Sun Life Financial

Application for life and/or critical illness insurance

Contents

Instructions for the advisor

Application use:

Use this application to apply for:

- all life insurance products for up to two proposed insureds and five children under the child term benefit (CTB)
- all critical illness insurance products with one proposed insured
- all replacements
- all conversions **with an increase in coverage (excluding the addition of a Child term benefit)**, and
- all options exercised **with an increase in coverage**.

Notes:

- If there are more people to be insured under the same policy, complete a second application form and complete section 1.2 of this application.
- If a tele-interview or paramedical will be completed, use the combined *RapidApp/Tele-interviewing application for life and/or critical illness insurance* (810-2815) instead of this application.
- For all conversions/options exercised **with no increase in coverage or if adding a Child term benefit**, use the *Application for conversion and exercising an option* (E260) instead of this application.
- For changes to the smoking status of your policy, **with an increase in coverage that requires underwriting**, complete an *Application for policy change, reinstatement and/or reconsideration of rating* (E110) instead of this application.
- For changes to the smoking status of your policy only (no other changes to be made), complete the *Declaration of smoking status (for changes on existing policies only)* form (E18) instead of this application.
- For all long term care insurance applications, complete the *Application for long term care insurance* (810-3523).

Important:

- If a child is to be one of the primary insureds, provide the information for that child in the '**Person 1**' or '**Person 2**' boxes.
- All cheques must be in Canadian funds, drawn from a Canadian financial institution and payable to Sun Life Assurance Company of Canada.
- Ensure you have arranged for all applicable age and amount evidence requirements.
- **Tear off** the Important information you should know page and give it to the proposed insured.
- **Tear off** the Certificate of temporary insurance page and give it to the proposed owner, if applied for.
- Indicate clearly with an X when selecting check boxes.
- A signed illustration **must** be completed for all **Sun Par Protector II**, **Sun Par Accumulator II, Sun Par Accelerator and SunUniversalLife II** applications.
- All pages of the application **must** be submitted with the exception of the tear away pages.

Ensure you have attached the following to the application:

- **if temporary insurance has been applied for**, a cheque or authorization to withdraw the initial payment
- the signed **illustration** for all **Sun Par Protector II, Sun Par Accumulator II, Sun Par Accelerator** and **SunUniversalLife II** applications, and
- **for replacements**, the appropriate replacement form(s), completed and signed.

Please submit only one copy of this document to Sun Life through your MGA or National Account.

Application for life and/or critical illness insurance

Sun Life Financial

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

Please PRINT clearly

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

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

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

Policies issued January 1, 2017 and later fall under the new tax guidelines.

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

These may include:

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

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

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 the *International tax classification for an entity* (4545-E) form.
- Canadian financial institutions are required under Part XVIII (Foreign Account Tax Compliance Act – FATCA) and Part XIX (Common Reporting Standard – CRS) of the Income Tax Act (Canada) to collect the information you provide on this application to determine if they have to report your financial account to the Canada Revenue Agency (CRA). The CRA may share that information with the government of a foreign jurisdiction that you are resident of for tax purposes. Additionally, if you are a United States person (which includes a United States citizen or resident for tax purposes), the CRA may share your account information with the Internal Revenue Service (IRS).
- You must notify us within 30 days of any changes and provide us with a new *International tax self-certification for Individuals* (4573-E) form. A change includes information that affects your tax residency outside of Canada, such as a change in address or telephone number. We will update the information in our records when you advise us of a change.

1 General information

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

1.1 What are you applying for?

Tell us what type of insurance you're applying for and complete the required illustration. Also, tell us if you're insuring any children under a child term benefit.

Select all that apply:

☐ Life insurance – number of people being insured under this policy number ☐

☐ New business *or* ☐ Conversion/option exercised **with an increase in coverage** or replacement

☐ Single life *or* ☐ Joint *or* ☐ Multi-life

☐ Critical illness insurance (CII)

☐ Child term benefit (CTB)

1.2 Are you applying for additional or optional coverage?

☐ Yes ☐ No If '**yes**', indicate the type of coverage you're applying for: ☐ Additional ☐ Optional

If '**yes**', indicate amount: $ ☐

1.3 What is the purpose of this insurance?

Select all that apply:

☐ Income replacement ☐ Tax or estate planning ☐ Buy-sell agreement

☐ Creditor protection ☐ Key person insurance ☐ Concept/other (give details in the box below)

☐

AAPPE

Please submit only one copy of this document to Sun Life through your MGA or National Account.

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

1 General information (continued)

If coverage is for business-related needs, complete the following:

First name(s) of business owner(s)	Last name(s)	% of business owned	Total amount of business insurance already in force with all companies	Total amount of new business insurance to be put into effect with all companies
		%	$	$
		%	$	$
		%	$	$
		%	$	$
Annual sales $	Net after tax income $		Fair market value $	

1.4 Have you completed another application for multi-life (more than 2 proposed insureds) or for Term insurance on an additional insured person under this application? ☐ Yes ☐ No If '**yes**', complete the applicable chart below.

Complete for multi-life

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

Complete for Term insurance on an additional proposed insured

Proposed insured	First name of proposed insured	Middle initial	Last name	Date of birth (dd-mm-yyyy)
Person 1				
Person 2				

1.5 What language would you like your policy to be in?

☐ Issue the policy in English
☐ Établir le contrat en français

2 Information about the people to be insured

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

2.1 Person 1

Note: Only provide Person 1's Social Insurance Number (SIN) if they are also the proposed owner.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Former last name (if any)	Country of birth		City of birth	
Residential address (street number and name)				Apartment or suite
City	Province	Country		Postal code
SIN (required for tax reporting for life insurance; do not provide if applying for CII only)	Driver's licence number			Province
Home phone number	Cell phone number		Business phone number Ext.	

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

2 Information about the people to be insured (continued)

What is your residency status?

☐ Canadian citizen ☐ Permanent resident status (landed immigrant) ☐ Other

If '**Permanent resident**' or '**Other**', provide details including number of years in Canada.

FATCA

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

☐ Reason A: I have applied for a TIN but have not yet received it.

☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other: Specify the reason _____

Does the proposed owner want to retain age? ☐ Yes ☐ No **Note**: Age may be retained up to 90 days.

2.2 Person 2

Note: Only provide Person 2's Social Insurance Number (SIN) if they are also the proposed owner.

☐ Address is same as Person 1 above. If you've ticked this box, you may leave the address boxes blank.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Former last name (if any)	Country of birth	City of birth

Residential address (street number and name)	Apartment or suite

City	Province	Country	Postal code

SIN (required for tax reporting for life insurance; do not provide if applying for CII only)	Driver's licence number	Province

Home phone number	Cell phone number	Business phone number Ext.

What is your residency status?

☐ Canadian citizen ☐ Permanent resident status (landed immigrant) ☐ Other

If '**Permanent resident**' or '**Other**', provide details including number of years in Canada.

FATCA

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are also a proposed owner and are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

☐ Reason A: I have applied for a TIN but have not yet received it.

☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other: Specify the reason _____

Does the proposed owner want to retain age? ☐ Yes ☐ No **Note**: Age may be retained up to 90 days.

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

3 Policy ownership

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

3.1 Proposed owner(s)

Who will own this policy? (Select all that apply.)

- ☐ Person 1 to be insured
- ☐ Person 2 to be insured
- ☐ Individual(s) other than Person 1 or 2
- ☐ Corporation or Trust

Note: For Person 1 and 2, proceed to section 3.2 on next page as the required information will be taken from section 2. For all others, complete the following applicable sections.

Proposed owner 1

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

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

City	Province	Country	Postal code

SIN (required for tax reporting for life insurance; do not provide if applying for CII only)	Relationship to the proposed insured

FATCA

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

- ☐ Reason A: I have applied for a TIN but have not yet received it.
- ☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.
- ☐ Other: Specify the reason _____

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

3 Policy ownership (continued)

Proposed owner 2

☐ Address is same as Proposed owner 1. If you've ticked this box, you may leave the address boxes blank.

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

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

City	Province	Country	Postal code

SIN (required for tax reporting for life insurance; do not provide if applying for CII only)	Relationship to the proposed insured

FATCA

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No If '**yes**', provide a U.S. Taxpayer Identification Number (TIN).

U.S. Taxpayer Identification Number

CRS

If you are applying for universal or permanent life insurance, the following question must be answered.

Are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

If '**yes**', provide your jurisdictions of tax residence and Taxpayer Identification Numbers (TINs).

Jurisdiction of tax residence	Taxpayer Identification Number	Jurisdiction of tax residence	Taxpayer Identification Number

If you do not have a Taxpayer Identification Number (TIN), give the reason using one of these choices:

☐ Reason A: I have applied for a TIN but have not yet received it.

☐ Reason B: My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other: Specify the reason _____

Corporation, trust or other entity

Note: For all non-individual owners, additional forms may be required as described under Note on page 1 and in section 8.

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

3.2 Additional information

The following question must be completed if:

- any proposed insured is age 65 or greater, and
- the application is for a universal or permanent life plan (including special issues), and
- the death benefit amount applied for is greater than $1,000,000.

