haven't received it yet. ☐ Your jurisdiction of tax residence doesn't issue TINs. ☐ Other – provide details:	If you do not have a Taxpayer Identification Number, check a box to give the reason: ☐ You've applied for one but haven't received it yet. ☐ Your jurisdiction of tax residence doesn't issue TINs. ☐ Other – provide details:

Verifying owner identity

Important information

Note: A licensed adminstrative assistant is not authorized to complete questions 3.8 - 3.15.

Complete questions 3.8 - 3.15 **ONLY** if:

- the owner is an individual or sole proprietor, and
- you are applying for **universal** or **permanent life insurance**.

Always verify the identity of clients and find out whether any third parties are involved. This helps us and you to manage risk and to comply with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and other relevant legislation/regulations. If you need more space to provide this information, complete **Form 4830**, *Identity verification, third party determination and politically exposed persons (PEP) for individual owners (Life insurance)* for each owner as required.

For an individual owner, confirm their identity using method A: Photo identification, or B: Dual process below. Record all the information; do notattach photocopies.

You must complete **Form 4355**, *Non face-to-face identify verification by agent or mandatary, third party determination and politically exposed persons (PEP)*, for any owner who **does not reside in Canada** or is a Canadian resident **but is not present** when you complete this application.

If any owner **is not an individual** (they are a corporation or other entity), you must complete **Form 4831**, *Identity verification and third party determination for entity owners* and **Form 4545**, *International tax classification for an entity* for that owner.

3.8 How are you confirming your identity?

☐ ***A: Photo identification***

Note: 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.

Owner 1			
Type of document		Document number	
Document expiry date (dd-mm-yyyy)	Province of issue	Country of issue	Date of verification (dd-mm-yyyy)

Owner 2			
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***

To use the Dual process method, complete **Form 4830**, *Identity verification, third party determination and politically exposed person (PEP) for individual owners*.

If you are using the Dual process method, skip to Section 4.

Policy number (for H.O. use only)

3 Owner information (continued)

Information about any third parties (Note: This is any party other than the owner (e.g. spouse).)

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

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

3.9 Is the contract to be paid for by a third party or used by or on behalf of a third party?

☐ Yes ☐ No – if none, skip to Section 3.13.

3.10 Third party payor 1

Check one and provide all applicable information below: ☐ Individual ☐ Entity

First name (or name of entity)	Middle initial	Last name

Relationship to owner	Detailed occupation/pre–retirement occupation/principal business

Residential address (street number and name – PO Box and General Delivery addresses not acceptable)	Apartment or suite number

City	Province	Country	Postal/Zip code

If individual:

Date of birth (dd-mm-yyyy)

If entity:

Registration number	Province/state of registration	Country of registration

3.11 Third party payor 2

Check one and provide all applicable information below: ☐ Individual ☐ Entity

First name (or name of entity)	Middle initial	Last name

Relationship to owner	Detailed occupation/pre–retirement occupation/principal business

Residential address (street number and name – PO Box and General Delivery addresses not acceptable)	Apartment or suite number

City	Province	Country	Postal/Zip code

If individual:

Date of birth (dd-mm-yyyy)

If entity:

Registration number	Province/state of registration	Country of registration

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

Policy number (for H.O. use only)

3 Owner information (continued)

Identifying any politically exposed persons (PEP)/Head of an international organization (HIO)

Important information

In these questions, Family member means spouse, civil union spouse or common-law partner, children, step-children, siblings, half siblings, step-siblings of the owner, biological parent, adoptive parent and step parent of the owner. It also means biological parent, adoptive parent and step-parent of the owner's spouse, civil union spouse or common-law partner.

In these questions, Close associate is someone who is closely associated with any owner for personal or business reasons. Examples of circumstances that may lead to the determination that someone is closely associated with any owner include, but are not limited to:

- transactions that occur between a PEP or a HIO and any owner,
- business activities between a PEP or a HIO and any owner,
- media coverage linking a PEP or a HIO and any owner, or
- a personal relationship such as a romantic relationship or close friendship between a PEP or a HIO and any owner.

If you need more space to provide this information, complete **Form 4830**, *Identity verification, third party determination and politically exposed persons (PEP) for individual owners (Life insurance)* for each owner as required.

Politically exposed foreign persons (PEFP)

3.13 To the best of your knowledge, have you, any family members or any close associates (living or deceased), ever held or currently hold any of the following positions?

1. Member of the executive council of government
2. President (head) of a state-owned company
3. President (head) of a state-owned bank
4. Deputy minister (or equivalent rank) in government
5. Ambassador
6. Counsellor of an ambassador
7. Attaché
8. Leader (or president) of a political party represented in a legislature
9. Head of state
10. Head of government
11. Head of a government agency
12. Judge of a supreme court, constitutional court or other court of last resort
13. Military officer with a rank of general or above
14. Member of a legislature

Owner 1 ☐ No PEFP association – If ***No*** and only 1 owner, skip to question 3.14. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of PEFP, if not owner	Middle initial	Last name	Relationship to Owner 1
Positions held (please list all the applicable numbers from the list in 3.13)		Countries where positions held	
		Organizations or institutions	

Owner 2 ☐ No PEFP association – If ***No*** and only 1 owner, skip to question 3.14. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of PEFP, if not owner	Middle initial	Last name	Relationship to Owner 2
Positions held (please list all the applicable numbers from the list in 3.13)		Countries where positions held	
		Organizations or institutions	

Policy number (for H.O. use only)

3 Owner information (continued)

Politically exposed domestic persons (PEDP)

3.14 To the best of your knowledge, have you, any family members, or any close associates (living or deceased), currently or in the last 5 years held any of the following positions?

1. Governor general
2. Lieutenant governor
3. Member of the Senate
4. Member of the house of commons
5. Member of a legislature
6. Deputy minister (or equivalent rank) in government
7. Ambassador
8. Counsellor of an ambassador
9. Attaché
10. Military officer with a rank of general or above
11. President of a corporation that is wholly owned directly by Her Majesty in right of Canada or a province
12. Head of a government agency
13. Judge of an appellate court in a province
14. Judge of the federal court of appeal
15. Judge of the supreme court of Canada
16. Leader (or president) of a political party represented in a legislature
17. Mayor

Owner 1 ☐ No PEDP association – If ***No*** and only 1 owner, skip to question 3.15. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of PEDP, if not owner	Middle initial	Last name	Relationship to Owner 1
Positions held (please list all the applicable numbers from the list in 3.14)		Countries where positions held	
		Organizations or institutions	

Owner 2 ☐ No PEDP association – If ***No*** and only 1 owner, skip to question 3.15. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of PEDP, if not owner	Middle initial	Last name	Relationship to Owner 2
Positions held (please list all the applicable numbers from the list in 3.14)		Countries where positions held	
		Organizations or institutions	

Head of an international organization (HIO)

3.15 To the best of your knowledge, are you, any family members or close associates, currently a head of an international organization?

An individual is a 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 include, but are not limited to, the following:

- 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

Owner 1 ☐ No HIO association – If ***No*** and only 1 owner, skip to section 4. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of HIO, if not owner	Middle initial	Last name	Relationship to Owner 1
Position held		Countries where positions held	
		Organizations or institutions	

Policy number (for H.O. use only)

3 Owner information (continued)

Owner 2 ☐ No HIO association – If ***No*** and only 1 owner, skip to section 4. ☐ Yes – provide details below.

Owner's first name	Middle initial	Last name	
First name of HIO, if not owner	Middle initial	Last name	Relationship to Owner 2
Position held		Countries where positions held	
		Organizations or institutions	

4 Beneficiary information

In this section, *you* and *your* refer to all owners of the policy.

Form required
If this application is for a *SunUniversalLife II* or *SunUniversalLife Pro* joint last-to-die policy with the Insurance amount plus policy fund option, the owner must complete **Form 272**, *Early death benefit beneficiary election and/or change* in addition to the beneficiary section below.

What you should know about beneficiaries

- A beneficiary is a person you name to receive proceeds payable on the death of an insured.
- You may name one or more primary beneficiaries. If you name more than one you can allocate a different payout percentage for each, but the total must add up to 100%.
- You may also name a contingent beneficiary to receive the proceeds if no primary beneficiaries are alive or qualify to receive the proceeds when an insured dies.
- If you do not name any beneficiaries, the proceeds will go to you, the owner, when an insured dies. If you're no longer alive, the proceeds go to your estate.
- For critical illness insurance, if you designate a payee you, the owner, will not receive the critical illness benefit payment.
- You may name a minor as a beneficiary, but proceeds will not be paid directly to them while they are still a minor. For more information, refer to 4.3.
- Irrevocable beneficiaries **cannot be changed** without their written consent or by a court order.
- In Quebec, if a primary beneficiary is no longer alive at the time of payout or no longer qualifies to receive the proceeds, their share will pass on the surviving beneficiaries only if you have designated beneficiaries to receive death benefits in **equal shares**. If the shares are not equal, the predeceased beneficiary's share will be paid to any contingent beneficiaries you've named, or otherwise to you or your estate.

4.1 Your life insurance beneficiaries. If you are not applying for life insurance, skip to 4.2.

Important information
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.

Primary beneficiaries for Insured 1

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation	% to be paid (must total 100%)
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
					100%

Policy number (for H.O. use only)

4 Beneficiary information (continued)

Contingent beneficiaries for Insured 1

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation	% to be paid (must total 100%)
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
					100%

Primary beneficiaries for Insured 2

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation	% to be paid (must total 100%)
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
					100%

Contingent beneficiaries for Insured 2

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation	% to be paid (must total 100%)
				☐ Revocable ☐ Irrevocable	
				☐ Revocable ☐ Irrevocable	
					100%

4.2 Your critical illness insurance benefit payee and return of premium on death benefit beneficiary. If you're not applying for critical illness insurance, skip to 4.3.

Important information
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.

For payment of critical illness insurance benefits – Check one box:

☐ Payment to go to the owner or the owner's estate ☐ Payment to go to the following payee:

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation
				☐ Revocable ☐ Irrevocable

For payment of the return of premium on death benefit – Check one box:

☐ Payment to go to the owner or the owner's estate (Default if beneficiary not named.)

☐ Payment to go to the following beneficiary:

Important information
If the policy is cancelled or benefits end, we pay any return of premium, if applicable, to you or your estate.

First name	Middle initial	Last name	Relationship to Insured (in Quebec, to Owner)	Beneficiary designation
				☐ Revocable ☐ Irrevocable

Policy number (for H.O. use only)

4 Beneficiary information (continued)

4.3 Trustee for any minor beneficiaries you've named (not applicable to Quebec minors). If none, skip to Section 5.

Important information
If the beneficiary you've named lives outside of Quebec, you should name a trustee to receive the funds on their behalf. The trustee may apply those funds solely for the support, maintenance, education and benefit of the minor.
If the minor you've named as beneficiary lives in Quebec, any amount payable to a minor is paid to their parents or legal guardian.

Would you like to appoint a trustee for minor beneficiaries?

☐ Yes – provide details below. ☐ No – skip to Section 5.

Trustee for minors who are life insurance primary beneficiaries

First name of trustee	Middle initial	Last name	Relationship to Insured

Trustee for minors who are life insurance contingent beneficiaries

First name of trustee	Middle initial	Last name	Relationship to Insured

Trustee for minors who are critical illness insurance benefit payee beneficiaries

First name of trustee	Middle initial	Last name	Relationship to Insured

Trustee for minors of critical illness insurance return of premium on death benefit beneficiaries

First name of trustee	Middle initial	Last name	Relationship to Insured

Trustee address

Residential address (street number and name)			Apartment or suite number
City	Province	Country	Postal code

5 Coverage and benefits you're applying for

In this section, *you* and *your* refer to all owners of the policy.

