Application for Sun Long Term Care Insurance

Sun Life Financial

Policy no.

This application may **ONLY** be used when applying for:
- a Sun Long Term Care Insurance policy, and
- payment will be made at the time of delivery.

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

Notes:
- Before completing this application, please first review the General eligibility questions in section 4 to determine if an application should be submitted.
- Ensure the required signed illustration is attached to this application.

1 General information

Information about the proposed insured

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Former last name (if any)
				_ _	

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

Home phone number	Business phone number	Cell or other phone number	Best time to call
_ _	_ _	_ _	☐ a.m. ☐ p.m.

Is the proposed insured an owner, planholder, insured person or annuitant on any other plan with Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies?

☐ Yes ☐ No If '**yes**', indicate one policy or account number: –

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

Proof of age

☐ Canadian, U.S.A. or U.K. birth certificate	☐ Canadian citizenship	☐ Current passport (other country)	☐ Baptismal certificate	☐ Age of majority
☐ Canadian, U.S.A. or U.K. driver's licence	☐ Current Canadian passport	☐ Military card	☐ Hospital certificate of birth	☐ Indian status card
☐ Permanent resident card	☐ Provincial identification card	☐ Register of civil status in Quebec	☐ Provincial ID health card with DOB displayed	

Registration number	Date of issue (dd-mm-yyyy)	☐ Other (describe)
OR	_ _	

Information about the proposed owner (If proposed owner is not the proposed insured.)

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Former last name (if any)
				_ _	

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

Is the proposed owner an owner, planholder, insured person or annuitant on any other plan with Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies?

☐ Yes ☐ No If '**yes**', indicate one policy or account number: –

Language choice

Language policy pages are to be in: ☐ English ☐ Français

2 Transaction type

1. Was this application completed in Quebec? ☐ Yes ☐ No

   If '**yes**', is this application intended to replace or reduce the benefits of any existing insurance policy or a pending insurance application of any company? ☐ Yes ☐ No

   If '**yes**' and Quebec, please submit the Notice of replacement of insurance of persons contract form.

2. Is this application intended to replace or reduce an existing **Sun Long Term Care Insurance** policy? ☐ Yes ☐ No

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

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

   Indicate amount to be replaced $

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

   ☐ Clarica ☐ Sun –

LTCAAPPE

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

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2 Transaction type (continued)

Notes:

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

3 Plan information

Notes:

1. The minimum benefit amount is $150 per week.
2. The maximum weekly benefit amount is $2,300 per week per insured person.
3. Benefit selection must result in monthly required payments of at least $30.00 or annual required payment of $333.33.

Comprehensive benefit

Benefit amount: $

Benefit period: ☐ 100 weeks ☐ 150 weeks ☐ 250 weeks ☐ unlimited

Waiting period: ☐ 90 calendar days ☐ 180 calendar days

Required payment period

☐ Policy anniversary following age 65 (available for issue ages 21 - 39)
☐ 25 years (available for issue ages 40 - 74)
☐ Lifetime – payable to policy anniversary following age 100 (available for issue ages 21 - 80)

Additional options

☐ Return of premium on death (available for issue ages 21 - 65)
Note: The beneficiary will be the:
- proposed owner or the estate of the proposed owner, or
- the beneficiary named by the proposed owner in the special instructions section of this application.

☐ Inflation protection (2% compounded annually increasing to 3% while receiving benefits)

☐ Inflation protection (3% compounded annually while receiving benefits)

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In sections 4 - 6, *you* and *your* refer to the proposed insured.

4 General eligibility

Note: If more space is required for any question in section 4, please provide additional details in section 7.

1. Height (without shoes) ☐ cm ☐ ft & in Weight ☐ kg ☐ lb
   Note: Advisors should refer to the underwriting guide to determine if build is eligible.
2. In the **last 12 months**, have you lost/gained more than 10lbs or 4.5 kgs? ☐ Yes ☐ No
   If '**yes**', provide details including how much weight has been lost/gained, specify if loss or gain and the reason for weight change in the box below.