Is this policy being purchased with the intent of transferring ownership in the policy? ☐ Yes ☐ No

If '**yes**', provide full details in the box below.

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

3 Policy ownership (continued)

3.3 Mailing information

Indicate the proposed owner's address selection for all notifications and policy statements:
(Choose one.)

- ☐ Address of Person 1 to be insured
- ☐ Address of Person 2 to be insured
- ☐ Address of Proposed owner 1
- ☐ Address of Proposed owner 2, or
- ☐ Other

If '**other**', provide address below.

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

3.4 Proposed contingent owner(s)

Notes:

- If one proposed owner and the policy will continue after that owner's death (where the proposed owner is not the proposed insured person).
- If more than one proposed owner with multiple owners outside of Quebec
  If this policy is owned by more than one person and an owner dies, their interest will pass in equal shares to the surviving owners unless a contingent owner is named for them. If, on the death of any owner, that deceased owner's interest is to pass to a named contingent owner, then the name of the contingent owner must be completed in the space provided below next to the applicable owner's name.
- If more than one proposed owner with multiple owners in Quebec
  Survivorship provisions do not apply in Quebec. If one of the owners die, their interest in the policy will pass to the contingent owner named below. The surviving owner will continue to own their interest in the policy. Indicate the name of the proposed owner and their contingent owner in the space provided below.

	Proposed owner	**Contingent owner**	**Relationship to the proposed owner**
Owner 1			
Owner 2			
Owner 3			
Owner 4			
Owner 5			

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

4 Beneficiary information

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

Notes:

- For **SunUniversalLife II** joint last-to-die with the Insurance amount plus policy fund option, complete the *Early death benefit beneficiary election and/or change* (E272) form.
- In Quebec, if you name your legal spouse (by marriage or civil union) as the beneficiary, this designation will be irrevocable unless you check the Revocable box in any beneficiary designation section.

4.1 Life insurance designations

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

Notes:

- If not completed, any beneficiary will be the proposed owner or the estate of the proposed owner.
- In Quebec, the share of the predeceasing beneficiary will pass on to the surviving beneficiary(ies) of the same level only if you have designated beneficiaries to receive death benefits in equal shares. In cases of unequal shares, the predeceased beneficiary's share will revert to you or your estate.

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation	% share of benefits to be paid	
(for Person 1)				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		Total 100%
(for Person 2)				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		
				☐ Revocable ☐ Irrevocable		Total 100%

b) Contingent beneficiaries (Share of benefits must add up to 100%.)

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation	% share of benefits to be paid
(for Person 1)				☐ Revocable ☐ Irrevocable	
(for Person 2)				☐ Revocable ☐ Irrevocable	

4.2 Critical illness insurance designations

Note: If you designate a payee, you will not receive the **critical illness** benefit payment.

a) Benefit payee beneficiary

Note: If not completed, the beneficiary is the proposed owner or the estate of the proposed owner.

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation
				☐ Revocable ☐ Irrevocable

b) Return of premium on death benefit beneficiary

Notes:

- If not completed, the beneficiary will be the proposed owner or the estate of the proposed owner.
- We pay any Return of premium on cancellation or expiry benefits to the proposed owner or the estate of the proposed owner.

First name	Middle initial	Last name	Relationship to proposed insured (In Quebec, relationship to proposed owner)	Beneficiary designation
				☐ Revocable ☐ Irrevocable

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

4 Beneficiary information (continued)

4.3 Trustee for minor beneficiary designations for life and critical illness

Notes:

- Complete when a minor beneficiary has been named in beneficiary designation sections 4.1 or 4.2.
- In all provinces other than Quebec, if you designate minor children as beneficiaries, you should also name a trustee to receive funds on their behalf.
- In Quebec, any amount payable to a minor beneficiary during their minority will be paid to the parent(s) or legal guardian of the minor child.

a) Primary beneficiaries: I appoint

b) Contingent beneficiaries: I appoint

c) Benefit payee beneficiary: I appoint

d) Return of premium on death benefit beneficiary: I appoint

as a trustee to receive any payments on behalf of any named minor beneficiary during their minority. The trustee may apply such payments solely for the support, maintenance, education and benefit of such beneficiary at the discretion of the trustee.

5 Conversions/replacements/options exercised

Complete this section for all conversions/options exercised **with an increase in coverage** and replacements.

Notes:

- Changes to policies issued prior to 2017 may result in the loss of grandfathering protection which may result in negative tax consequences.
- 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.
- The policies listed below will be terminated or amended on the date that any insurance applied for in this application becomes effective.
- Termination or amendment of the policies listed below may result in the loss of one or more benefits such as: Waiver of Premium Disability, Accidental death, policy loans at 6% interest, Guaranteed insurability, Disability income, Critical illness insurance, insurance coverage on other lives or beneficial tax treatments.
- This transaction may result in a taxable policy gain.
- Any change may be subject to restrictions on the amount of premium and death benefit, as determined by the company at the time of the change.
- The company may require evidence of insurability.
- If there is a credit from the terminated policy and/or from payment made with this application, it will be applied to the premium fund or policy fund (depending upon the new plan), subject to applicable minimum/maximum limits unless you tell us otherwise.
- If only applying for a change to the smoking status of your policy, with an increase in coverage that requires underwriting, complete an Application for policy change, reinstatement and/or reconsideration of rating (E110) instead of this application.

5.1 Disability status

Note: This question must be answered by the proposed insured. If the proposed insured is under age 16 (18 in Quebec), the question must be answered by the parent or legal guardian.

Is the proposed insured currently disabled or claiming on the disability benefit of any of their policies? ☐ Yes ☐ No

If '**yes**', indicate policy number:

5.2 Conversions, replacements and options exercised information

a) Provide the policy number of any insurance policies with the company to be **fully terminated** by this application (e.g., replacements, full conversion or partial conversion **with balance terminated or attached to the new plan**).

b) Provide the policy number of any insurance policies with the company on which the **death benefit is being reduced** (e.g., partial conversion or conversion of attached plan **with balance being retained in the existing policy**).

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

5 Conversions/replacements/options exercised (continued)

c) Provide the policy number of any insurance policies with the company on which **a Guaranteed insurability option, or options on Child term, Spousal term, Attached term on the insured spouse, Attached term on the additional insured person, Business value protection or Partner protection is being exercised**.

d) Additional instructions

6 Plan/benefit information

In this section:

- *you* and *your* refer to the proposed owner(s), and
- *Person 1* and *Person 2* refer to proposed insured person 1 and proposed insured person 2 unless otherwise indicated.

6.1 SunTerm $ ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year

a) ☐ Single life ☐ Joint first-to-die ☐ Multi-life $ ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year
(Complete for Person 2.)

b) Risk classification applied for on Person 1
☐ 1 non-smoker ☐ 2 non-smoker ☐ 3 non-smoker ☐ 4 smoker ☐ 5 smoker

c) Risk classification applied for on Person 2
☐ 1 non-smoker ☐ 2 non-smoker ☐ 3 non-smoker ☐ 4 smoker ☐ 5 smoker

6.2 Sun Par Protector II $ *or* **Sun Par Accumulator II** $

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

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

c) Dividend options (Choose one.)
☐ Paid-up additional insurance (PUA)
☐ Annual premium reduction (Only available if premiums are payable on an annual basis.)
☐ Cash payment
☐ Dividends on deposit
☐ Enhanced insurance

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

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

6 Plan/benefit information (continued)

d) Premium offset

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

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

e) Request to receive mail about policyholder meetings and change

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

Do you want to receive notice of these meetings and related information? ☐ Yes ☐ No If not completed, we will assume response as '**yes**'.

6.3 Sun Par Accelerator

$ _____ (Base insurance amount + Enhanced amount)

a) ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die (Premiums payable to second death.)

b) Request to receive mail about policyholder meetings and change

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

Do you want to receive notice of these meetings and related information? ☐ Yes ☐ No If not completed, we will assume response as '**yes**'.

6.4 SunUniversalLife II

$ _____

a) ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die
- ☐ COI payable to first death
- ☐ COI payable to second death

b) Death benefit options (Choose one.)
- ☐ Insurance amount plus policy fund
- ☐ Level insurance amount
- ☐ Level plus indexed insurance amount at _____ % per year (specify between 1% and 8%, in multiples of 0.25%)
- ☐ Level plus return of payments
- ☐ Level plus adjusted cost basis

c) Cost of insurance (COI)
- ☐ Level
- ☐ Yearly to 85
- ☐ Yearly to 70
- ☐ Level for 10 years
- ☐ Level for 15 years
- ☐ Level for 20 years

d) Investment account options

You must allocate your payment to any of the following Investment account options. Your choices must be in multiples of 5% and they must add up to 100%. Each of your investment accounts must also have a minimum amount of $100.00. We'll move your payment to your Investment account options when the amount you give us is large enough to put at least $100.00 in each of your selected options.

6 Plan/benefit information (continued)

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

Interest rate accounts	Percentage
Daily interest account	
Guaranteed interest accounts (GIAs) 1 year	
3 year	
5 year	
10 year	
Sun Life Diversified Account Note: $10,000 minimum (net of first year cost of insurance) is required.	