Important information
For ***Sun Par Protector II***, ***Sun Par Accumulator II***, ***Sun Par Accelerator, SunUniversalLife II*** and ***SunUniversalLife Pro,*** you must have the owner sign an illustration for the policy they're applying for and submit it with this application.

Life insurance

5.1 *SunTerm* term life insurance

a) What *SunTerm* coverage are you applying for? Amount $

Term – Check one box: ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year

Type of policy – Check one box: ☐ Single life ☐ Joint first-to-die ☐ Multi-life – provide details for Insured 2 below:

What coverage do you want for Insured 2? Amount $ ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year

b) Underwriting risk class for *Insured 1*

☐ Risk class 1: non-smoker ☐ Risk class 2: non-smoker ☐ Risk class 3: non-smoker ☐ Risk class 4: smoker ☐ Risk class 5: smoker

c) Underwriting risk class for *Insured 2*

☐ Risk class 1: non-smoker ☐ Risk class 2: non-smoker ☐ Risk class 3: non-smoker ☐ Risk class 4: smoker ☐ Risk class 5: smoker

Optional benefits for *SunTerm*

For *SunTerm 10 year* only: Renewal protection – Check all that apply: ☐ Insured 1 ☐ Insured 2

For three or more people to be insured only: ☐ Partner protection

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

5.2 *Sun Par Protector II* or *Sun Par Accumulator II* participating life insurance

a) What coverage are you applying for? Check one box:

☐ *Sun Par Protector II* ☐ *Sun Par Accumulator II*

Amount
$

b) Your payment option – Check one box:

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

c) Type of policy – Check one box:

☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die – Check one of the two boxes: ☐ Premiums payable to the first death ☐ Premiums payable to the last death

d) Your dividend option – Check one box:

☐ Dividends on deposit ☐ Cash payment ☐ Paid-up additional insurance

☐ Annual premium reduction – available only if you're paying annually. ☐ Enhanced insurance – provide details in the three boxes below:

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

e) Do you want us to notify you if your policy becomes eligible for premium offset? **Please read the explanation of premium offset below before answering.**

☐ Yes ☐ No

Important information

Note: If left blank or you've indicated ***Yes*** on either this application or the illustration, we will assume response as ***Yes***.

Explain to the owner how premium offset works. 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 payments.

f) When your policy is issued, you'll have the right to attend and vote at the meetings of the voting policyholders of Sun Life Assurance Company of Canada. You can also vote by proxy if you're unable to attend meetings. Do you want us to notify you of these meetings and send you related information? ☐ Yes ☐ No

Note: If you don't answer, we'll assume you answered ***Yes***.

Optional benefit for *Sun Par Protector II* or *Sun Par Accumulator II*

☐ For *10 pay* (*Sun Par Accumulator II* only) and *20 pay or Life pay (to age 100)* only: Plus premium benefit (PPB) – provide details below:

Indicate the amount you'd like to pay for your Plus premium benefit:

Amount
$

You'll choose to pay this amount either monthly or annually in Section 7, *Paying for the policy*.

5.3 *Sun Par Accelerator* participating life insurance

a) What amount of *Sun Par Accelerator* coverage are you applying for? Provide the basic insurance amount **plus** the enhanced amount:

Amount
$

b) Type of policy – Check one box:

☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die (premiums payable to second death)

c) When your policy is issued, you'll have the right to attend and vote at the meetings of the voting policyholders of Sun Life Assurance Company of Canada. You can also vote by proxy if you're unable to attend meetings. Do you want us to notify you of these meetings and send you related information? ☐ Yes ☐ No

Note: If you don't answer, we'll assume you answered ***Yes***.

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

5.4 *Sun Permanent Life* non-participating life insurance

a) What amount of *Sun Permanent Life* coverage are you applying for? Amount $

b) **Your payment option** – Check one box:

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

c) **Type of policy** – Check one box:

☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die – Check one of the two boxes: ☐ Premiums payable to the first death (Available on Life Pay only.)

☐ Premiums payable to the last death

Optional benefit for *Sun Permanent Life*

☐ For *15 and 20 pay* only: Guaranteed return of premium on death

5.5 *SunUniversalLife II* universal life insurance

Note:

If you don't fully answer the questions for *SunUniversalLife II*

If you don't complete the questions we ask for (or if we don't receive an illustration with this application), we'll set up your *SunUniversalLife II* policy as follows:

- Death benefit option – insurance amount plus your policy fund value;
- Cost of insurance – guaranteed level rates;
- Investment account options – 100% Daily interest account;
- Withdrawal and transfer instructions: proportional based on account balances;
- Tax-exempt status – 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.). This adjustment is not available for the "Level plus" death benefit options;
- Service account – transfer to Daily interest account.

a) What amount of *SunUniversalLife II* coverage are you applying for? Amount $

b) **Type of policy** – Check one box:

☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die – Check one of the two boxes: ☐ Cost of insurance payable to the first person's death.

☐ Cost of insurance payable to the second person's death.

c) **Your death benefit option** – Check one box:

☐ Insurance amount plus policy fund ☐ Level insurance amount ☐ Level plus return of payments ☐ Level plus adjusted cost basis

☐ Level plus indexed insurance amount at the rate of: % annually % ▶ specify between 1% and 8%, in multiples of 0.25%

d) **Your cost of insurance (COI) option** – Check one box:

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

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

e) What investment account options would you like within your *SunUniversalLife II* policy?

Important information

Please read the explanation below before answering.

The owner must allocate their payments to any of the following Investment account options.

There's a $100 minimum – We move amounts to their investment account options only when they've paid us enough to put at least $100.00 in each option they select.

If an investment account option the owner selects is no longer available – We'll move their allocations to a Daily interest account. We will move their funds out of the Daily interest account to their new selections on the date they tell us to. **You can get a copy of the most up to date options available on our Advisor site and Advisor guide.**

Your interest account options	Percentage (in multiples of 5%)
Daily interest account	%
Guaranteed interest account – 1 year	%
Guaranteed interest account – 3 year	%
Guaranteed interest account – 5 year	%
Guaranteed interest account – 10 year	%
Sun Life Diversified Account	%
Sub total	%

+

Your managed account options	Percentage (in multiples of 5%)
BlackRock Global Equity Index	%
BlackRock US Equity Index	%
CI Cambridge Canadian Equity Corporate Class	%
CI Signature Income & Growth	%
Sun Life BlackRock Canadian Equity Index	%
Sun Life BlackRock Canadian Universe Bond Fund	%
Sun Life Dynamic Strategic Yield	%
Sun Life Granite Balanced Portfolio	%
Sun Life Granite Balanced Growth Portfolio	%
Sun Life Granite Conservative Portfolio	%
Sun Life Granite Enhanced Income Portfolio	%
Sun Life Granite Growth Portfolio	%
Sun Life Granite Income Portfolio	%
Sun Life Granite Moderate Portfolio	%
Sun Life MFS Canadian Bond	%
Sun Life MFS Canadian Equity Growth	%
Sun Life MFS Global Value	%
Sun Life MFS US Equity	%
Sub total	%

= **Total for all options must equal: 100%**

f) If you selected a Guaranteed interest account, we'll automatically transfer balances to your Activity account when your account matures, unless you check the following box:

☐ Rollover to a new account of the same term.

g) In what order do you want us to process your investment account withdrawals and transfers? – Check one box.

Note: If you don't answer this question, we'll use ***Proportional***.

☐ **Proportional**

Withdraw or transfer funds proportionally from all of my investment accounts, based on their value at the time of withdrawal.

☐ **Alternate order 1**

Withdraw or transfer funds in this order:

1. Daily interest account.
2. Managed accounts, in proportion to the balance in each account.
3. Guaranteed interest accounts, taken first from accounts closest to maturity.
4. Sun Life Diversified Account.

☐ **Alternate order 2**

Withdraw or transfer funds in this order:

1. Daily interest account.
2. Guaranteed interest accounts, taken first from accounts closest to maturity.
3. Managed accounts, in proportion to the balance in each account.
4. Sun Life Diversified Account.

h) Tell us how you'd like us to adjust your insurance amount and cost of insurance in order to maintain your policy's tax-exempt status – Check one box:

☐ Keep your insurance amount the same.

☐ 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.). This adjustment is not available for the "Level **plus**" death benefit options.

☐ Increase your insurance amount to a maximum of 8% when needed and adjust your cost of insurance, but do not reverse this increase.

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

i) At times, we may need to transfer excess funds in your policy to a service account in order to maintain your policy's tax-exempt status. Select the type of service account you want us to use if this happens – Check one box:

☐ Daily interest account ☐ Guaranteed interest account – 1 year

5.6 *SunUniversalLife Pro* universal life insurance

Note: **If you don't fully answer the questions for *SunUniversalLife Pro***

If you don't complete the questions we ask for (or if we don't receive an illustration with this application), we'll set up your *SunUniversalLife Pro* policy as follows:

- Death benefit option – insurance amount plus your policy fund value;
- Cost of insurance – guaranteed level to 100.
- Service account – Transfer to DIA.
- Tax-exempt status – 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.).
  This adjustment is not available for the "Level plus adjusted cost basis death benefit option".
- Investment account options – Daily interest account 100%.
- Withdrawal order – Proportional per account balance.

a) What amount of *SunUniversalLife Pro* coverage are you applying for?

Amount
$

b) Type of policy – Check one box:

☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die – Check one of the two boxes: ☐ Cost of insurance payable to the first person's death.
☐ Cost of insurance payable to the second person's death.

c) Your death benefit option – Check one box:

☐ Insurance amount plus policy fund ☐ Level insurance amount ☐ Level plus adjusted cost basis

d) Your cost of insurance (COI) option – Check one box:

☐ Level ☐ Yearly to 85 ☐ Yearly to 100

e) What investment account options would you like within your *SunUniversalLife Pro* policy?

Important information

Please read the explanation below before answering.

The owner must allocate their payments to any of the following Investment account options.

There's a $100 minimum – We move amounts to their investment account options only when they've paid us enough to put at least $100.00 in each option they select.

If an investment account option the owner selects is no longer available – We'll move their allocations to a Daily interest account. We will move their funds out of the Daily interest account to their new selections on the date they tell us to. **You can get a copy of the most up to date options available on our Advisor site and Advisor guide.**

Your interest account options	Percentage (in multiples of 5%)
Daily interest account	%
Guaranteed interest account – 10 year	%
Sun Life Diversified Account Pro	%
Total	%

Total for all options must equal 100%.

f) If you selected a Guaranteed interest account – 10 year, we'll automatically transfer balances to your Activity account when your account matures, unless you check the following box:

☐ Rollover to a new account of the same term.

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

g) In what order do you want us to process your investment account withdrawals and transfers? – Check one box.

Note: If you don't answer this question, we'll use ***Proportional***.

☐ Proportional

Withdraw or transfer funds proportionally from all of my investment accounts, based on their value at the time of withdrawal.

☐ Alternate order

Withdraw or transfer funds in this order:

1. Daily interest account.
2. Guaranteed interest accounts, taken first from accounts closest to maturity.
3. Sun Life Diversified Account Pro.

h) Tell us how you'd like us to adjust your insurance amount and cost of insurance in order to maintain your policy's tax-exempt status – Check one box:

☐ Keep your insurance amount the same.

☐ 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.). This adjustment is not available for the "Level plus adjusted cost basis death benefit option".

☐ Increase your insurance amount to a maximum of 8% when needed and adjust your cost of insurance, but do not reverse this increase.

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

5.7 Optional benefits available for life insurance plans

Important information
The options we list below may not be available for all types of life insurance. To get a list of the most current options available, go to our illustration software, or the product information on our Advisor web site.

a) Please provide details for the optional benefits you're applying for.

Optional benefits	**Insured 1** amount	**Insured 2** amount
Total disability waiver	☐ Yes	☐ Yes
Accidental death insurance	$	$
Guaranteed insurability	$	$
Business value protection	$	$
Child term insurance	$	$

Optional term life insurance	**Insured 1**	**Insured 1**'s additional person	**Insured 2**	**Insured 2**'s additional person
10 year renewable term	$	$	$	$
10 year with renewal protection	$	$	$	$
15 year renewable term	$	$	$	$
20 year renewable term	$	$	$	$
30 year renewable term	$	$	$	$

Optional premium waiver for owners	Select the owner who is applying for this benefit – Check one box:	Select type of owner waiver being applied for – Check one box:
Only one owner can apply for a premium waiver. To apply, the owner must answer the *Insurance*, *employment and financial*, *Lifestyle* and *Medical* questions in this application.	☐ Owner 1 **or** ☐ Owner 2	☐ Owner waiver disability ☐ Owner waiver death ☐ Owner waiver disability and death

Critical illness insurance

5.8 *Sun Critical Illness Insurance*

a) What *Sun Critical Illness Insurance* coverage are you applying for?

Amount
$

☐ Term 10 year

☐ Term 75, with the following guaranteed payment period – Check one box: ☐ 15 years ☐ To age 75

☐ Lifetime, with the following guaranteed payment period – Check one box: ☐ 10 years ☐ 15 years ☐ To age 100

b) If you're applying to convert an existing critical illness policy, answer the following:

Will this policy cover more illnesses than you're covered for under your previous policy? ☐ Yes ☐ No

If ***Yes***, do you want to apply to be covered for the additional illness and provide evidence? ☐ Yes ☐ No

Policy number (for H.O. use only)

5 Coverage and benefits you're applying for (continued)

Optional benefits for *Sun Critical Illness Insurance*

We don't allow additions or increases to critical illness optional benefits after we've issued the policy, except as described below for juvenile policies.

For a juvenile policy, owners may apply to have the long term care conversion option added. To be considered, owners must apply for it after the policy anniversary nearest the insured person's 18th birthday but before the the policy anniversary nearest the insured person's 19th birthday.

What *Sun Critical Illness Insurance* optional benefits are you applying for? Check all that apply:

☐ Total disability waiver ☐ Long term care conversion option ☐ Return of premium on death

☐ Return of premium – provide details below:

Benefit type	Option
☐ Expiry or cancellation (available for Term 10 or Term 75 policies only)	☐ Adult: ☐ 15 years ☐ age 65 ☐ age 75 ☐ Child: ☐ Advanced ☐ age 35
☐ Cancellation (available for Lifetime policies only)	☐ Adult: ☐ 15 years ☐ age 65 ☐ age 75 ☐ Child: ☐ Advanced ☐ age 35

Optional premium waiver for owners	Select the owner who is applying for this benefit – Check one box:	Select type of owner waiver being applied for – Check one box:
Only one owner can apply for a premium waiver. To apply, the owner must answer the *Insurance*, *employment and financial*, *Lifestyle* and *Medical* questions in this application.	☐ Owner 1 **or** ☐ Owner 2	☐ Owner waiver disability ☐ Owner waiver death ☐ Owner waiver disability and death

Your acknowledgement that many variables can affect the performance of an insurance policy

You acknowledge that 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,
- any policy loans, and
- future federal income tax rules and provincial income and premium taxes.

More specifically, you 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. You understand that past performance does not predict nor is it a good indicator of future results.

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

You 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. You realize they are neither an estimate nor a guarantee of future policy performance.

You 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.

Policy number (for H.O. use only)

6 If you're replacing, converting or exercising options to increase coverage

In this section, *you* and *your* refer to all owners and the people being insured.

Important information

Please read all instructions carefully and ensure you have discussed with your advisor all possible advantages and/or disadvantages that may result from your application.

If you're changing a policy issued before 2017, it may lose grandfathering protections, or result in negative tax consequences.

These changes may also affect premium rates and death benefits and result in:

- policy gains that are taxable,
- the loss of: waiver of premium disability benefit, accidental death benefit, policy loans at 6% interest, guaranteed insurability benefit, disability income benefit, critical illness insurance benefit, insurance coverage on other lives or beneficial tax treatments.

Any change may be subject to restrictions on the amount of premium and death benefit, as determined by us at the time of the change.

We will cancel or change the policies listed below on the date the new insurance becomes effective.

For replacements

- For replacements, a Comparison Disclosure Statement or Life Insurance Replacement Declaration is required by regulation for a life insurance application that will replace an existing life insurance policy or application (not required for critical illness insurance except in Quebec).
- For partial replacements, when terminating the rest of the existing policy number being replaced, a Comparison Disclosure Statement or Life Insurance Replacement Declaration is required by regulation.
- If more than one policy is being replaced, a separate Comparison Disclosure Statement or Life Insurance Replacement Declaration is required for each policy that is being replaced.

For replacements and conversions

For all **full and partial replacements**, and for **conversions with an increase in coverage**, you must provide us with evidence of insurability by completing the *Insurance, employment and financial*, *Lifestyle* and *Medical* questions in Sections 8-10 of this application.

The new policy being applied for will follow the rules of the policies we have available at the time of application.

If premiums have been overpaid in the policy being converted or replaced, we'll automatically apply a credit toward the new policy. **If you want us to handle premium credits differently, you must tell us otherwise.**

6.1 If you're replacing or converting a policy

Provide details and the policy numbers to be replaced or converted, below – Check one box:

☐ **Fully replace or convert** and cancel the policies listed below with the new policy you're applying for.

☐ **Partially replace or convert** the policies listed below with the new policy you're applying for and reduce the death benefit to: Amount $

The death benefit amount not being replaced is to: ☐ remain in force ☐ be cancelled

Policy number	Policy number	Policy number	Policy number	Policy number

Additional instructions:

6.2 If you're converting a policy

Question for the people being insured:

Are you currently disabled or claiming a disability benefit on any of the insurance policies being converted?

Insured 1	Insured 2
☐ Yes – provide policy number below: ☐ No	☐ Yes – provide policy number below: ☐ No
Policy number	Policy number

6.3 If you're exercising a policy option with an increase in coverage

Provide the policy numbers this option you're exercising applies to below – Check one box:

☐ Guaranteed insurability option ☐ Child term ☐ Spousal term ☐ Partner protection

☐ Business value protection ☐ Attached term on the insured spouse ☐ Attached term on the additional insured person

Policy number	Policy number	Policy number	Policy number	Policy number

Additional instructions:

Policy number (for H.O. use only)

7 Paying for the policy

In this section, *you* and *your* refer to the owners and to the persons paying for the policy (if different from the owner).

The person paying for the policy

7.1 Who will be paying the premiums? Check all that apply:

☐ Owner 1 ☐ Owner 2 ☐ Insured 1 ☐ Insured 2

☐ Another person – provide name below: ☐ Another person – provide name below:

Note: If another person or company is paying for the policy, have them sign Section 16, *Agreements and signatures*.

Name of payor

Name of payor

7.2 a) What is the source of payment for this policy? Check all that apply:

☐ Salary or earned income ☐ Social benefits ☐ Gifted funds ☐ Owner's savings

☐ An investment account ☐ Pension income ☐ Inheritance ☐ Other – provide details:

☐ Proceeds from death benefits or an estate ☐ Sale of property ☐ Business income

b) Do you intend to make any ownership changes to the policy and/or are there any other parties with an ownership stake in this application not declared?

☐ Yes – If ***Yes***, provide details below. ☐ No

Note: Questions c) – d) must be answered on all term, universal and permanent life applications.

c) Within the next two years, other than the owners and beneficiaries of this policy, are there any other parties who will have a financial interest in the policy after it is issued? ☐ Yes ☐ No

Name	Details of financial interest

d) Within the next two years, are you considering assigning this policy (or in Quebec, granting a hypothec on it), as collateral for a loan? ☐ Yes – provide details below. ☐ No

Note: If you've indicated ***Yes***, you are also confirming that you've read and agree to the Front-end leveraging arrangement acknowledgment and release in Section 16, *Agreements and signatures*.

Name of lender	
What collateral will be used to secure the loan?	
How do you plan to use the loan?	☐ Pay policy premiums ☐ Fund investments ☐ Business re-investment ☐ Other (provide details)

Policy number (for H.O. use only)

7 Paying for the policy (continued)

Backdating the policy date

7.3 Does the owner want to save age? You can save age up to 90 days.

Check one box:

☐ Yes – backdate the policy to save age. ☐ No

If ***Yes***, who do you want to retain age on? ☐ Insured 1 ☐ Insured 2 ☐ Both

Initial payment

Important information

We do not accept cash payments.

If a method of payment is not selected, we will proceed on a Payment on delivery of policy basis and we assume pre-authorized chequing (PAC) with payment instruction will be provided on delivery.

All PAC payors must agree to all of the terms mentioned in the Agreement for pre-authorized chequing (PAC) payments in Section 16, *Agreements and signatures*.

If the owner is applying for temporary insurance, you must make an initial payment with this application. The initial payment must total at least 1/12th of the annual premium for the policy being applied for.

Advisors: Review the Certificate of temporary insurance with your clients so they understand the terms, conditions and exclusions that apply to temporary insurance.

7.4 Are you making an initial payment to apply for temporary insurance? (See section 13.1 to determine if you qualify.)

☐ Yes – provide details below. ☐ No – skip to question 7.5.

Amount of initial payment: $

Method of payment – Check one box:

☐ Pre-authorized chequing (PAC) from the account listed in question 7.9. ☐ Cheque made payable to Sun Life Assurance Company of Canada.

Regular payments

7.5 How do you want to make the regular payments? Check your preferred frequency and payment method:

☐ **Annually** – Check one box:

Payment with application – Required if temporary insurance has been applied for.

☐ Cheque for total annual premium, made payable to Sun Life Assurance Company of Canada.

Amount of cheque: $

Payment on delivery of policy – Not applicable if applying for temporary insurance.

☐ Cheque for total annual premium.

☐ One time special withdrawal for annual premium. (Monies will be withdrawn at time of policy placement.)

☐ **Monthly** – Check one box:

Payment with application – Required if temporary insurance has been applied for.

☐ Pre-authorized chequing (PAC) from the account listed in question 7.9.

Payment on delivery of policy – Not applicable if applying for temporary insurance.

☐ Pre-authorized chequing (PAC) from the account listed in question 7.9.

☐ Pre-authorized chequing (PAC) – account details and instructions provided on delivery.

If you're applying for universal life insurance

7.6 What is the monthly or annual amount you want to pay?

Frequency: ☐ Monthly ☐ Annual

Amount you want to pay: $

Pre-authorized chequing payments – if none, skip to Section 8.

7.7 Do you want to set up a new pre-authorized chequing (PAC) agreement, or use an existing one you have with Sun Life?

Check one box:

☐ Set up a new monthly PAC using the bank information in 7.9.