Managed accounts	Percentage
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 Index	
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 Value	
Sun Life MFS Global Value	
Sun Life MFS US Equity	
Sun Life Multi-Strategy Target Return	

Sub total ____ % + Sub total ____ % = 100%

Your GIA earnings will automatically compound until the account matures.

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

☐ Rollover to a new account of the same term

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

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

or ☐ **Alternate order 1:**

Funds are withdrawn in the following order:
- DIA
- Managed accounts in proportion to the balance of each managed account
- GIAs (taken first from layers closest to maturity)
- Sun Life Diversified Account

or ☐ **Alternate order 2:**

Funds are withdrawn in the following order:
- DIA
- GIAs (taken first from layers closest to maturity)
- Managed accounts in proportion to the balance of each managed account
- Sun Life Diversified Account

e) Maintaining your policy's tax-exempt status

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

☐ Retain insurance amount

☐ Increase insurance amount as required (to a maximum of 8%) but reverse the increase when this can be done without losing tax-exempt status (note the cost of insurance will be changed accordingly) **Note**: Not available if the death benefit option selected is Level plus indexed insurance amount, Level plus return of payments or Level plus adjusted cost basis.

☐ Increase insurance amount as required (to a maximum of 8% and the cost of insurance will be increased accordingly), but do not reverse the increase.

In addition, a service account must be established for any excess funds. **Note**: If not indicated, default will be DIA.

☐ Daily interest account

☐ Guaranteed interest account - 1 year

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

6 Plan/benefit information (continued)

f) Defaults

If the required illustration isn't attached with this application and/or you haven't provided all the required information, your policy will have the following options:

- Death benefit option – Insurance amount plus your policy fund value
- Cost of insurance – Guaranteed level rates
- 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)
- Investment account options – DIA 100%
- Withdrawal order – Proportional per account balance

6.5 Sun Critical Illness Insurance

$

☐ Term 10

☐ Term 75

Guaranteed payment period

☐ 15 years ☐ To age 75

☐ Lifetime

Guaranteed payment period

☐ 10 years ☐ 15 years ☐ To age 100

If you are applying for a conversion and if the previous critical illness policy did not have all illnesses that are available on the base plan you have applied for, do you want to apply for these illnesses and submit evidence? ☐ Yes ☐ No

6.6 Other

$

Name of plan

6.7 Optional benefits

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

a) Available on life plans

☐ Total disability waiver ☐ Person 1 ☐ Person 2

☐ Term insurance benefit on Person 1

- ☐ 10 Year Renewable Term $
- ☐ 10 Year with Renewal protection $
- ☐ 15 Year Renewable Term $
- ☐ 20 Year Renewable Term $
- ☐ 30 Year Renewable Term $

☐ Term insurance benefit on Person 1's additional insured person

- ☐ 10 Year Renewable Term $
- ☐ 10 Year with Renewal protection $
- ☐ 15 Year Renewable Term $
- ☐ 20 Year Renewable Term $
- ☐ 30 Year Renewable Term $

☐ Term insurance benefit on Person 2

- ☐ 10 Year Renewable Term $
- ☐ 10 Year with Renewal protection $
- ☐ 15 Year Renewable Term $
- ☐ 20 Year Renewable Term $
- ☐ 30 Year Renewable Term $

☐ Term insurance benefit on Person 2's additional insured person

- ☐ 10 Year Renewable Term $
- ☐ 10 Year with Renewal protection $
- ☐ 15 Year Renewable Term $
- ☐ 20 Year Renewable Term $
- ☐ 30 Year Renewable Term $

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

6 Plan/benefit information (continued)

☐ Guaranteed insurability Person 1 $ Person 2 $

☐ Accidental death Person 1 $ Person 2 $

☐ Child term Person 1 $ Person 2 $

☐ Owner waiver disability **Note:** Complete sections 9 - 13 on the proposed owner.

☐ Owner waiver death **Note:** Complete sections 9 - 13 on the proposed owner.

☐ Business value protection Person 1 $ Person 2 $

☐ Other

☐ Person 1	$	Benefit name
☐ Person 2	$	Benefit name

b) Sun Par Protector II and Sun Par Accumulator II only

☐ Plus premium benefit (PPB) (Not available on **10 pay**.)

Payment option for PPB
Scheduled (regular monthly or annual payments): ☐ Monthly $ ☐ Annual $

c) SunTerm only

☐ Renewal protection (**SunTerm 10 year**): ☐ Person 1 ☐ Person 2

☐ Partner protection (Only with 3 or more proposed insureds.)

d) Sun Critical Illness Insurance only

Note: An increase or addition to the **Sun Critical Illness** attached benefits is not available after the policy is issued, with the exception of the Long term care conversion option. This option may **only** be added after the policy is issued on juvenile policies between the policy anniversaries nearest the insured person's 18th and 19th birthday.

☐ Total disability waiver

☐ Long term care conversion option

☐ Return of premium on:

- ☐ Death
- ☐ Cancellation or expiry (Term 10 or Term 75)
  - ☐ Adult:
    - ☐ 15 years
    - ☐ age 65
    - ☐ age 75
  - ☐ Child
    - ☐ Advanced
    - ☐ age 35
- ☐ Cancellation (Lifetime only)
  - ☐ Adult:
    - ☐ 15 years
    - ☐ age 65
    - ☐ age 75
  - ☐ Child
    - ☐ Advanced
    - ☐ age 35
- ☐ Owner waiver disability **Note:** Complete sections 9 - 13 on the proposed owner.
- ☐ Owner waiver death **Note:** Complete sections 9 - 13 on the proposed owner.

7 Acknowledgement of variability

In this section, I refers to the proposed owner(s).

I acknowledge there are many variables that can affect an insurance policy's performance, including the following (where applicable):

- the type of and future investment performance of the Investment account option(s) selected
- the future investment performance of the participating account
- future dividend scales
- the timing and amount of future payments to and withdrawals from the policy
- the cost of insurance
- mortality and morbidity rates, lapse rates and expenses
- policy loans, and
- future federal income tax rules and provincial income and premium taxes.

More specifically, I understand interest rates, future dividend scales and the performance of securities markets in particular can fluctuate significantly and that even a small change in any one of these variables could have a dramatic negative or positive impact on the policy's non-guaranteed benefits and values. I understand that past performance does not predict nor is it a good indicator of future results.

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

I understand that, unless indicated as 'Guaranteed', the benefits and values in an illustration are not guaranteed, are hypothetical only and are based on assumptions that are certain to change. I realize they are neither an estimate nor a guarantee of future policy performance.

I understand actual results will differ upward or downward from those illustrated because they are highly dependent upon a number of variables (including those listed above) and that even a small change in any one of these variables could have a dramatic negative or positive impact on the non-guaranteed figures shown in an illustration.

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

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

Completion of this section is mandatory if:

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

Notes:

- In this section, *you* and *your* refer to the proposed owner(s), which includes sole proprietors.
- The questions must be answered by the proposed owner(s) of this application.
- If any proposed owner **is not an individual** (ie Corporation or other entity), form 4831 (*Identity verification and third party determination for entity owners*) and form 4545 (*International tax classification for an entity*) must be completed for that proposed owner.
- Additional form 4355 (*Non face-to-face identity verification by agent or mandatary, third party determination and politically exposed persons (PEP)*) must be completed for any proposed owner who:
  - **is a Canadian resident but is not present at the time this application is being completed**, or
  - **does not reside in Canada**.

Always verify the identity of clients and find out whether any third parties are involved. This helps Sun Life Financial 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 additional space is required for any part of this section, complete form 4830 for each proposed owner.

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

Identity verification

Proposed owner 1's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Detailed occupation/pre-retired occupation/principal business

Residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.

City	Province	Country	Postal code

Identification method - Complete one of the below methods (a or b). Record all the information; do not attach photocopies.

☐ a) Photo identification:

View an original, valid and current Canadian passport, driver's licence or document issued by a Canadian federal, provincial or territorial government for that individual. A foreign photo identification document is acceptable if it is equivalent to an acceptable Canadian photo identification document.

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

☐ b) Dual process:

View 2 original, valid and current documents from 2 different independent and reliable sources. Must collect all information from 2 out of the 3 options listed below;

1. Name and address.
2. Name and date of birth.
3. Name and proof of Canadian deposit account, or Canadian loan account.

Note: Some examples of acceptable reliable sources would be: federal, provincial, territorial and municipal levels of government, crown corporations, financial entities or utility providers. Detailed information is required (i.e. CIBC/Union Gas/BC marriage certificate).

Source 1	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)

PIVERIDE

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

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

Proposed owner 2's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Detailed occupation/pre-retired occupation/principal business

Address/residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.

City	Province	Country	Postal code

Identification method - Complete one of the below methods (a or b). Record all the information; do not attach photocopies.

☐ a) Photo identification:

View an original, valid and current Canadian passport, driver's licence or document issued by a Canadian federal, provincial or territorial government for that individual. A foreign photo identification document is acceptable if it is equivalent to an acceptable Canadian photo identification document.

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

☐ b) Dual process:

View 2 original, valid and current documents from 2 different independent and reliable sources. Must collect all information from 2 out of the 3 options listed below;

1. Name and address.
2. Name and date of birth.
3. Name and proof of Canadian deposit account, or Canadian loan account.

Note: Some examples of acceptable reliable sources would be: federal, provincial, territorial and municipal levels of government, crown corporations, financial entities or utility providers. Detailed information is required (i.e. CIBC/Union Gas/BC marriage certificate).

Source 1	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)
Source 2	Type of document	Account or reference number	Information collected according to method used ☐ Name ☐ Date of birth ☐ Address ☐ Financial account	Date of verification (dd-mm-yyyy)

8.1 Third party determination

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

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

Is the contract to be paid for by a third party or used by or on behalf of a third party? ☐ Yes ☐ No

If '**yes**', what is the type of third party? ☐ Individual ☐ Entity ☐ Both

Name (If individual, indicate first name, middle initial and last name.)	If individual, date of birth (dd-mm-yyyy)

Type of third party	Relationship to proposed owner	Detailed occupation/pre-retired occupation/principal business

Address/residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.	Apartment or Suite

City	Province/State	Country	Postal/Zip code

If an entity, registration number	Province/state of registration	Country of registration

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

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

Name (If individual, indicate first name, middle initial and last name.)	If individual, date of birth (dd-mm-yyyy)

Type of third party	Relationship to proposed owner	Detailed occupation/pre-retired occupation/principal business

Address/residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable.	Apartment or Suite

City	Province/State	Country	Postal/Zip code

If an entity, registration number	Province/state of registration	Country of registration

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

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

To the best of every proposed owner's knowledge, has any proposed owner, their family members or close associates, held any of the positions indicated in a), b) or c) below? Indicate **Yes** or **No** in a), b) and c) below.

Record all that apply in the charts below.

Notes:

- Family member means spouse, civil union spouse or common-law partner, children/step children, siblings/half siblings/step siblings of any proposed owner, biological/adoptive/step parent of any proposed owner, biological/adoptive/step parent of spouse, civil union spouse or common-law partner.
- Close associate is someone who is closely associated with any proposed owner for personal or business reasons. Examples of circumstances that may lead to the determination that someone is closely associated with any proposed owner include, but are not limited to:
  - Transactions that occur between a PEP or an HIO and any proposed owner;
  - Business activities between a PEP or an HIO and any proposed owner;
  - Media coverage linking a PEP or an HIO and any proposed owner; or
  - A personal relationship such as a romantic relationship or close friendship between a PEP or an HIO and any proposed owner.

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

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

Proposed owner 1's first name	Middle initial	Last name

First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)

Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)

Proposed owner 1's first name	Middle initial	Last name

First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)

Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)

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

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

Proposed owner 2's first name	Middle initial	Last name	
First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 2's first name	Middle initial	Last name	
First name (PEFP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEFP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

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

1. governor general
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. holder of any prescribed office or position
18. mayor

Proposed owner 1's first name	Middle initial	Last name	
First name (PEDP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 1's first name	Middle initial	Last name	
First name (PEDP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 2's first name	Middle initial	Last name	
First name (PEDP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 2's first name	Middle initial	Last name	
First name (PEDP) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (PEDP)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

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

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

c) Head of an international organization (HIO) - (currently held) ..... ☐ Yes ☐ No

An individual is an HIO if the individual is the head of an international organization or the head of an institution established by an international organization. An international organization is an organization set up by the governments of more than one country and established by means of a formally signed agreement between those governments.

Examples of international organizations include, but are not limited to:

- North Atlantic Treaty Organization (NATO)
- Organization for Economic Co-operation and Development (OECD)
- International Monetary Fund (IMF)
- World Bank Group
- World Health Organization (WHO)
- La Francophonie

Proposed owner 1's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 1's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 2's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Proposed owner 2's first name	Middle initial	Last name	
First name (HIO) if not proposed owner	Middle initial	Last name	Relationship to proposed owner (HIO)
Country where position held	Organization or institution	Position held (Indicate all applicable numbers from list)	

Source of payment and purpose of product

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

☐ salary or earned income
☐ existing investment account
☐ proceeds from death benefits or estate
☐ social benefits
☐ other (give details below)
☐ proposed owner's savings
☐ pension income
☐ sale of property
☐ borrowed funds
☐ business income
☐ gifted funds
☐ inherited funds

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

☐ income replacement
☐ estate protection
☐ other (give details below)
☐ mortgage protection
☐ business protection
☐ creditor protection
☐ charitable donation
☐ asset protection
☐ tax or estate planning

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#

9 Personal information

In this section, *you* and *your* refer to the proposed insured(s) and/or proposed owner. The questions must be answered by the proposed insured(s) and/or the proposed owner of the policy who has applied for an owner waiver disability or death benefit. If a proposed insured is under age 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.

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.

Notes:

- If applying for a Term insurance benefit on an additional insured person or a multi-life policy with more than 2 proposed insureds, a separate application must be completed/submitted to provide the required evidence of insurability.
- Only provide information for the proposed owner in sections 9-13 if you've applied for additional Owner waiver disability or death benefits.

9.1 Smoking and tobacco use

Notes:

- Question in 9.1 does not need to be answered for proposed insureds under the age of 16.
- Question in 9.1 does not need to be answered on conversion applications where smoker/non-smoker rates are being carried over to the new policy.

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

If '**yes**', provide details.

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

9.2 Insurance history and replacement/disclosure statements and/or Life Insurance Replacement Declarations

	Person 1	**Person 2**	**Proposed owner**
a) Do you have any existing life and/or critical illness insurance in force on your life? ..	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

Proposed insured	**Date(s) issued (mm-yyyy)**	**Plan type(s)**	**Amount(s) (including benefits)**	**Company name(s)**	**Replacing**	**Business or personal**
Person 1		☐ Life ☐ CII			☐ Yes ☐ No	☐ Business ☐ Personal
Person 2		☐ Life ☐ CII			☐ Yes ☐ No	☐ Business ☐ Personal
Proposed owner		☐ Life ☐ CII			☐ Yes ☐ No	☐ Business ☐ Personal

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#

9 Personal information (continued)

b) 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.

Is this application intended to replace or reduce benefits of any existing insurance policy or a pending insurance application of any company (other than by conversion)? ☐ Yes ☐ No

Notes:

- If '**yes**', complete and attach the required applicable replacement disclosure form.
- If more than one policy is being replaced, a separate replacement disclosure form is required for each policy being replaced.
- For critical illness insurance applications, a replacement form is required for Quebec applications only.
- A replacement disclosure form is not required when the application is a conversion or when replacing mortgage insurance with a bank or creditor insurance.

	Person 1	**Person 2**	**Proposed owner**
c) Do you have any applications for life, disability, critical illness or long term care insurance **currently** pending or contemplated? ..... If '**yes**', provide details below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Proposed insured	**Company name(s)**	**Plan type(s)**	**Amount(s) applied for**	**Total amount of new insurance to be put into effect with all companies**
Person 1				
Person 2				
Proposed owner				

	Person 1	**Person 2**	**Proposed owner**
d) 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? ..... If '**yes**', indicate when, which company and why in the box below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Person 1	
Person 2	
Proposed owner	

9.3 Employment information

Note: Questions in 9.3 do not need to be answered for proposed insureds under the age of 16.

a) What is your occupation?

Person 1	
Person 2	
Proposed owner	

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#

9 Personal information (continued)

b) What are your occupational duties?

Person 1	
Person 2	
Proposed owner	

c) What is your employer's name and address?

Person 1	
Person 2	
Proposed owner	

9.4 Financial information

Note: Questions in 9.4 do not need to be answered for proposed insureds under the age of 16.

	Person 1	Person 2	Proposed 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 5 years**, have you declared or been petitioned into personal or corporate bankruptcy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**', provide details below.

	Date discharged (dd-mm-yyyy)	Circumstances of bankruptcy
Person 1		
Person 2		
Proposed owner		

f) If a proposed insured is financially dependent on their spouse, provide the following information on the income earner, if not already indicated in this application.

Spouse's annual income	Amount of life insurance in force on the spouse	Amount of CII in force on the spouse
$	$	$

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#

9 Personal information (continued)

9.5 Drug and alcohol use

Note: Questions in 9.5 do not need to be answered for proposed insureds under the age of 16.