☐ Add to an existing PAC that is paying for policy number:

Note: We'll withdraw **regular payments** for this new policy on the same day each month as the existing policy listed above, unless you indicate a different date in 7.8.

Policy number (for H.O. use only)

7 Paying for the policy (continued)

7.8 When would you like regular automatic withdrawals to start? Check one box:

☐ One month from the policy date. ☐ On the following day of each month: (day of the month, e.g. 1st, 10th, 16th)

7.9 Bank account details for a new pre-authorized chequing (PAC) agreement – Check one box:

☐ You've provided a sample cheque marked Void for the account you want us to debit.

☐ You'd like us to set up the new PAC using the following account:

Account holder's first name	Last name		
Joint account holder's first name	Last name		
Name of financial institution	Address of financial institution (street number and name)		Apartment or suite number
City	Province	Country	Postal code
Branch transit number	Account number		

Person 1	Evidence number (for H.O. use only) E#	**Person 2**	Evidence number (for H.O. use only) E#	**Proposed owner**	Evidence number (for H.O. use only) E#

8 Insurance, employment and financial questions

In this section, *you* and *your* refer to the owner and the people being insured.

Important information

Unless named otherwise, these insurance, employment and financial questions are for:

- all the people being insured, and
- an owner who is applying for an owner waiver disability or death benefit. **Only one owner may apply.**

If you need more space, use a separate sheet signed and dated by the person answering the questions.

Note: 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 Insurance history

a) Do you have any existing life and/or critical illness insurance in force on your life?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, complete the table below:

Person being insured	Type of insurance		Amount, including benefits	Date issued (mm-yyyy)	Company names	Do you want to replace this insurance?
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Business ☐ Personal	☐ Life ☐ Critical illness	$			☐ Yes ☐ No
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Business ☐ Personal	☐ Life ☐ Critical illness	$			☐ Yes ☐ No
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Business ☐ Personal	☐ Life ☐ Critical illness	$			☐ Yes ☐ No

b) Do you have any applications for life, disability, critical illness or long term care insurance **currently** pending or contemplated?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, complete the table below:

Person applying	List all the companies you're applying with	Type of insurance you're applying for	Amount of coverage	Total amount of new insurance to be put into effect with all companies
Insured 1			$	Total for Insured 1
			$	$
			$	
Insured 2			$	Total for Insured 2
			$	$
			$	
Owner			$	Total for Owner
			$	$
			$	

Person 1	Evidence number (for H.O. use only) E#	**Person 2**	Evidence number (for H.O. use only) E#	**Proposed owner**	Evidence number (for H.O. use only) E#

8 Insurance, employment and financial questions (continued)

c) 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?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

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

Insured 1	
Insured 2	
Owner	

8.2 Employment information. For children under age 16 – skip to question 8.4.

a) What is your employment status?

Insured 1	**Insured 2**	**Owner**
☐ Employed or self-employed ☐ Retired ☐ Houseperson or stay-at-home parent ☐ Student ☐ Unemployed	☐ Employed or self-employed ☐ Retired ☐ Houseperson or stay-at-home parent ☐ Student ☐ Unemployed	☐ Employed or self-employed ☐ Retired ☐ Houseperson or stay-at-home parent ☐ Student ☐ Unemployed

b) If **employed or self-employed**, provide details **only** if not already provided in 3.1 or 3.2.

Person being insured	**Detailed occupation or principal business details (ensure specific details are provided)**	**Name and address of employer or business**
Insured 1		
Insured 2		
Owner		

c) If **houseperson or stay-at-home parent**, provide details.

Person being insured	**Are you financially dependent on a spouse or partner?**	**If *Yes*, what is your spouse or partner's annual earned income?**	**If *Yes*, what is the amount of life insurance in force or applied for on spouse or partner?**
Insured 1	☐ Yes ☐ No	$	$
Insured 2	☐ Yes ☐ No	$	$
Owner	☐ Yes ☐ No	$	$

d) If **student**, provide details.

Person being insured	**Name of educational institution**	**Field of study**	**Expected date of graduation (dd-mm-yyyy)**
Insured 1			
Insured 2			
Owner			

Policy number (for H.O. use only)

8 Insurance, employment and financial questions (continued)

e) If **unemployed**, provide details.

Person being insured	Reason for unemployment	How was this amount of insurance determined?
Insured 1		
Insured 2		
Owner		

8.3 Financial information

For children under age 16 – skip to question 8.4.

a) Complete the following for each person to be insured.

	Insured 1	Insured 2	Owner
a) What is your annual earned income, including salary, commissions, and bonuses?	$	$	$
b) What is your annual unearned income from other sources, including pensions, dividends, interest and income from real estate?	$	$	$
c) What is your personal Canadian net worth?	$	$	$
d) What is your personal foreign net worth?	$	$	$
e) **In the last five years**, have you declared or been petitioned into personal or corporate bankruptcy? If ***Yes***, give us details below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Person being insured	Date discharged (dd-mm-yyyy)	Circumstances of bankruptcy
☐ Insured 1 ☐ Insured 2 ☐ Owner		
☐ Insured 1 ☐ Insured 2 ☐ Owner		

b) If any of the people being insured are financially dependent on their spouse or partner, give us the following financial information on the income earner. **If you've already provided this information in question 8.2 c) or 8.3 a), you don't have to give it to us again.**

Check all that apply:

☐ Insured 1 ☐ Insured 2 ☐ Owner is financially dependent on their spouse or partner

Spouse or partner's annual income: Amount $

Amount of existing life insurance covering the spouse or partner: Amount $

Amount of existing critical illness insurance covering the spouse or partner: Amount $

8.4 Financial information for children under age 16

Complete the following for children being insured under the policy. **Do not complete for children to be covered for the child term benefit.**

a) What is the **annual income** of the parents or legal guardians of the child?

First parent or guardian	Other parent or guardian
$	$

8 Insurance, employment and financial questions (continued)

b) What is the total amount of **existing and applied for** life, critical illness, disability and long term care insurance on the parents or legal guardians?

Parent or guardian	Life	Critical illness	Disability	Long term care
First parent or guardian	$	$	$	$
Other parent or guardian	$	$	$	$

c) What is the **net worth** of the parents or legal guardians?

Parent or guardian	Canadian net worth
First parent or guardian	$
Other parent or guardian	$

d) Does the child being insured have any siblings age 15 or younger? ☐ Yes ☐ No

If ***Yes***, for all insurable siblings **age 15 or less**, is there a similar amount of life and/or critical illness insurance in force, currently pending or contemplated?

☐ Yes ☐ No – provide details below:

Insurance being applied for	Amount of sibling's insurance	Reason for the different amounts
Life	$	
Critical illness	$	

9 Lifestyle questions

In this section, *you* and *your* refer to the owner and the people being insured.

Important information

If you've chosen to give us this evidence in a tele-interview, complete 9.1 *Smoking and tobacco use and 10.1 Medical Information: Physician or health care professional*, then skip to Section 12.

Unless we specify otherwise, these lifestyle questions are for:

- all the people being insured, and
- an owner who is applying for an owner waiver disability or death benefit. **Only one owner may apply.**

If you need more space, use a separate sheet signed and dated by the person answering the questions.

9.1 Smoking and tobacco use

Smoking questions for ages 16 and older.

Important information

You must complete this question if you've ordered a tele-interview.

Skip this question if:

- you've ordered a paramedical exam, or
- you're converting an existing policy and carrying over existing tobacco use risk classes to the new policy.

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

Complete the chart below.

Note: A simple test may be required to check your answer.

Person being 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
Insured 1	☐	☐	☐ Date last used (dd-mm-yyyy):	☐	☐
Insured 2	☐	☐	☐ Date last used (dd-mm-yyyy):	☐	☐
Owner	☐	☐	☐ Date last used (dd-mm-yyyy):	☐	☐

Policy number (for H.O. use only)

9 Lifestyle questions (continued)

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

Person being insured	Products (check all that apply)	Dates last used (dd-mm-yyyy)	# used in last 12 months for large cigars only
Insured 1	☐ Large cigars ☐ Other tobacco and nicotine products	Large cigars: _____ Other: _____	Large cigars only: _____
Insured 2	☐ Large cigars ☐ Other tobacco and nicotine products	Large cigars: _____ Other: _____	Large cigars only: _____
Owner	☐ Large cigars ☐ Other tobacco and nicotine products	Large cigars: _____ Other: _____	Large cigars only: _____

9.2 Alcohol and drug use

Alcohol and drug questions for ages 16 and older.

a) Do you drink alcohol? Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No

If ***Yes***, complete the table below.

Please describe how much you consume of the following:

Type of alcohol	Insured 1	Insured 2	Owner
Beer: number of bottles	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only
Wine: number of glasses	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only
Liquor: number of 1.5 fl oz or 45 ml of liquor	Number: _____ 1.5 fl oz _____ 45 ml How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ 1.5 fl oz _____ 45 ml How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only	Number: _____ 1.5 fl oz _____ 45 ml How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Special occasions only

b) In the **last 5 years**, have you used marijuana or hashish?

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No

If ***No***, skip to g).

If ***Yes***, indicate which of the following best describes your average frequency of use.

Person being insured	Daily	Weekly	Monthly	Less than once per month	Date last used (dd-mm-yyyy)
Insured 1	☐ # per day: _____ Amount per use in grams: _____	☐ # per week: _____	☐ # per month: _____	☐	☐ _____
Insured 2	☐ # per day: _____ Amount per use in grams: _____	☐ # per week: _____	☐ # per month: _____	☐	☐ _____
Owner	☐ # per day: _____ Amount per use in grams: _____	☐ # per week: _____	☐ # per month: _____	☐	☐ _____

Policy number (for H.O. use only)

9 Lifestyle questions (continued)

c) If ***Yes*** to b), do you mix the marijuana or hashish with tobacco?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

d) If ***Yes*** to b), do you use it for medicinal purposes?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

e) If ***Yes*** to d), did a physician prescribe it?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, is this your usual physician or health care professional?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, provide details in 10.1.

If ***No***, provide details below.

First name	Middle initial	Last name	
Physician's residential address (street number and name)			Apartment or suite number
City	Province	Country	Postal code

f) If ***Yes*** to e), what condition is being treated?

g) 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)?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, provide details below.

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

h) Have you ***ever*** been treated, counselled or gone to meetings for alcohol or drug abuse?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

i) If ***No*** to h), has a doctor or health care professional ever recommended you get treatment or counselling or limit the amount of alcohol or drugs you use?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

Form required

If ***Yes*** to h) or i), complete and attach the appropriate **Form 26**, *Alcohol usage questionnaire* and/or **Form 12**, *Drug questionnaire*.

Policy number (for H.O. use only)

9 Lifestyle questions (continued)

9.3 Foreign residence/travel

Foreign residence/travel questions for all ages.

a) **In the last 12 months** did you travel or reside outside Canada? (don't include travel or residence of less than six months in the United States).

Person being insured	Yes/No	Cities and countries	Length of stay	Date(s) of travel if known (mm-yyyy)	Reason for travel or residence
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				

b) **In the next 12 months** do you intend to travel or reside outside of Canada? (don't include travel or residence of less than six months in the United States)

Person being insured	Yes/No	Cities and countries	Length of stay	Date(s) of travel if known (mm-yyyy)	Reason for travel or residence
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Yes ☐ No				

9.4 Driving offences

Driving offences questions for ages 16 and older.

a) **In the last 10 years,** have you been charged with or convicted of an alcohol or drug related driving offence or refusing a breathalyzer test?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

b) **In the last 3 years,** have you been charged with or convicted of any other driving offences? (Don't include parking tickets or not being able to show insurance or ownership cards.)

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

9 Lifestyle questions (continued)

If ***Yes***, to questions a) or b) above, give us details below.

For speeding convictions, include the number of kilometres per hour over the speed limit.

Person being insured	Dates of offences (dd-mm-yyyy)	Types of offences	Details of each
☐ Insured 1 ☐ Insured 2 ☐ Owner			
☐ Insured 1 ☐ Insured 2 ☐ Owner			
☐ Insured 1 ☐ Insured 2 ☐ Owner			

9.5 Aviation and hazardous activities

Aviation and hazardous activities questions for anyone age 10 or older.

a) **In the last 12 months,** have you flown in an aircraft as a pilot, crew member or flight attendant, or do you intend to do so **in the next 12 months**?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

b) **In the last 12 months,** have you participated in motorized racing, underwater diving, mountain climbing, skydiving, hang gliding, heli-skiing, backcountry or out of bounds skiing, snowboarding, snowmobiling or any other dangerous activity, or do you intend to do so **in the next 12 months**?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

Form required

If ***Yes*** to questions a) or b) complete and attach **Form 4**, *Aviation questionnaire*, or the form that's appropriate for the activity.

9.6 Criminal offences

Criminal offences questions for anyone age 10 or older.

In the last 10 years, have you been charged with, convicted of or imprisoned for any criminal offence, or are you currently on probation, parole or statutory release?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

If ***Yes***, provide details below.

Person being insured	Details
☐ Insured 1 ☐ Insured 2 ☐ Owner	
☐ Insured 1 ☐ Insured 2 ☐ Owner	
☐ Insured 1 ☐ Insured 2 ☐ Owner	

Person 1	Evidence number (for H.O. use only) E#	**Person 2**	Evidence number (for H.O. use only) E#	**Proposed owner**	Evidence number (for H.O. use only) E#

10 Medical questions

In this section, *you* and *your* refer to the owner and the people being insured.

Important information

If you've chosen to give us this evidence in a paramedical exam, complete Section 10.1 , and then skip to Section 12.

Unless we specify otherwise, these questions are for:

- all the people being insured, and
- the owner who will be applying for an owner waiver disability or death benefit. **Only one owner may apply.**

If you need more space, use a separate sheet signed and dated by the person answering the questions.

10.1 Medical Information: Physician or health care professional

Insured 1

What type of health care professional do you see for your usual medical or health care? Check one box and provide details below:

☐ Family doctor ☐ Nurse practitioner ☐ Medical clinic ☐ You don't use traditional medicine at all, but do see a:

First name of health care professional	Middle initial	Last name		
Address	City		Province	Postal code
Date of your first consultation (dd-mm-yyyy)	Date of your last appointment (dd-mm-yyyy)	Reason for your appointment		
Treatment or medication prescribed				
Results of the visit, and any follow-up planned				

Insured 2

What type of health care professional do you see for your usual medical or health care? Check one box and provide details below:

☐ Family doctor ☐ Nurse practitioner ☐ Medical clinic ☐ You don't use traditional medicine at all, but do see a:

First name of health care professional	Middle initial	Last name		
Address	City		Province	Postal code
Date of your first consultation (dd-mm-yyyy)	Date of your last appointment (dd-mm-yyyy)	Reason for your appointment		
Treatment or medication prescribed				
Results of the visit, and any follow-up planned				

Policy number (for H.O. use only)

10 Medical questions (continued)

Owner

What type of health care professional do you see for your usual medical or health care? Check one box and provide details below:

☐ Family doctor ☐ Nurse practitioner ☐ Medical clinic ☐ You don't use traditional medicine at all, but do see a:

First name of health care professional	Middle initial	Last name	
Address	City	Province	Postal code
Date of your first consultation (dd-mm-yyyy)	Date of your last appointment (dd-mm-yyyy)	Reason for your appointment	
Treatment or medication prescribed			
Results of the visit, and any follow-up planned			

10.2 Height and weight

Height and weight questions for anyone over age 10.

a) Provide your current height and weight details below.

Person being insured	Height	Weight	In the last 12 months, have you lost more than 4.5 kg (10 lb)?
☐ Insured 1	_____ cm or ____ feet ____ inches	_____ kg or _____ lb	☐ Yes ☐ No If ***Yes***, provide details including amount of weight loss and cause of the weight loss.
☐ Insured 2	_____ cm or ____ feet ____ inches	_____ kg or _____ lb	☐ Yes ☐ No If ***Yes***, provide details including amount of weight loss and cause of the weight loss.
☐ Owner	_____ cm or ____ feet ____ inches	_____ kg or _____ lb	☐ Yes ☐ No If ***Yes***, provide details including amount of weight loss and cause of the weight loss.

Height and weight questions for children age 1 to 10.

b) **In the last 2 years,** have you been told by a doctor or health care professional that the child's height, weight or physical development were not meeting normal milestones?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No

c) **In the last 2 years,** have you been told by a doctor or health care professional that the child should gain or lose weight or to follow a diet?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No

d) **In the last 12 months,** has the child had a weight loss of more than 4.5 kg (10 lbs)?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No

10 Medical questions (continued)

e) If ***Yes*** to questions b), c), or d), provide the child's measured height and weight below.

Person being insured	Height	Weight	Provide details including diagnosis and doctor's recommendation. If there has been any weight loss in the *last 12 months*, indicate amount of weight loss and cause of the weight loss.
☐ Insured 1 ☐ Insured 2	_____ cm or ____ feet ____ inches	_____ kg or _____ lb	

Height and weight questions for children under age 1.

f) Was the birth premature by more than four weeks, or is there any indication of failure to thrive or gain weight?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No

g) Have you been told by a doctor or health care professional that the child's weight or physical development are not meeting normal milestones?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No

If ***No*** to f) and g), skip to question 10.3.

h) If ***Yes*** to questions f) or g), provide the child's birth weight and current measured height and weight.

Person being insured	Birth weight	Current height	Current weight
☐ Insured 1 ☐ Insured 2	_____ kg or _____ lb	_____ cm or ____ feet ____ inches	_____ kg or _____ lb

i) If ***Yes*** to questions f) or g), provide details including current status of the the child's health and any other relevant information below.

Person being insured	Current state of the child's health
☐ Insured 1 ☐ Insured 2	

10.3 Personal medical history

Important information
For all ***Yes*** answers in 10.3, you must provide additional details, either in the box provided under the question, or in 10.5 *Details about your personal medical history*. **Do not tell us about genetic testing or genetic test results.**

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

- anemia
- any other blood or bleeding disease or disorder

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

▶ **If *Yes* to a), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

10 Medical questions (continued)

b) Cancer, abnormal growths or malignancy Have you *ever* been treated for or had any symptoms or indication of:

- cancer
- leukemia
- lymphoma
- melanoma
- tumour
- polyp(s)
- cyst(s)
- any other growths or malignancy

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to b), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

c) Heart and circulatory system Have you *ever* been treated for or had any symptoms or indication of:

- high blood pressure
- high cholesterol
- chest pain
- heart attack
- coronary artery disease (CAD)
- transient ischemic attack (also referred to as a mini-stroke or TIA)
- stroke or cerebrovascular accident (CVA)
- heart murmur
- irregular pulse
- blood clot or blood clots
- aneurysm
- any other disease or disorder of the heart or blood vessels

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to c), provide details below.**

Under ***Details of condition***, provide the date of diagnosis, the names and addresses of the doctors involved, the treatments you've used, the dates and duration of treatments, and treatment results. Also include the names and addresses of any hospitals and clinics you consulted or were treated at.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

d) Mental health Have you *ever* been treated for or had any symptoms or indication of:

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

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to d), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

Policy number (for H.O. use only)

10 Medical questions (continued)

e) Glands and/or endocrine system Have you *ever* been treated for or had any symptoms or indication of:

- diabetes
- gestational diabetes
- abnormal blood sugar
- pre-diabetes
- thyroid disease or disorder (such as nodule or goitre)
- lymph or gland disease or disorder
- any other endocrine disease or disorder

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to e), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

f) Musculoskeletal system Have you *ever* been treated for or had any symptoms or indication of:

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

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to f), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

g) Gastrointestinal system Have you *ever* been treated for or had any symptoms or indication of:

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

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to g), provide details in section 10.5.**

10 Medical questions (continued)

h) Skin disorders Have you *ever* been treated for or had any symptoms or indication of the following? Exclude poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema.

- dysplastic nevus (atypical mole)
- any other disease or disorder of the skin:

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to h), provide details below.**

Under ***Details of condition***, list each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

Person with condition	Name of condition	Details of condition
☐ Insured 1		
☐ Insured 2		
☐ Owner		

i) Immune system Have you *ever* been treated for or had any symptoms or indication of:

- lupus
- systemic scleroderma
- AIDS
- testing positive for HIV (the virus that causes AIDS)
- any other disease or disorder of the immune system

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to i), provide details in section 10.5.**

j) Genitourinary system Have you *ever* been treated for or had any symptoms or indication of:

- prostatitis or any other prostate disease or disorder
- breast lump(s) or cyst(s)
- abnormal pap smear
- hysterectomy
- disease or disorder of the ovary or uterus
- disease or disorder of the genital organs
- nephritis
- sugar, blood or protein in the urine
- any other kidney or bladder disease or disorder

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to j), provide details in section 10.5.**

k) Respiratory system Have you *ever* been treated for or had any symptoms or indication of:

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

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to k), provide details in section 10.5.**

l) Nervous system Have you *ever* been treated for or had any symptoms or indication of:

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

Insured 1 ☐ Yes ☐ No | Insured 2 ☐ Yes ☐ No | Owner ☐ Yes ☐ No ▶ **If *Yes* to l), provide details in section 10.5.**

10 Medical questions (continued)

m) Eyes, ears, nose, throat and mouth Have you *ever* been treated for or had any symptoms or indication of the following?
Exclude routine check-ups where no follow-up is required, such as tonsillectomy, adenoidectomy, sinusitis or any other disorder requiring eye glasses, contact lenses, or ear tubes.

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

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

▶ **If *Yes* to m), provide details in section 10.5.**

10.4 Medical tests and consultations

Important information
Have the people being insured answer the following. For each ***Yes*** answer, provide details in question 10.5 *Details about your personal medical history*.

a) **In the last 5 years**, have you had any medical tests that were not mentioned elsewhere in this application? Such as ECG, MRI, ultrasounds, mammograms or blood tests. **Do not tell us about genetic testing or genetic test results.**

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

b) **Other than for conditions already disclosed**, have you had an illness or injury which prevented you from performing your usual activities or the regular duties of your occupation for a period of **more than two weeks?**

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

c) **Other than for conditions already disclosed, in the last 5 years**, have you been admitted to a hospital or other medical facility, for **24 hours or more**? Exclude miscarriage, vasectomy, tubal ligation, appendectomy, hernia repair, child birth, cosmetic surgery or gall bladder surgery.

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

d) **Other than for conditions already disclosed**, has a doctor or other health care professional requested any tests or made any referrals that have not yet been completed, or are you currently awaiting tests or test results?
Do not tell us about genetic testing or genetic test results.

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

e) **Other than for conditions already disclosed**, have you been prescribed or are you taking any prescription medications?