	Person 1	Person 2	Proposed owner
a) In the **last 10 years**, have you used marijuana or hashish, cocaine, LSD, ecstasy or other psychoactive drugs, heroin, fentanyl or other narcotics, anabolic steroids or other performance enhancing drugs? ..... If '**yes**', complete the following.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Product(s)	Amount(s) and frequency of use	Date last used (dd-mm-yyyy)
☐ marijuana or hashish mixed with tobacco		
☐ marijuana or hashish without tobacco		
☐ other _____		
☐ other _____		

b) Do you currently drink alcohol? ..... If '**yes**', provide details below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Proposed insured	Product(s) Indicate all that apply	Amount and frequency of use		
Person 1	☐ Beer ☐ Wine ☐ Liquor	Beer: # of bottles: _____ per ☐ day ☐ week or ☐ month	Wine: # of glasses: _____ per ☐ day ☐ week or ☐ month	Liquor: # of oz: _____ # of ml: _____ per ☐ day ☐ week or ☐ month
Person 2	☐ Beer ☐ Wine ☐ Liquor	Beer: # of bottles: _____ per ☐ day ☐ week or ☐ month	Wine: # of glasses: _____ per ☐ day ☐ week or ☐ month	Liquor: # of oz: _____ # of ml: _____ per ☐ day ☐ week or ☐ month
Proposed owner	☐ Beer ☐ Wine ☐ Liquor	Beer: # of bottles: _____ per ☐ day ☐ week or ☐ month	Wine: # of glasses: _____ per ☐ day ☐ week or ☐ month	Liquor: # of oz: _____ # of ml: _____ per ☐ day ☐ week or ☐ month

	Person 1	Person 2	Proposed owner
c) Have you **ever** received treatment or been told to reduce use or frequency of use, seek treatment, counselling or medical advice due to your use of drugs or alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**', complete and attach the appropriate *Alcohol usage questionnaire* (E26) and/or *Drug questionnaire* (E12).

9.6 Driving history

Note: Questions in 9.6 do not need to be answered for proposed insureds under the age of 16.

	Person 1	Person 2	Proposed owner
a) Have you been charged with or convicted of:			
i) in the **last 10 years**, an alcohol or drug related driving offence or refusing a breathalyzer test?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ii) in the **last 3 years**, any other driving offences **(Exclude tickets for parking and failure to provide insurance or ownership cards.)**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Note: If '**yes**' to i) or ii), provide details below. For speeding convictions, include the number of kilometres per hour over the speed limit.

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#

9 Personal information (continued)

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

9.7 Foreign residence/travel

a) In the **last 12 months**, have you **travelled** or **resided** outside of Canada? **(Exclude travel or residence of less than 6 months in the United States.)** ..... ☐ Yes ☐ No (Person 1) ☐ Yes ☐ No (Person 2) ☐ Yes ☐ No (Proposed owner)

If '**yes**' provide details below.

Proposed insured	Countries and cities	Length of stay in each	Purpose of stay in each	Date(s) of travel (mm-yyyy)
Person 1				
Person 2				
Proposed owner				

b) In the **next 12 months**, do you intend to **travel** or **reside** outside of Canada? **(Exclude travel or residence of less than 6 months in the United States.)** ..... ☐ Yes ☐ No (Person 1) ☐ Yes ☐ No (Person 2) ☐ Yes ☐ No (Proposed owner)

If '**yes**' provide details below.

Proposed insured	Countries and cities	Length of stay in each	Purpose of stay in each	Date(s) of travel (mm-yyyy)
Person 1				
Person 2				
Proposed owner				

9.8 Other information

Note: Questions in 9.8 do not need to be answered for proposed insureds under the age of 10.

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**? ..... ☐ Yes ☐ No (Person 1) ☐ Yes ☐ No (Person 2) ☐ Yes ☐ No (Proposed owner)

If '**yes**', complete and attach an *Aviation questionnaire* (E4).

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**? ..... ☐ Yes ☐ No (Person 1) ☐ Yes ☐ No (Person 2) ☐ Yes ☐ No (Proposed owner)

If '**yes**', complete and attach the appropriate questionnaire.

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#

9 Personal information (continued)

	Person 1	Person 2	Proposed owner
c) 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**', provide details below.

Proposed insured	Details
☐ Person 1 ☐ Person 2 ☐ Proposed owner	
☐ Person 1 ☐ Person 2 ☐ Proposed owner	
☐ Person 1 ☐ Person 2 ☐ Proposed owner	

9.9 Individual insurance for a child

Note: Complete the following section if the proposed insured is under the age of 16 and applying for individual life or critical illness insurance **(excluding CTB)**.

a)

Relationship of proposed owner to the proposed insured	Does the proposed insured live with the proposed owner? ☐ Yes ☐ No
If '**no**', with whom and where does the proposed insured live (name, city/town)?	
Does the proposed owner have full knowledge of the proposed insured's medical history? ☐ Yes ☐ No If '**no**', provide name and relationship of person who is providing the required personal and medical information on this child. This person must also sign on page 40.	

b) What is the total amount of existing and applied for life, critical illness, disability and long term care insurance and the annual earned income on one of the parents?

Life	Critical illness	Disability	Long term care	Annual earned income
$	$	$	$	$

c) What is the total amount of existing and applied for life, critical illness, disability and long term care insurance and the annual earned income on the other parent?

Life	Critical illness	Disability	Long term care	Annual earned income
$	$	$	$	$

d) What is the Canadian net worth of the parents? $

e) What is the foreign net worth of the parents? $

f) Does the proposed insured have any siblings age 15 or less? ☐ Yes ☐ No If '**no**', proceed to section 10.

i) 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

ii) If '**no**' **to i) and applying for life insurance coverage**, provide the sibling's amount of insurance and reason for the difference in the box below.

iii) If '**no**' **to i) and applying for critical illness insurance coverage**, provide the sibling's amount of insurance and reason for the difference in the box below.

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#

10 Medical advisor/clinic information

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

Person 1

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

Person 2

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

Proposed owner

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

Note: If you are having a paramedical or medical exam completed, you may proceed to section 15.

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#

Note: In sections 11 - 13, *you* and *your* refer to the proposed insured(s) and proposed owner. The questions must be answered by the proposed insured(s) and/or the proposed owner of the policy who has applied for an owner waiver disability or death benefit. If a proposed insured is under age 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.

11 Family history

Note: Questions in 11 do not need to be completed for individuals **over the age of 65. Do not tell us about genetic testing or genetic test results.**

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

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

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

Proposed insured	Relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death
Person 1					
Person					
Proposed owner					

12 Height and weight

12.1 Proposed insureds over the age of 10

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

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

12.2 Children age 1 to 10

a) In the **last 2 years**, have you been told by a doctor or health practitioner that your height, weight or physical development were not meeting normal milestones? ☐ Yes ☐ No

b) In the **last 2 years**, have you been told by a doctor or health practitioner to gain or lose weight or to follow a diet? ☐ Yes ☐ No

c) In the **last 12 months**, have you had a weight loss of more than 4.5 kg (10 lbs)? ☐ Yes ☐ No

If '**yes**' to a), b) or c), indicate your current measured height ☐ ft/in ☐ cm and weight ☐ lbs ☐ kg.

Provide details including diagnosis and doctor's recommendations. If there has been any weight loss in the **last 12 months**, indicate amount of weight loss and cause of the weight loss.

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 Height and weight (continued)

12.3 Children under the age of 1

	Person 1	Person 2
a) Was the birth premature by more than 4 weeks or is there any indication of failure to thrive or gain weight?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you been told by a doctor or health practitioner that your height, weight or physical development were not meeting normal milestones?	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**' to a) or b), indicate your birth weight ☐ lbs ☐ kg, and your current measured height ☐ ft/in ☐ cm and weight ☐ lbs ☐ kg.

Provide details including current status and any other relevant information.

Person 1	
Person 2	

13 Personal medical history

13.1 Medical information

In this section, *you* and *your* refer to the proposed insured(s) and/or proposed owner. The questions must be answered by the proposed insured(s) and/or the proposed owner of the policy who has applied for an owner waiver disability or death benefit. If a proposed insured is under age 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.

a) Heart and circulatory system

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- high blood pressure
- high cholesterol
- angina
- chest pain
- heart attack
- coronary artery disease (CAD)
- transient ischemic attack (TIA)
- stroke or cerebrovascular accident (CVA)
- heart murmur
- irregular pulse
- blood clot(s)
- peripheral vascular disease (poor circulation)
- aneurysm
- any other disease or disorder of the heart or blood vessels

If '**yes**' has been answered to any condition in a), provide details the box below. List each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

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

Proposed insured	**Details**
☐ Person 1 ☐ Person 2 ☐ Proposed owner	
☐ Person 1 ☐ Person 2 ☐ Proposed owner	

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 Personal medical history (continued)

b) Abnormal growths or malignancy

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- cancer
- leukemia
- lymphoma
- melanoma
- dysplastic nevus (atypical mole)
- basal cell carcinoma
- tumour
- cyst(s)
- polyp(s)
- any other growths or malignancy

If '**yes**' has been answered to any condition in b), provide details in the box below. List each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

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

Proposed insured	**Details**
☐ Person 1 ☐ Person 2 ☐ Proposed owner	
☐ Person 1 ☐ Person 2 ☐ Proposed owner	

c) Glands and/or endocrine system

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- diabetes
- gestational diabetes
- abnormal blood sugar
- goitre
- hyperthyroidism
- hypothyroidism
- lymph or gland disease or disorder
- any other thyroid, pituitary or endocrine disease or disorder

If '**yes**' has been answered to any condition in c), provide details below.

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

Proposed insured	**Details**
☐ Person 1 ☐ Person 2 ☐ Proposed owner	
☐ Person 1 ☐ Person 2 ☐ Proposed owner	

d) Blood

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- anemia
- hemophilia
- any other blood or bleeding disease or disorder

If '**yes**', provide details in section 13.3.