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

f) Are you pregnant? If ***Yes***, indicate which trimester you're in, and your pre-pregnancy weight:

Insured 1	☐ Yes – provide details ☐ No	The trimester you're in ☐ 1st trimester (1 - 3 months) ☐ 2nd trimester (4 - 6 months) ☐ 3rd trimester (7 - 9 months)
Insured 2	☐ Yes – provide details ☐ No	
Owner	☐ Yes – provide details ☐ No	

Your weight before you became pregnant
_____ kg
or
_____ lb

g) Do you have any symptoms for which you have not yet consulted a health care professional or received treatment for? **Don't include common cold, flu or seasonal allergy symptoms.**

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

Policy number (for H.O. use only)

10 Medical questions (continued)

10.5 Details about your personal medical history

If you answered ***Yes*** to any question in 10.3 *Personal medical history*, or 10.4 *Medical tests and consultations*, provide additional details below.

Important information
Under ***Details of condition***, provide the date of diagnosis, names and addresses of the doctors involved, treatments received, the dates and duration of treatments and the treatment results. Also include the names and addresses of any hospitals and clinics they consulted or were treated at.
Do not tell us about genetic testing or genetic test results.
If you need more space, use a separate sheet signed and dated by the person who has the condition.

Person being insured	Details for question number:	Name of condition	Details of condition
☐ Insured 1 ☐ Insured 2 ☐ Owner			
☐ Insured 1 ☐ Insured 2 ☐ Owner			
☐ Insured 1 ☐ Insured 2 ☐ Owner			

11 Family medical history

In this section, *you* and *your* refer to the owner and the people being insured.

Important information
Ask these questions for the people being insured and an owner who has applied for an owner waiver disability or death benefit, up to age 65 only. **Do not tell us about genetic testing or genetic test results.**

11.1 Have any of your parents, brothers or sisters been diagnosed before age 65 with:

- heart disease
- stroke
- mini-stroke (transient ischemic attack)
- diabetes
- Parkinson's disease or cancer (including leukemia, lymphoma and Hodgkin's disease)

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

▶ **If Yes to 11.1, provide details in 11.3.**

11.2 Have any of your parents, brothers or sisters ever been diagnosed with:

- Huntington's disease
- polycystic kidney disease
- multiple sclerosis
- muscular dystrophy
- Alzheimer's disease
- Lou Gehrig's disease or ALS (amyotrophic lateral sclerosis)
- any other hereditary disease or disorder

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner ☐ Yes ☐ No

▶ **If Yes to 11.2, provide details in 11.3.**

Policy number (for H.O. use only)

11 Family medical history (continued)

11.3 Details about your family medical history.

If you answered ***Yes*** to any question in *11.1* or *11.2*, provide additional details below.

Person being insured	Relationship to family member	Condition (if cancer, include type)	Name of condition
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Mother ☐ Father ☐ Brother ☐ Sister		Age at onset: _____ Age if living: _____ Age at death: _____
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Mother ☐ Father ☐ Brother ☐ Sister		Age at onset: _____ Age if living: _____ Age at death: _____
☐ Insured 1 ☐ Insured 2 ☐ Owner	☐ Mother ☐ Father ☐ Brother ☐ Sister		Age at onset: _____ Age if living: _____ Age at death: _____

12 Child term benefit questions

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

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

The children to be insured

12.1 List the children you want insured under the child term benefit.

Child being insured	First name	Middle initial	Last name	Gender	Relationship to Insured 1	Date of birth (dd-mm-yyyy)
Child 1				☐ M ☐ F	☐ Child ☐ Step-child ☐ Adopted	
Child 2				☐ M ☐ F	☐ Child ☐ Step-child ☐ Adopted	
Child 3				☐ M ☐ F	☐ Child ☐ Step-child ☐ Adopted	
Child 4				☐ M ☐ F	☐ Child ☐ Step-child ☐ Adopted	
Child 5				☐ M ☐ F	☐ Child ☐ Step-child ☐ Adopted	

12.2 Do the people being insured have full knowledge of the children's medical history?

☐ Yes – skip to question 12.3. ☐ No – provide details below:

If ***No***, is the person with the most knowledge of the children's medical history present to answer questions?

☐ Yes – provide their information below. ☐ No

Note: **If the person who has the most knowledge of the medical history of the children is not present, you may not apply for this benefit.**

First name	Last name	Relationship to Insured

Policy number (for H.O. use only)

Person 1	Evidence number (for H.O. use only) E#	**Person 2**	Evidence number (for H.O. use only) E#	**Proposed owner**	Evidence number (for H.O. use only) E#

12 Child term benefit questions (continued)

12.3 Who do all the listed children live with?

Child 1

☐ Insured 1 ☐ Insured 2 ☐ Someone else – provide details below:

First name of the person Child 1 lives with	Middle initial	Last name	What's this person's relationship to Child 1?
Their residential address (street number and name)			Apartment or suite number
City		Province	Postal code

Child 2

☐ Insured 1 ☐ Insured 2 ☐ Someone else – provide details below:

First name of the person Child 2 lives with	Middle initial	Last name	What's this person's relationship to Child 2?
Their residential address (street number and name)			Apartment or suite number
City		Province	Postal code

Child 3

☐ Insured 1 ☐ Insured 2 ☐ Someone else – provide details below:

First name of the person Child 3 lives with	Middle initial	Last name	What's this person's relationship to Child 3?
Their residential address (street number and name)			Apartment or suite number
City		Province	Postal code

Child 4

☐ Insured 1 ☐ Insured 2 ☐ Someone else – provide details below:

First name of the person Child 4 lives with	Middle initial	Last name	What's this person's relationship to Child 4?
Their residential address (street number and name)			Apartment or suite number
City		Province	Postal code

Child 5

☐ Insured 1 ☐ Insured 2 ☐ Someone else – provide details below:

First name of the person Child 5 lives with	Middle initial	Last name	What's this person's relationship to Child 5?
Their residential address (street number and name)			Apartment or suite number
City		Province	Postal code

Insurance history

12.4 Has any insurance application on any of the children to be covered ever been declined, rated or modified in any way?

☐ Yes – provide details in question 12.8. ☐ No

Policy number (for H.O. use only)

12 Child term benefit questions (continued)

Medical questions

12.5 Has any child ever been treated for or had any symptoms or indication of the following? If ***Yes***, provide details in question 12.8.

a) heart murmur or any other disease or disorder of the heart or blood vessels	☐ Yes ☐ No
b) cancer, leukemia or any other growths or malignancy	☐ Yes ☐ No
c) diabetes or any other thyroid or endocrine disease or disorder	☐ Yes ☐ No
d) hemophilia, bleeding disorder or any other blood disease or disorder	☐ Yes ☐ No
e) Crohn's disease, ulcerative colitis, hepatitis or any other disease or disorder of the bowel, stomach or liver	☐ Yes ☐ No
f) asthma, cystic fibrosis, tuberculosis or any other respiratory disease or disorder	☐ Yes ☐ No
g) depression, anxiety, attention deficit disorder or any other psychological, emotional or nervous disease or disorder	☐ Yes ☐ No
h) disease or disorder of the kidney or urinary tract	☐ Yes ☐ No
i) muscular dystrophy, multiple sclerosis or any other neurological disease or disorder	☐ Yes ☐ No
j) down syndrome, developmental delay, autism, cerebral palsy or any other congenital disease or disorder	☐ Yes ☐ No
k) epilepsy, seizure or any other disease or disorder of the brain	☐ Yes ☐ No

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

☐ Yes – provide details in question 12.8. ☐ No

12.7 Are there any medical conditions (not already mentioned) which any child had or is waiting for investigation, treatment or is under observation?

Don't include 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 – provide details in question 12.8. ☐ No

12.8 If you answered Yes to any of questions 12.4, 12.5, 12.6 or 12.7, provide details below.

Important information

Under **Details of condition**, provide the date of diagnosis, names and addresses of the doctors involved, treatments received, the dates and duration of treatments and the treatment results. Also include the names and addresses of any hospitals and clinics they consulted or were treated at.

Do not tell us about genetic testing or genetic test results.

If you need more space, use a separate sheet signed and dated by the person who has the condition.

Person being insured	Details for question number:	Name of condition	Details of condition
☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5			
☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5			
☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5			

Policy number (for H.O. use only)

Person 1	Evidence number (for H.O. use only) E#	**Person 2**	Evidence number (for H.O. use only) E#	**Proposed owner**	Evidence number (for H.O. use only) E#

13 Temporary insurance questions (continued)

13 Temporary insurance questions – if not applying, skip to Section 14.

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

Important information

To qualify for temporary insurance, an initial payment must accompany this application. The people being insured must also read the Note text, near the beginning of Section 8, and answer all of the questions below. If any questions are answered ***Yes* or not answered**, there is **no** temporary insurance coverage.

For those who qualify, make sure to go over the *Certificate of temporary life insurance* with the owner, so they understand how temporary insurance works.

Note: **Temporary insurance is not available for policy conversions.**
If the total amount of all pending life insurance applications exceeds $3,000,000.00, you are not eligible for temporary insurance coverage. If you submit a payment for temporary insurance, we will reject the payment.

13.1 Temporary insurance questions

	Insured 1	Insured 2
a) **In the last 12 months,** have you seen a health care professional for chest pain, or do you know or suspect that you've had a heart attack, stroke, cancer or HIV/AIDS?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you **ever** had any applications for life, critical illness or health insurance declined, rated, postponed, cancelled or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
c) **In the last 60 days** have you: • been told to be admitted or admitted to a hospital or clinic as an in-patient for **24 hours or more**? Or • been told to have any medical tests, referrals or procedures that you haven't had done? **Exclude miscarriage, vasectomy, tubal ligation, appendectomy, hernia repair, child birth, cosmetic surgery or gall bladder surgery.**	☐ Yes ☐ No	☐ Yes ☐ No

Policy number (for H.O. use only)

14	If someone translated this application	Policy number (For H.O. use only.)

Owner and insured translation agreement

In this section, *you* and *your* refer to the owner or owners and the people being insured.

Note: The translator must be 18 years of age or older and may not be:
- a beneficiary,
- an owner, or
- any other person who has an interest in the policy (excluding the advisor).

14.1 Was this application translated into a language other than English? Check one box:

☐ Yes – provide details below ☐ No – skip to Section 15.

14.2 Who was this application translated for? Check all that apply:

☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2

14.3 What language was this application translated into?

☐ Insured 1		☐ Insured 2	
☐ Owner 1		☐ Owner 2	

14.4 Do you agree that the translator fully explained this application to you in your preferred language, and did you understand all the information provided by the translator? Check all that apply:

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner 1 ☐ Yes ☐ No	Owner 2 ☐ Yes ☐ No

Note: If you answered *No* to this question, we are unable to continue with this application. Do NOT submit this application.

14.5 Do you agree that your answers to the questions asked in this application and translated for you are complete and true, and do you understand they form part of this application? Check all that apply:

Insured 1 ☐ Yes ☐ No	Insured 2 ☐ Yes ☐ No	Owner 1 ☐ Yes ☐ No	Owner 2 ☐ Yes ☐ No

Note: If you answered *No* to this question, we are unable to continue with this application. Do NOT submit this application.

14.6 Name of person who provided the translation:

First name	Middle initial	Last name

14.7 Translator's relationship to the person the translation was provided for.

☐ Insured 1		☐ Insured 2	
☐ Owner 1		☐ Owner 2	

Translator's agreement and declaration (if other than advisor)

In this section, *you* and *your* refer to the owner or owners and the people being insured.

By signing below, you declare that for any person noted in question 14.2, 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,
- explained the information and everyone understood the contents of this application and provided all requested information, and
- have no interest in this application and are age 18 or older.

Signed at (province)	Date signed (dd-mm-yyyy)	Translator's signature
		X

PAPRSIGE

Policy number (For H.O. use only.)

15 Special instructions

16 Agreements and signatures

In this section, *you* and *your* refer to the owners, the people being insured and the parent or legal guardian of any children being insured.

By signing below, you confirm you have received, read and agree to the following:

- the document entitled Thank you for applying with Sun Life containing the Sun Life Privacy Statement for Canada;
- if you have applied for temporary insurance, the Certificate of temporary insurance; and
- if you have applied for critical illness insurance, the Guide to critical illness definitions.

Your consent to share information with your advisor

In this section, *you* and *your* refer to the owner who has applied for an owner waiver disability or death benefit, the people being insured and the parent or legal guardian of any children being insured.

Purpose

If you check ***Yes*** and sign 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 condition 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*** and signing 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.

First name	Middle initial	Last name	Advisor's code

By checking ***Yes*** and signing 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
- you understand that 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.

Check a box below to indicate if we may share information with your advisor.

Insured 1	Insured 2	Owner
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Note: If you don't check a box, we'll assume your answer is ***No***.

Policy number (For H.O. use only.)

16 Agreements and signatures (continued)

Your permission for us to collect your email address

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

Note: Do not provide an email address for an owner who is a corporation, trust or entity.

Permission to collect and save your email address for the purposes of sending you messages about your policy, product information, surveys and marketing material.

You can unsubscribe or update your communication preferences on the mySunLife.ca site at any time.

Owner 1 ☐ Yes ☐ No **Note:** If you don't check a box, we'll assume your answer is ***No***.

Email address

Owner 2 ☐ Yes ☐ No **Note:** If you don't check a box, we'll assume your answer is ***No***.

Email address

Your consent for us to release additional information

In this section, *you* and *your* refer to the people being insured and the parent or legal guardian of any children being insured.

By signing below, you authorize:

- any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigative agencies, MIB, Inc., or other organization, institution or person, including the members of the Sun Life group of companies, which includes this company, that have records or knowledge about about 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;
- Sun Life to disclose to your regular physician, health care professional or any other physician indicated by you, the underwriting decision on this application for insurance;
- 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.

Front-end leveraging arrangement acknowledgement and release

In this section, *you* refer to the owner or owners.

Acknowledgement

By signing below, you acknowledge and confirm that:

- you should obtain independent tax and legal advice about the potential tax and legal consequences that may arise from implementing a leveraging strategy involving the assigning of a life insurance policy (or in Quebec, granting a hypothec on it), to a lender as collateral security for a loan;
- you should carefully consider, among other things, whether any leveraging strategy you implement is appropriate for you and/or your corporation, and that the strategy conforms to your long-term financial plans and goals;
- you should carefully consider the impact that changes in interest and tax rates, changes in the amount borrowed, and changes in the life insured's assumed life expectancy could have on the values illustrated for this strategy, and that such values are illustrative only, and are not predictions or guarantees;
- you should carefully review the loan agreement and all the documents associated with that agreement, including the potential that you and/or your corporation may be required to provide additional security for the loan, and/or repay part or all of the loan at the lender's demand; and
- **you take full responsibility for any tax and legal consequences that may arise from implementing a leveraging strategy involving the use of a life insurance policy as collateral security for a loan.**

Release

By signing below, you agree to the following:
In exchange for Sun Life agreeing to issue you a life insurance policy, you release and agree to not start or continue any legal proceeding against Sun Life, its subsidiaries, successors and assigns, its past, present and future officers, directors, employees and advisors, from any claim you may have relating to the tax and legal consequences resulting from using a life insurance policy as collateral security for a loan.

16 Agreements and signatures (continued)

Agreement for pre-authorized chequing (PAC) payments

In this section, *you* and *your* refer to the owners of the pre-authorized chequing (PAC) account.

By signing below, you agree to the following terms and conditions:

- we may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from the bank account indicated or any account you may designate in the future;
- all PAC withdrawals will be processed as personal under the Payments Canada rules. This means you have 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 you, under this agreement, may be sent to the owner's most recent address that we have on record at the time a notice is sent if you have not provided us with your address;
- we may terminate this agreement if any withdrawal is not honoured;
- all persons whose signatures are required to sign on this account, have signed this agreement;
- for a joint account requiring more than one signature to withdraw funds, all the account holders must sign the authorization section;
- we may not assign this authorization, either directly or indirectly, by operation of law, change of control or otherwise, without providing you at least 10 days prior written notice; and
- **to waive the requirement that the company notify you 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 you or the company.

We will withdraw funds to pay all payments, including the initial payment if selected, on this policy each month (monthly) from the bank account shown on the sample cheque attached or any account designated.

We will withdraw the initial payment immediately.

You may cancel this authorization at any time, subject to giving us 10 days' notice. Contact your financial institution about your rights regarding cancellation. A sample cancellation form is available at *www.payments.ca*.

You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your 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

Policy number (for H.O. use only)

16 Agreements and signatures (continued)

Declarations and signatures – please sign here

In this section, *you* and *your* refer to the owners, the people being insured and the parent or legal guardian of any child being insured, and the owners of the pre-authorized chequing (PAC) account.

By signing below, you acknowledge, declare and confirm:

- you were present when your portion of this application with Sun Life Assurance Company of Canada (company) was completed;
- you reviewed all of your answers and statements recorded in the application:
- all the information you supplied in connection with this application is complete and true, and you provided it to the advisor (or some other person authorized by the company) for underwriting, administration of insurance and claims paying purposes, as well to help Sun Life to manage risk and to comply with the Proceeds of Crime (Money Laundering) and Terrorists Financing Act and other relevant legislation/regulations;
- you understand that if you do not completely and truthfully answer all of your questions (if you misrepresent any of your answers or statements) the company may void the policy or policies;
- you agree that your personal, medical and financial information may be shared as set out in the Sun Life Privacy Statement for Canada;
- you agree that your 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 Privacy Statement for Canada;
- you have read and agreed to the disclosure in Section 5 called *Your acknowledgement that many variables can affect the performance of an insurance policy*;
- you are satisfied with the level of product information you received before signing this application and are aware that additional product information is available 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):
- you are aware that any changes made to policies issued before 2017 may result in a loss of grandfathering protection, which may have negative tax consequences, and you had an opportunity to discuss this with your financial, legal and tax advisors and understand the tax consequences that policy changes may cause;
- you understand the company is not responsible for the validity of any beneficiary appointments; and
- the owners of the PAC account agree to the terms and conditions of the PAC agreement.

Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **Owner 1** (indicate title of signing officer if applicable) X
Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **Owner 2** (indicate title of signing officer if applicable) X
Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **Insured 1** (if other than owner or if under 16 [18 in Quebec] signature of parent or legal guardian) X
Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **Insured 2** (if other than owner) X
Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **pre-authorized chequing (PAC) account holder** (if different from the insured or owner) X
Signed at (province)	Date signed (dd-mm-yyyy)	Signature of **pre-authorized chequing (PAC) joint account holder** (if different from the insured or owner) X

17 Advisor's report

Policy number (For H.O. use only.)

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

17.1 If this application qualifies for a policy cover, would you like one provided with the printed policy?

☐ Yes ☐ No **Note:** If you don't answer this question, we'll assume your answer is ***No***.

17.2 Advisor information and how commission will be shared

Is commission being shared? ☐ Yes ☐ No If ***Yes***, indicate shares of commission below.

Lead advisor

First name	Middle initial	Last name		
Email address	Sun Life advisor code	Office	Share of commission (must be at least 10%)	
Phone number	Company name			
What's the name of your distribution partner? For example, MGA or NA.				

Advisor sharing commission, or if applicable, Estate Planning Specialist

First name	Middle initial	Last name		
Email address	Sun Life advisor code	Office	Share of commission (must be at least 10%)	
Phone number	Company name			
What's the name of your distribution partner? For example, MGA or NA.				

17.3 Your relationship to the owner or owners and the people being insured

Are you related (as defined below) to the owner or owners of this policy, or the people being insured?	**Lead advisor** ☐ Yes ☐ No – skip to 17.4.	**Advisor sharing commission** ☐ Yes ☐ No – skip to 17.4.
	▶ **If *Yes*, how are you related? Provide details below:**	
☐ A family member such as spouse, parent, grandparent, brother or sister, child, grandchild or in-law.	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2
☐ A corporation where you or a family member, individually or together own 50% or more of any class of shares of the corporation.	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2
☐ Where your business is incorporated, any director, officer, employee or agent and any parent, subsidiary or affiliated corporation.	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2
☐ 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.	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2	☐ Insured 1 ☐ Insured 2 ☐ Owner 1 ☐ Owner 2

AGTSTMTE

Policy number (For H.O. use only.)

17 Advisor's report (continued)

17.4 About the people being insured

Insured 1

How long have you known this person?

Did you meet the insured person, or their parent or legal guardian if a minor, in person to complete the application?

☐ Yes ☐ No – tell us why not below.

Insured 2

How long have you known this person?

Did you meet the insured person, or their parent or legal guardian if a minor, in person to complete the application?

☐ Yes ☐ No – tell us why not below.

Note: If you did not meet with the insured or the insured's parent or legal guardian face-to-face, a tele-interview is mandatory.

17.5 Complete chart(s) below to indicate how evidence will be provided.

Insured 1

How will evidence be provided?	Existing evidence from another source	Medical tests	
Check one box: ☐ in this application (Sections 9 - 11) ☐ tele-interview arranged by Sun Life ☐ paramedical exam	☐ Sun Life policy number ☐ Other insurance company Name Policy number ☐ Inspection report ☐ Other	☐ Vitals: height, weight, blood pressure ☐ Blood profile ☐ Other	Company you've ordered tests from: Reference/order number

Insured 2

How will evidence be provided?	Existing evidence from another source	Medical tests	
Check one box: ☐ in this application (Sections 9 - 11) ☐ tele-interview arranged by Sun Life ☐ paramedical exam	☐ Sun Life policy number ☐ Other insurance company Name Policy number ☐ Inspection report ☐ Other	☐ Vitals: height, weight, blood pressure ☐ Blood profile ☐ Other	Company you've ordered tests from: Reference/order number

Policy number (For H.O. use only.)

17 Advisor's report (continued)

Owner applying for an owner waiver disability or death benefit

How will evidence be provided?	Existing evidence from another source	Medical tests	
Check one box: ☐ in this application (Sections 9 - 11) ☐ tele-interview arranged by Sun Life ☐ paramedical exam	☐ Sun Life policy number ☐ Other insurance company Name Policy number ☐ Inspection report ☐ Other	☐ Vitals: height, weight, blood pressure ☐ Blood profile ☐ Other	Company you've ordered tests from: Reference/order number

17.6 If you're requesting a tele-interview, what is the best time to contact the people being insured or in the case of a minor insured, their parent or legal guardian.