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

13 Personal medical history (continued)

e) Gastrointestinal system

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

Person 1 | **Person 2** | **Proposed owner**

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

If '**yes**', provide details in section 13.3.

f) Eyes, ears, nose, throat and mouth

Have you **ever** been treated for or had any symptoms or indication of **(excluding 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)**: ..... ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

Person 1 | **Person 2** | **Proposed owner**

- 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

If '**yes**', provide details in section 13.3.

g) Respiratory system

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

Person 1 | **Person 2** | **Proposed owner**

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

If '**yes**', provide details in section 13.3.

h) Mental health

Have you **ever** been treated for or had any symptoms or indication of: ..... ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

Person 1 | **Person 2** | **Proposed owner**

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

If '**yes**', provide details in section 13.3.

i) Skin and connective tissue

Have you **ever** been treated for or had any symptoms or indication of **(excluding poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema)**: ..... ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

Person 1 | **Person 2** | **Proposed owner**

- lupus
- scleroderma
- any other skin or connective tissue disease or disorder

If '**yes**', provide details in section 13.3.

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

13 Personal medical history (continued)

j) Genitourinary system

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- abnormal prostate specific antigen (PSA)
- prostatitis or any other prostate disease or disorder
- breast lump(s) or cyst(s)
- abnormal mammogram
- abnormal pap smear
- hysterectomy
- disease or disorder of the ovary or uterus
- sexually transmitted disease
- disease or disorder of the genital organs
- kidney stone(s)
- nephritis
- urinary tract infection
- sugar, blood or protein in the urine
- any other kidney or bladder disease or disorder

If '**yes**', provide details in section 13.3.

k) Musculoskeletal system

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- 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

If '**yes**', provide details in section 13.3.

l) Nervous system

	Person 1	Person 2	Proposed owner
Have you **ever** been treated for or had any symptoms or indication of:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- autism
- cerebral palsy
- Down syndrome
- developmental delay
- epilepsy or seizure(s)
- multiple sclerosis (MS)
- loss of balance, consciousness, sensation or speech
- coma
- concussion
- 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

If '**yes**', provide details in section 13.3.

13.2 Medical tests and consultations

	Person 1	Person 2	Proposed owner
a) **Have** you **ever** been tested for or has anyone **ever** recommended that you should be tested for exposure to the HIV (AIDS) virus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) **Have** you **ever** been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?.....	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) In the **last 5 years**, have you had any medical or diagnostic tests, such as ECG, scans, MRI, ultrasounds, biopsies, blood or urine tests? **(Exclude any tests you've already told us about in this application. Do not tell us about genetic testing or genetic testing results.)**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Are you pregnant?.....	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**', indicate which trimester and pre-pregnancy weight:

☐ 1st (1 - 3 months) ☐ 2nd (4 - 6 months) ☐ 3rd (7 - 9 months)

pre-pregnancy weight ☐ lb ☐ kg

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 Personal medical history (continued)

	Person 1	Person 2	Proposed owner
e) **Other than for conditions already disclosed**, in the **last 5 years**, 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 **exceeding 2 weeks**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Do you have any symptoms for which you have not yet consulted a physician or received treatment? **(Exclude common cold, flu or seasonal allergy symptoms.)**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) **Other than for conditions already disclosed**, has a doctor or other health care advisor requested any tests or made any referrals that have not yet been completed, or are you currently awaiting test **(Do not tell us about genetic testing or genetic testing results.)**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) **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.)**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) **Other than for conditions already disclosed**, have you been prescribed or are you taking any prescription medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If '**yes**' to any question a) - i), provide details in section 13.3.

13.3 Details

If '**yes**' has been answered to any condition in 13.1 d) - l), and 13.2, provide details in the box below. List each condition along with all related treatments, dates, durations, results, names and addresses of all doctors, hospitals and clinics consulted.

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

Proposed insured	**Question number(s)**	**Details**
Person 1		
Person 2		
Proposed owner		

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#

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

Complete this section only if you are applying for a child term benefit.

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

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

Child	First name	Middle initial	Last name	Relationship to proposed insured	Sex	Date of birth (dd-mm-yyyy)
1				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
2				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
3				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
4				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	
5				☐ child ☐ step-child ☐ adopted child	☐ Male ☐ Female	

Do all of the listed children live with you? ☐ Yes ☐ No

If '**yes**', who do the children live with? ☐ Person 1 ☐ Person 2

If '**no**', complete the following.

Child 1	First name of person the child lives with	Middle initial	Last name	Relationship to child	
	Residential address (street number and name)	Apartment or suite	City	Province	Postal code
Child 2	First name of person the child lives with	Middle initial	Last name	Relationship to child	
	Residential address (street number and name)	Apartment or suite	City	Province	Postal code
Child 3	First name of person the child lives with	Middle initial	Last name	Relationship to child	
	Residential address (street number and name)	Apartment or suite	City	Province	Postal code
Child 4	First name of person the child lives with	Middle initial	Last name	Relationship to child	
	Residential address (street number and name)	Apartment or suite	City	Province	Postal code
Child 5	First name of person the child lives with	Middle initial	Last name	Relationship to child	
	Residential address (street number and name)	Apartment or suite	City	Province	Postal code

Does the proposed insured have full knowledge of each child's medical history? ..... ☐ Yes ☐ No

If '**no**', is the person who has the most knowledge of the medical history of the children present? ..... ☐ Yes ☐ No

Note: If not present, this benefit may not be applied for at this time.

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

Name of person answering questions	Relationship to the children

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

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#

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

1. Has any child **ever** been treated for or had any symptoms or indication of:
   a) heart murmur or any other disease or disorder of the heart or blood vessels ☐ Yes ☐ No
   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
2. Has any child **ever** been tested for exposure to the HIV (AIDS) virus? ☐ Yes ☐ No
3. Are there any medical conditions, not already mentioned, for which any child had or is awaiting investigation, treatment or is under observation? **(Exclude routine check-ups where no follow-up is required, colds, flu, tonsillectomy, adenoidectomy, appendectomy, hernia repair and tubes in ears. Do not tell us about genetic testing or genetic testing results.)** ☐ Yes ☐ No

If '**yes**' to any questions in 1 - 3, provide details in the box below.

	Question number(s)	**Details**
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		

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

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

15 Authorization to disclose information to your advisor

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

Purpose

If you check '**yes**' below, you give us permission to disclose your personal information to your advisor, who may use it to discuss insurance options with you.

We don't need this authorization to review and make a decision about your application.

Sharing of information

The information we may share with your advisor could include:

- medical testing and laboratory results
- other confidential personal information about illness, including mental illness, infectious diseases, other medical 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**' below, you authorize the company to share information about you:

- which was collected for underwriting this application, and
- only to the advisor indicated in the box below.

Advisor's first name	Middle initial	Last name	Advisor code

By checking '**yes**' below, you also understand that:

- even though you have indicated '**yes**' below, we have the right to withhold highly sensitive personal information from your advisor
- you may cancel this authorization at any time by calling us at 1-877-SUN-LIFE (1-877-786-5433), and
- 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.

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

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

PAPRSIGE

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

16 Temporary insurance/payments/policy statements

In this section, *you* and *your* refer to the proposed insured(s). The questions must be answered by the proposed insured(s) of the policy. If a proposed insured is under age 16 (18 in Quebec), the questions must be answered by the parent or legal guardian.

16.1 Temporary insurance **(Not available on conversions.)**

Does the proposed owner wish to apply for temporary insurance? ☐ Yes ☐ No If '**yes**', answer questions a) - c) below. If '**no**', proceed to section 16.2.

Note: If questions a), b) or c) are answered '**yes**' or not answered, there is no temporary insurance coverage. **Advisors: Review the Certificate of temporary insurance with your clients so they understand the terms, conditions and exclusions that apply to temporary insurance.**

	Person 1	Person 2
a) Within the **last 12 months**, have you consulted a doctor for chest pain, any known or suspected heart attack, stroke, cancer or HIV/AIDS?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you **ever** applied for life, critical illness or health insurance and been refused coverage or been offered coverage that is modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
c) Within the **last 60 days**, have you been admitted or told to be admitted to a hospital or clinic as an in-patient **(except for pregnancy or childbirth)** or have you been told to have any tests or surgery not yet done?	☐ Yes ☐ No	☐ Yes ☐ No

16.2 Payments

If temporary insurance has been applied for, payment is required. Provide at least 1/12th of the annual premium to secure temporary insurance or pay by pre-authorized chequing (PAC). To pay by PAC, complete section b).

If not to be made by PAC, indicate amount paid to advisor with application. $

a) Method of payment information

Notes:

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

i) ☐ Pre-authorized chequing (PAC)

Notes:

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

ii) ☐ Annual

If **annual**, submit the total annual payment to the advisor at the time the application is completed. Make the cheque payable to Sun Life Assurance Company of Canada.

$ Amount paid to advisor with application.

iii) ☐ Payment on delivery (POD) **Note:** Not applicable if applying for temporary insurance.