Person being insured	Language for the tele-interview	Best time to call	Best number to call
Insured 1	☐ English ☐ French ☐ Other	☐ Morning (8 a.m. – 12 noon) ☐ Afternoon (12 noon – 5 p.m.) ☐ Evening (5 p.m. – 9 p.m.)	☐ Home ☐ Cell ☐ Work
Insured 2	☐ English ☐ French ☐ Other	☐ Morning (8 a.m. – 12 noon) ☐ Afternoon (12 noon – 5 p.m.) ☐ Evening (5 p.m. – 9 p.m.)	☐ Home ☐ Cell ☐ Work
Owner applying for an owner waiver disability or death benefit	☐ English ☐ French ☐ Other	☐ Morning (8 a.m. – 12 noon) ☐ Afternoon (12 noon – 5 p.m.) ☐ Evening (5 p.m. – 9 p.m.)	☐ Home ☐ Cell ☐ Work
Minor insured	☐ English ☐ French ☐ Other Parent or legal guardian's first name / Middle initial / Last name / Date of birth (dd-mm-yyyy)	☐ Morning (8 a.m. – 12 noon) ☐ Afternoon (12 noon – 5 p.m.) ☐ Evening (5 p.m. – 9 p.m.)	☐ Home ☐ Cell ☐ Work

17.7 Additional comments

Policy number (For H.O. use only.)

17 Advisor's report (continued)

17.8 If a licensed administrative assistant completed this application

Did a licensed administrative assistant complete this application?

☐ Yes – the assistant must read and sign 17.9. ☐ No – skip to 17.10.

Note: A licensed assistant isn't authorized to complete the questions in Section 3 called *Owner information about verifying owner identity, Information about any third parties, and Identifying any PEPs/HIOs* (3.8 - 3.15).

17.9 Licensed administrative assistant declaration and signature

In this section, *you* and *your* refer to the licensed administrative assistant that helped complete this application.

By signing below, you confirm the following:

- you have reviewed the details provided in this application with each owner/sole proprietor, insured and PAC payor;
- to the best of your knowledge, all details in this application are complete, true and given to you by the client in a face-to-face meeting;
- it has all the facts material to the insurance applied for; and
- you saw every person sign this application.

Licensed administrative assistant's first name	Middle initial	Last name

Administrative assistant's signature	Date (dd-mm-yyyy)
X	

Note: **Do you suspect money laundering?**
If you have a reason to suspect money laundering, you must let us know. If you suspect that there's an undisclosed third party, a politically exposed person or head of an international organization involved with this application, e-mail details to *money.laundering@sunlife.com*.

Policy number (For H.O. use only.)

17 Advisor's report (continued)

17.10 Advisor's declaration, notice of disclosure and signature

By signing below, with the understanding that Sun Life will rely on all of the information collected to process this application to conduct customer due dilligence and to satisfy applicable regulatory requirements, you, the advisor, confirm that:

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

If applicable (see 17.9 above), you, the advisor also confirm that:

- you reviewed the details provided in this application with each owner/sole proprietor, insured and PAC payor;
- to the best of your knowledge, all details in this application are complete, true and given to you by the client in a face-to-face meeting (unless **Form 4355**, *Non face-to-face identity verification by agent or mandatory, third party determination and politically exposed persons (PEP)* has been completed);
- it has all the facts material to the insurance applied for; and
- you saw every person sign this application.

If you acted as the primary translator for this sale, you declare that for the owner or owners, or for the people being insured, indicated in Section 14, that 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, and
- explained the information and everyone understood the contents of this application and provided all requested information.

Advisor's signature X			Date (dd-mm-yyyy)
Supervisor's name	Middle initial	Last name	
Supervisor's signature X			Date (dd-mm-yyyy)

Certificate of temporary insurance

Sun Life

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

Policy number (for H.O. use only)

Note:

Temporary insurance is not available for policy conversions.

If the total amount of all pending life insurance applications exceeds $3,000,000.00, you are not eligible for temporary insurance coverage. If you submit a payment for temporary insurance, we will reject the payment.

Complete, tear off and leave this Certificate with the owner if the temporary insurance conditions have been met.

What is this certificate?

This certificate is a legal agreement between you, the owners of the policy, and us, Sun Life Assurance Company of Canada, a member of the Sun Life group of companies and it forms part of your application for insurance. Insurance coverage is subject to certain conditions and exclusions, which depend on the type of insurance you applied for.

It may take up to 90 days for us to process your insurance application. During the application process, if a person to be insured dies or suffers a covered critical illness while we're processing your application, we'll pay the benefit amount we would have paid if we had already issued the policy you've applied for and according to the conditions and exclusions, we set out below.

It provides immediate insurance coverage until it ends, as explained below.

Please read this certificate carefully, so your temporary coverage stays in place. If the health of the people being insured changes from what we were told in your application, you must contact us immediately. It could affect your coverage. Call your advisor or Sun Life at **1-877-SUN-LIFE** (1-877-786-5433). The beneficiary for temporary insurance is the person or persons named as beneficiary in this application.

When your temporary coverage starts and ends

This temporary insurance starts on the date the people being insured signed Section 16, *Agreements and signatures*, as long as:

- the people being insured truthfully answered ***No*** to all of the Temporary insurance questions in Section 13,
- the people being insured truthfully and completely answered all other required questions in this application, and
- you've included a payment with your application of at least 1/12th of the annual premium for your base plan and any optional benefits.

This temporary insurance ends on the earliest of:

- the date the insurance you've applied for comes into effect;
- the date we decline this application for insurance, following which we will mail a notice of the decline to the address given in the application;
- the date you decline our offer for insurance;
- the date you ask us to cancel this application;
- the 30th day after the date you signed this application and we have not received the required Identity verification and third party determination information; or
- the 90th day after the date you signed this application.

If your temporary insurance ends, we'll refund any amount you've paid us while we were processing your application, except if it ends because the insurance you've applied for comes into effect.

Reduction of death benefit or coverage

If you've asked us to cancel an in force Sun Life policy in this application, and a person to be insured dies or suffers a covered critical illness while during the application process, we will:

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

Conditions and exclusions

How much we'll pay under temporary life insurance (Conditions):

The total death benefit we'll pay is **the smallest of**:

- $100,000 **(for any person to be insured who is age 71 or older)**
- $1,000,000 **(for any person to be insured who is under age 71)**
- the total of any death benefit plus any accidental death benefit you've applied for in this application, or
- the total of any death benefit plus any accidental death benefit you've applied for in any other insurance application with us.

Policy number (For H.O. use only.)

We won't pay a death benefit if a person being insured (Exclusions):

- or owner misrepresents or fails to disclose any fact within their knowledge that affects how we evaluate our risk of offering insurance or would change our decision to issue a policy;
- on the date they signed this application:
  a. wasn't able to perform their usual activities or occupation for **more than two weeks**, due to illness or injury;
  b. was confined in a hospital, nursing home, sanitarium, psychiatric facility or any other health-related facility in the **last 45 days**; or
  c. has or had any signs or symptoms associated with cancer, or suffered a stroke or a heart attack in the **last 12 months**;
- takes their own life, whether or not they had a mental illness or understood or intended the consequences of their actions; or
- dies before reaching the age of **15 days**.

How much we'll pay under temporary critical illness insurance (Conditions):

The total benefit we'll pay is **the smallest of**:

- $250,000 **(for the person to be insured who is age 17 or under)**
- $500,000 **(for the person to be insured who is between ages 18 and 65)**
- the total amount of critical illness you applied for in this application, or
- the total amount of critical illness you applied for any other insurance application with us.

We won't pay a critical illness benefit if a person being insured (Exclusions):

This temporary insurance only covers illnesses and medical conditions covered in the critical illness insurance you applied for. We won't pay benefits for any illness or condition not specifically mentioned in that policy.

We also won't pay a critical illness benefit if a person being insured:

- or an owner, withholds or misrepresents information that is important for us for our assessment of this application or affects our risk of offering insurance;
- is over age 65,
- had or has signs or symptoms associated with:
  a. cancer or benign brain tumour, or Parkinson's disease or any specified atypical parkinsonian disorders;
- on the date they signed this application:
  a. had previously been diagnosed with a covered critical illness or had any signs or symptoms of a covered critical illness;
  b. had any medical consultations, investigations, tests, treatments or counselling that lead to a diagnosis of a covered critical illness;
  c. had any signs or symptoms of a chronic kidney, liver or lung disease, medical consultations, investigations, tests, treatment or counselling that led to a diagnosis of chronic kidney, liver or lung disease within the **last 24 months**;
  d. was not able to perform their usual activities or occupation for **more than two weeks**, due to illness or injury; or
  e. was confined to a hospital, nursing home, sanitarium, psychiatric facility or any other health-related facility **in the last 45 days**.
- suffers a covered critical illness that's directly or indirectly associated with:
  a. attempting to take their own life or causing their own physical injury, whether or not they had a mental illness or understood or intended the consequences of their actions;
  b. committing or attempting to commit a criminal offence;
  c. intentionally taking any intoxicant, narcotic or poisonous substance;
  d. intentionally taking any drug other than drugs prescribed to them by a licensed medical practitioner;
  e. intentionally overdosing or not following the instructions for safely taking a drug prescribed to them; or
  f. operating a vehicle while their blood alcohol level was more than 80 milligrams of alcohol per 100 millilitres of blood. A vehicle includes any form of ground, air or water transportation that can be made to move by any means, including muscular power. We consider that a person is operating a vehicle even if the vehicle isn't moving;
- dies **within 30 days** after the date they were diagnosed with a covered critical illness.

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

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

Your receipt

Did you you make an initial payment with this application for temporary coverage? ☐ Yes – provide details below. ☐ No

Name of person who provided payment	Amount	Date (dd-mm-yyyy)
	$	

Method of payment – check one box:

☐ Pre-authorized withdrawal. Banking information is provided in 7.9 of this application, and the pre-authorized payment agreement is signed.

☐ Cheque: All cheques must be made payable to Sun Life Assurance Company of Canada.

Advisor's signature
X

Thank you for applying with Sun Life

Policy number (for H.O. use only)

Important information you should know

During the application process, if your health changes from what you've provided in your application, you must let us know immediately. If you don't, you risk losing your coverage. If your health changes, contact your advisor.

What to expect in the coming weeks

Now that you've applied with us, it may take up to 90 days to process your application. During this time, we may contact you with additional questions. In addition, we may ask you to take a medical exam. If you any have questions about what to expect or the status of your application during this time, ask your advisor.

If you qualified for temporary insurance

If you qualified for temporary insurance, you'll have this for up to 90 days while we process your application. This temporary coverage is similar to the coverage you've applied for. You can learn more by reading the *Certificate of temporary insurance*.

What you need to do if you're having a tele-interview

If your advisor has arranged for a tele-interview to gather your personal and medical information, we'll call you to set a time.

The phone interview takes 20 minutes to an hour, depending on the amount of information they gather. We'll use this information to assess whether or not you're eligible for the insurance you're applying for. As we process your application, we may also ask you for more information, or additional tests. In advance of the interview, please pull together the following details and have them at hand when they call:

- **Your family doctor:** their name, address and the date of your last visit with them.
- **Your medical conditions:** diagnosis, treatments and follow-ups, with dates.
- **Lifestyle information:** your tobacco and alcohol use, driving record, travel outside Canada and the U.S., any dangerous sports or activities you take part in.
- **Your medication –** name, frequency and how long you've taken them.
- **Your parents and sibling medical history:** any medical conditions they have and their age when they were diagnosed.

If you have any questions about the interview or the application process, contact your advisor or call us at **1-855-491-9604**.

Sun Life Financial Privacy Statement for Canada

Respecting your privacy

Respecting your privacy is a priority for the Sun Life 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 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, please visit our website at ***www.sunlife.ca*** or call ***1-877-SUN-LIFE*** (1-877-786-5433).