If **POD**, indicate how initial payment will be made:

☐ cheque on delivery for full annual payment
☐ cheque on delivery for initial monthly payment with subsequent payments as per PAC information provided in section b) below
☐ PAC withdrawal based on PAC information provided in section b) below, or
☐ PAC withdrawal with PAC information/payment instructions to be provided on delivery

Complete for universal life applications.

Future periodic payment information $

16 Temporary insurance/payments/policy statements (continued)

b) Pre-authorized chequing (PAC) authorization

Note: All PAC payors must agree to all of the following terms in order to use the PAC payment option.

All PAC payors agree:

- Sun Life Assurance Company of Canada (company) may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from their bank account indicated in this application for insurance,
- all pre-authorized debits will be processed as personal under the Payments Canada rules (this means having 90 calendar days from the date any payment is processed to claim reimbursement for any unauthorized payment),
- the withdrawal amount is considered variable under the Payments Canada rules,
- any notices to be sent to them under this agreement may be sent to the proposed owner/owner's most recent address that the company has on record at the time a notice is sent,
- the company may charge a fee and may cancel the PAC for any withdrawal that is not honoured,
- all persons whose signatures are required to sign on the bank account indicated below have signed section 18 as a PAC payor,
- the company may not assign this authorization to another company or person in order to permit them to debit the PAC payor's account for these payments (e.g., where there has been a change in control of the company) without providing at least 10 days prior written notice, and
- **to waive the requirement that the company notify them of:**
  - **this authorization before the first payment is processed,**
  - **any subsequent payments, and**
  - **any changes to the amount or date of the payment initiated by them or the company.**

i) Withdraw funds to pay the initial payment ☐ Yes ☐ No
(If '**yes**', complete ii) or iii). If '**no**', submit the total initial payment to the advisor at the time the application is completed.) We will immediately withdraw 1/12th of the annual payment as the initial payment.

ii) Start a new PAC ☐ Yes ☐ No
(If '**yes**', complete iv) and v). Regular PAC withdrawals for this policy will start one month from the policy date, unless otherwise indicated in iv).)

iii) Add to existing PAC that is paying for policy _____ ☐ Yes ☐ No
(Regular PAC withdrawals for this policy will be withdrawn on the same day each month as the existing PAC for the policy number listed above, unless otherwise indicated in iv).)

iv) Sun Life Assurance Company of Canada 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.

All persons whose signatures are required to sign on this account must sign the authorization on page 40. For a joint account requiring more than one signature to withdraw funds, all the account holders must sign the authorization on page 40.

We will withdraw the initial payment immediately.

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

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

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

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

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

16 Temporary insurance/payments/policy statements (continued)

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

Account holder's first name	Last name	Account holder's first name	Last name

Name of financial institution	

Address of financial institution (street number and name)	Apartment or suite

City	Province	Postal code

Transit number	Account number

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

17 Translation agreement and declaration

Was this application translated for any proposed insured(s) and/or proposed owner(s) in a language other than English? ☐ Yes ☐ No
If '**yes**', you must complete the sub sections below.

Note: The translator must be 18 years of age or older and may not be:

- a beneficiary,
- a proposed owner, or
- any other person who has an interest in the policy (excluding the advisor).

17.1 Proposed insured(s) and/or proposed owner(s) agreement

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

1. Who was this application translated for in a language other than English?
   ☐ Person 1 ☐ Person 2 ☐ Proposed owner 1 ☐ Proposed owner 2
2. Do you agree that your answers to the questions asked and translated for you are complete and true, and do you understand they form part of the application?
   Person 1: ☐ Yes ☐ No Person 2: ☐ Yes ☐ No Proposed owner 1: ☐ Yes ☐ No Proposed owner 2: ☐ Yes ☐ No
   Note: If '**no**', we are unable to continue with your application at this time. The application must not be submitted.
3. Do you agree that this application was fully explained to you in your preferred language, and do you understand the content provided by the translator?
   Person 1: ☐ Yes ☐ No Person 2: ☐ Yes ☐ No Proposed owner 1: ☐ Yes ☐ No Proposed owner 2: ☐ Yes ☐ No
   Note: If '**no**', we are unable to continue with your application at this time. The application must not be submitted.
4. Name of person who provided the translation:

Translator's first name	Middle initial	Last name

5. Relationship to proposed insured:

Person 1	☐ Advisor ☐ Other Indicate:	Proposed owner 1	☐ Advisor ☐ Other Indicate:
Person 2	☐ Advisor ☐ Other Indicate:	Proposed owner 2	☐ Advisor ☐ Other Indicate:

6. In what language where the questions translated?

Proposed insured 1		Proposed owner 1	
Proposed insured 2		Proposed owner 2	

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

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

By signing below, you declare that for any proposed insured(s) and/or proposed owner(s) indicated above in sub-section 17.1, you:

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

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

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

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

18 Acknowledgement and agreement

Acknowledgement and agreement

The proposed owner(s) confirm they've received, read and agree to:
- the Certificate of temporary insurance, when applicable, and
- the Guide to critical illness definitions, if critical illness insurance was applied for.

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

Declaration

The proposed owner(s), proposed insured(s) and pre-authorized chequing (PAC) payor(s) confirm:
- they were present when their portion of this application with Sun Life Assurance Company of Canada (company), was completed,
- they reviewed all of their answers and statements recorded in the application,
- that all the information they supplied in connection with this application is complete and true, and was provided by them to the advisor (or some other person authorized by the company) for underwriting, administration of insurance and claims paying purposes,
- they understand that if they do not completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements) the company may void the policy(ies),
- they agree that their personal, medical and financial information may be shared as set out in the Sun Life Financial Privacy Statement for Canada,
- they have read and agreed to the Acknowledgement of variability, if applicable,
- they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under the "Products and services" section of the website at *www.sunlife.ca* or by calling our toll-free Customer Care Centre at 1-877-SUN-LIFE (1-877-786-5433),
- they acknowledge that by signing below they:
  - are aware that changes made to policies issued prior to 2017 may result in a loss of grandfathering protection, which may have negative tax consequences, and
  - had an opportunity to discuss this with their financial, legal and tax advisors and understand the tax consequences that policy changes may cause.
- they understand the company is not responsible for the validity of any beneficiary appointments, and
- PAC payors, by signing below, agree to the terms of the PAC authorization, as set out in section 16.2.

The proposed insured(s) confirm the information described in section 15, may be shared with their advisor if they answered **'yes'** in that section.

Authorization of all proposed insureds

The proposed insureds (parent or legal guardian, if proposed insured is under age 16 (18 in Quebec)) authorize:
- any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigation agencies, MIB Inc. or other organization, institution or person, including the members of the Sun Life Financial group of companies, which includes this company, that have records or knowledge of any proposed insured, to give only that information necessary for underwriting, administration of insurance and claims paying purposes to the company, its representatives and its reinsurers,
- the performance of such examinations, electrocardiograms, blood profiles, and tests for HIV (AIDS) antibody and hepatitis, if needed to underwrite this application, and
- the company to release only the necessary personal information obtained during the underwriting process to their personal physician, to MIB, Inc., to the company's reinsurers, to any insurance company, if an application has been made to that company for an insurance policy on their life, and for any infectious or communicable disease, to the Medical Office of Health where required by law.

Province signed	Date (dd-mm-yyyy)	Signature
	Signed on:	Proposed owner (indicate title of signing officers if applicable) X
	Signed on:	Proposed owner (indicate title of signing officers if applicable) X
	Signed on:	Proposed insured (if other than proposed owner or if under 16 [18 in Quebec] signature of parent or guardian) X
	Signed on:	Proposed insured (if other than proposed owner) X
	Signed on:	PAC payor (if other than proposed owner or proposed insured) X
	Signed on:	PAC payor (if other than proposed owner or proposed insured) X

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

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

19 Advisor's report

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

Attach a business card.

If this application qualifies for a policy cover, would you like one provided with the printed policy? ☐ Yes ☐ No
(If not indicated, answer is '**no**'.)

19.1 About the advisor(s)

Is commission being shared? ☐ Yes ☐ No If '**yes**', provide details below.
Note: Shares must be a minimum of 10%.

Lead service advisor

First name	Middle initial	Last name

Sun Life advisor code	Office	Share
		%

Advisor sharing commission

First name	Middle initial	Last name

Sun Life advisor code	Office	Share
		%

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

Are you related to the people to be insured and/or proposed owner(s)? ☐ Yes ☐ No
Related means:

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

If '**yes**', provide details below.

19.2 About the proposed insured(s)

Person 1

Did you meet with the proposed insured in person? ☐ Yes ☐ No If '**no**', provide details below.
Details
How long have you known the proposed insured?

Person 2

Did you meet with the proposed insured in person? ☐ Yes ☐ No If '**no**', provide details below.
Details
How long have you known the proposed insured?

AGTSTMTE

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

19 Advisor's report (continued)

19.3 Underwriting requirements

Indicate which underwriting requirements you have arranged for and/or will be submitting for the people being insured. (Select all that apply.)

	Person 1	Person 2
None	☐	☐
Tele-interview which will be arranged by Sun Life	☐	☐
Paramedical	☐	☐
Vitals (height, weight, blood pressure)	☐	☐
Blood profile	☐	☐

	Person 1	Person 2
Inspection report	☐	☐
Other (specify)	☐	☐
Provide name of insurance company we are to obtain medical evidence from:	☐	☐

Additional comments or special instructions

Indicate which service provider you have ordered the medical evidence from:

☐ Exam One ☐ Dynacare (QUS)

☐ Hooper Holmes ☐ Watermark

☐ Other (indicate name) _____

Information required if a tele-interview is to be completed.

Proposed insured	Language to be conducted in	Best time to call	Preferred phone number
Person 1	☐ English ☐ French ☐ Other (specify) _____	☐ Morning (8 a.m - 12 noon) ☐ Afternoon (12 noon - 5 p.m.) ☐ Evening (5 p.m. - 9 p.m.)	☐ Home ☐ Cell ☐ Business
Person 2	☐ English ☐ French ☐ Other (specify) _____	☐ Morning (8 a.m - 12 noon) ☐ Afternoon (12 noon - 5 p.m.) ☐ Evening (5 p.m. - 9 p.m.)	☐ Home ☐ Cell ☐ Business

19.4 Advisor declaration and notice of disclosure (Must be signed by advisor only.)

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

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

If indicated in the Translation agreement and declaration section that I acted as a translator, by signing below, I declare that for any proposed insured(s) and/or proposed owner(s) indicated in that section, I:

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

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

19 Advisor's report (continued)

If applicable (see 19.5 below) I, the advisor, also confirm that:

- I have reviewed the details provided in this application with each proposed owner/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the client in a face-to-face meeting (unless form 4355 has been completed);
- it has all the facts material to the insurance applied for; and
- I saw every person sign this application.

If there are reasonable grounds to suspect that there is an undisclosed third party, PEP or HIO involved with this contract, email details to *money.laundering@sunlife.com*.

Advisor's first name		Middle initial	Last name
Office	Advisor code	E-mail address	
Date (dd-mm-yyyy)	Advisor's signature X		
Date (dd-mm-yyyy)	Supervisor's signature X		

19.5 Licensed administrative assistant's declaration

Note: This must be completed if a licensed administrative assistant completed the application.

Did a licensed administrative assistant complete the application (excluding section 8, if applicable)? ☐ Yes ☐ No

I, the licensed administrative assistant, confirm that:

- I have reviewed the details provided in this application with each proposed owner/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the client in a face-to-face meeting (unless form 4355 has been completed);
- it has all the facts material to the insurance applied for; and
- I saw every person sign this application.

Licensed administrative assistant's first name		Middle initial	Last name
Date (dd-mm-yyyy)	Licensed administrative assistant's signature X		

Important information you should know

Sun Life Financial

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

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

Sun Life Financial Privacy Statement for Canada

Respecting your privacy

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

Access to your information

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

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

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

MIB, Inc.
330 University Avenue
Suite 501
Toronto, Ontario M5G 1R7

You may ask to see your personal information on file with MIB, Inc. and correct anything that is inaccurate or incomplete.

About Sun Life Financial

As a leading international financial services organization, we're proud to offer a diverse range of wealth accumulation and protection products and services. Tracing our roots back to 1865, Sun Life Financial has operations in key markets around the world. But most importantly, we're in business to help people achieve and maintain the peace of mind that comes from having sound financial solutions in place.

If you'd like more information about Sun Life Financial, please visit our website at *www.sunlife.ca* or call 1-877-SUN-LIFE (1-877-786-5433).

ADMIN1E

Certificate of temporary insurance

Sun Life Financial

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

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

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

Sun Life Assurance Company of Canada and you, the proposed owner, agree to the following:

What is this certificate?

This certificate provides immediate insurance coverage until it ends as described below.

This means if a proposed insured dies or suffers a covered critical illness during our underwriting process, we'll pay the benefit amount we would have paid if we had issued the policy being applied for, subject to the conditions and exclusions set out below.

When does this certificate come into effect?

This certificate comes into effect on the date the proposed insured signs section 18 of this application if:

a) the temporary insurance questions in the application have been truthfully answered *no*
b) all other required questions in the application have been truthfully and completely answered, and
c) a payment of at least 1/12th of the annual premium for your base plan and any additional benefits has been made with the application.

A decision to accept or decline your application for insurance may take up to 90 days.

The beneficiary for temporary insurance is the person or persons named as beneficiary in your application.

When does temporary insurance end?

The temporary insurance automatically ends on the earliest of:

a) the instant the insurance applied for comes into effect
b) the date we decline your application for insurance, following which we will mail a notice of the decline to the address given in the application
c) the 90th day following the date the application for insurance was signed
d) the date the proposed owner asks us to cancel the application
e) the date the proposed owner declines our offer of insurance, or
f) the 30th day following the date the application for insurance was signed and we have not received the required Identity verification and third party determination information with this application.

If the temporary insurance ends for reasons b), c), d), e) or f), we'll refund any amount you've paid us while your application was being processed.

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.

Conditions and exclusions

This certificate forms part of your application for insurance. Insurance coverage is subject to certain conditions and exclusions, which depend on the type of insurance you requested.

Reduction of death benefit or coverage

If you've asked us to cancel an in force Sun Life Financial policy in this application and a proposed insured dies or suffers a covered critical illness while we're underwriting this application, we will:

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

The following conditions and exclusions apply to life insurance:

1. Amount we pay under this certificate (Conditions)

If any of the proposed insureds are age 71 or older, then the total amount of any death benefit payable under this certificate is the lesser of $100,000 and the total amount of any death benefit (including any accidental death benefit) applied for under this application and any other pending life insurance applications with the company.

If the proposed insureds are all under age 71, then the total amount of any death benefit payable under this certificate is the lesser of $1,000,000 and the total amount of any death benefit (including any accidental death benefit) applied for under this application and any other pending life insurance applications with the company.

Please complete, detach and leave with the proposed owner if the temporary insurance conditions are met.

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

2. When we won't pay benefits under this certificate (Exclusions)

We won't pay a death benefit under this certificate if:

a) a proposed insured takes their own life, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
b) a proposed insured or proposed owner misrepresents or fails to disclose any fact within their knowledge that is material to the risk
c) a proposed insured dies before reaching the age of 15 days, or
d) on the date the application for insurance was signed, a proposed insured named on the application:
   i) due to illness or injury, was prevented from performing their usual activities or occupation for a period **exceeding 2 weeks**
   ii) has or had any signs or symptoms associated with cancer within the **last 12 months**
   iii) had suffered a stroke or a heart attack within the **last 12 months**, or
   iv) was confined to a hospital, nursing home, sanitarium, psychiatric facility, or any other health-related facility in the **last 45 days.**

The following conditions and exclusions apply to critical illness insurance:

1. Amount we pay under this certificate (Conditions)

If the proposed insured is age 17 or under, the total amount payable under this certificate is the lesser of $250,000 and the total amount of critical illness insurance applied for under this application and any other pending critical illness insurance applications with the company.

If the proposed insured is between the ages of 18 and 65, the total amount payable under this certificate is the lesser of $500,000 and the total amount of critical illness insurance applied for under this application and any other pending critical illness insurance applications with the company.

2. When we won't pay benefits under this certificate (Exclusions)

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

We won't pay the critical illness insurance benefit under this certificate if:

a) the proposed insured is over age 65
b) on the date the application for insurance was signed, the proposed insured:
   i) had previously been diagnosed with a covered critical illness or had any signs or symptoms of a covered critical illness, medical consultations, investigations, tests, treatment or counselling that led to a diagnosis of a covered critical illness
   ii) 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**
   iii) due to illness or injury, was prevented from performing their usual activities or occupation for a period **exceeding 2 weeks**, or
   iv) was confined to a hospital, nursing home, sanitarium, psychiatric facility, or any other health-related facility in the **last 45 days**
c) the proposed insured suffers a covered critical illness which is directly or indirectly associated with:
   i) attempting to take their own life or causing themselves bodily injury, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
   ii) committing or attempting to commit a criminal offence
   iii) intentionally taking any drug other than as prescribed by a licensed medical practitioner and in accordance with the instructions given
   iv) intentionally taking any intoxicant, narcotic, poisonous substance, or
   v) was operating a vehicle while their blood alcohol level was more than 80 milligrams of alcohol per 100 milliliters of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle was in motion.
d) the proposed insured had or has signs or symptoms associated with:
   i) cancer or benign brain tumour, or
   ii) Parkinson's disease or any specified atypical parkinsonian disorders
e) the proposed owner or proposed insured misrepresents or fails to disclose any fact within their knowledge that is material to the risk, or
f) the proposed insured does not survive for 30 days following the date of diagnosis of a covered critical illness.

How your universal life funds will be invested.

Any money paid with this application will be invested in the Investment account options selected, subject to applicable minimums, on the date we have received all requirements and they are satisfactory to us.

All cheques must be payable to Sun Life Assurance Company of Canada.

Receipt – Received from:

Name	Amount paid for initial payment for this application	Date (dd-mm-yyyy)
	$ _____ (Indicate 'Nil' if no payment.)	

Banking information provided and PAC agreement signed to take initial payment by pre-authorized chequing? ☐ Yes ☐ No

Advisor's signature
X