3. Have you **ever** been diagnosed with, treated for or consulted with a medical or health care professional for any of the following:

	Yes	No
a) acquired immune deficiency syndrome (AIDS) or HIV positive, or AIDS related complex (ARC)	☐	☐
b) Alzheimer's disease	☐	☐
c) amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)	☐	☐
d) chronic congestive heart failure	☐	☐
e) cirrhosis of the liver	☐	☐
f) current use of narcotic pain medication more than once per week	☐	☐
g) cystic fibrosis	☐	☐
h) Huntington's disease	☐	☐
i) Marfan's syndrome	☐	☐
j) memory loss, senility, dementia, confusion or organic brain syndrome	☐	☐
k) multiple myeloma	☐	☐
l) multiple sclerosis or demyelinating disease	☐	☐
m) muscular dystrophy	☐	☐
n) neurogenic bladder or renal/kidney failure	☐	☐
o) paraplegia, hemiplegia, quadriplegia	☐	☐
p) Parkinson's disease	☐	☐
q) post polio syndrome	☐	☐
r) schizophrenia	☐	☐
s) sickle cell anemia	☐	☐
t) systemic lupus erythematosus	☐	☐
u) two or more (individually or in combination): mini-stroke, transient ischemic attack (TIA), stroke, cerebrovascular accident (CVA)	☐	☐

4. Do you use a medical appliance or therapeutic medical equipment such as a chronic nebulizer (mask), dialysis, feeding tube, hospital bed, Hoyer lift, motorized cart, multi-pronged cane, oxygen equipment, respirator, stair-lift, walker or wheelchair? ☐ Yes ☐ No
5. Has it been recommended that you have any medical tests, investigations or healthcare consultations that are not yet completed or for which the results are not yet known **(exclude routine preventative testing)**? ☐ Yes ☐ No
6. Do you need the assistance or supervision of another person for bathing, dressing, toileting, transferring, (such as moving to or from a bed or chair), continence or feeding? ☐ Yes ☐ No
7. Do you need the assistance or supervision of another person for **more than one** of the following: using the telephone, managing finances, taking transportation, shopping, laundry, housework, preparing meals/cooking or taking medications? ☐ Yes ☐ No

If you answered 'yes' to question 3, 4, 5, 6, or 7, you are ineligible for long term care insurance with us. Please do not proceed with this application.

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4 General eligibility (continued)

8. a) Have any of your biological parents, brothers or sisters, **ever** been diagnosed with amyotrophic lateral sclerosis (ALS), Alzheimer's disease, Huntington's disease, polycystic kidney disease or retinitis pigmentosa? ☐ Yes ☐ No

Relationship to family member	Condition	Age at onset	Age if living	Age at death

b) If '**yes**', did you inherit the gene that causes Huntington's disease or polycystic kidney disease? ☐ Yes ☐ No ☐ Unknown

9. a) In the **last 12 months**, have you smoked or used cigarettes, cigarillos, small or large cigars, pipes, marijuana, hashish, betelnut, chewing tobacco, nicotine gum or patches, nicotine or tobacco in any other form? ☐ Yes ☐ No

If '**yes**', specify which type and date last smoked or used.

Product	Date last smoked or used (dd-mm-yyyy)
	– –

b) Have you **ever** consulted a medical or health care professional or been treated for or had any signs or symptoms of:

	Yes	No
i) aneurysm	☐	☐
ii) arteritis	☐	☐
iii) carotid artery disease	☐	☐
iv) coronary artery disease (CAD) including angina and heart attack	☐	☐
v) cardiomyopathy	☐	☐
vi) congestive heart failure (CHF)	☐	☐
vii) diabetes	☐	☐
viii) lung, throat or mouth cancer	☐	☐
ix) neuropathy	☐	☐
x) peripheral vascular disease (PVD)	☐	☐
xi) stroke	☐	☐

If you have answered 'yes' to question 9 a) and 'yes' to any of the conditions in 9 b), you are ineligible for long term care insurance with us. Please do not proceed with this application.

c) Have you **ever** consulted a medical or health care professional or been treated for or had any signs or symptoms of:

	Yes	No
i) asthma **(exclude childhood asthma)**	☐	☐
ii) chronic bronchitis	☐	☐
iii) chronic obstructive pulmonary disease (COPD)	☐	☐
iv) emphysema	☐	☐
v) pulmonary fibrosis	☐	☐
vi) shortness of breath, sleep apnea, or other lung problems or breathing conditions **(excluding colds and flus)**	☐	☐

Excluding the use of betelnut, chewing tobacco, nicotine gum or patches in the last 12 months, if you have answered 'yes' to 9 a) and 'yes' to any of the conditions in 9 c), you are ineligible for long term care insurance with us. Please do not proceed with this application.

5 Personal information for proposed insured

Note: If more space is required for any question in section 5, please provide additional details in section 7.

1. Have you resided in Canada for the **last 12 months**? ☐ Yes ☐ No If '**no**', provide details below.

2. Citizenship
☐ Canadian citizen ☐ Permanent resident status ☐ Other If other:

Specify citizenship	Country of birth	Date arrived in Canada (dd-mm-yyyy)
		– –
Current status in Canada	**Intention for residency**	

3. In the **last 12 months**, have you travelled outside of Canada or the United States, or do you intend to do so within the **next 12 months**? ☐ Yes ☐ No If '**yes**', provide details below.

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5 Personal information for proposed insured (continued)

4. a) Occupation

   b) If unemployed or retired, is this for health reasons? ☐ Yes ☐ No If '**yes**', please provide details including why you are unemployed, how long you have been unemployed, what your previous occupation was and when/if you plan to gain employment.

   c) If you are a student, provide details including field of study and expected graduation date.

5. Do you have any long term care insurance in force with any company, including Sun Life Assurance Company of Canada? ☐ Yes ☐ No If '**yes**', please complete the following chart.

Insurance company	Insurance date (mm-yyyy)	Weekly benefit amount	Being replaced
	–		☐ Yes ☐ No
	–		☐ Yes ☐ No

6. a) Do you have any applications for long term care insurance currently pending or contemplated? ☐ Yes ☐ No
   If '**yes**', indicate company names, plan types, amounts applied for and total amount of new insurance to be put into effect in the box below.

   b) Have you **ever** had any applications for life, critical illness, disability or long term care insurance declined, rated, postponed, cancelled or modified in any way? ☐ Yes ☐ No
   If '**yes**', provide details including date of application, decision, reason and name of company in the box below.

7. What is your annual earned income, including salary, commissions and bonuses? $
8. What is your annual unearned income from other sources, including pensions, dividends, interest and income from real estate? $

   Source of income

9. What is your personal Canadian net worth? $
10. What is the total annual earned and unearned income for your spouse/partner (if applicable)? $
11. In the **last 5 years**, have you declared or been petitioned into personal or corporate bankruptcy? ☐ Yes ☐ No
    If '**yes**', complete the following.

Circumstances regarding the bankruptcy	Date of discharge (dd-mm-yyyy)
	– –

12. Have you **ever** received treatment or been advised to reduce use or frequency of use, treatment, counselling or medical advice due to your use of drugs or alcohol? ☐ Yes ☐ No If '**yes**', indicate type of counselling or treatment and dates attended. Please include any participation in organizations such as Alcoholics Anonymous and Narcotics Anonymous.

Type of counselling or treatment	Dates attended (dd-mm-yyyy)

13. Do you currently drink alcohol? ☐ Yes ☐ No If '**yes**' indicate the type and amount you drink in an average week.

Product (spirits, wine or beer)	Amount consumed in an average week

14. In the **last 10 years**, have you been charged with or convicted of an alcohol or drug related driving offence or refusing a breathalyzer test? ☐ Yes ☐ No If '**yes**', provide details below.

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5 Personal information for proposed insured (continued)

15. In the **last 10 years**, have you used marijuana, hashish, cocaine, LSD or other psychoactive drugs, heroin or any other narcotics?
☐ Yes ☐ No If '**yes**', indicate the type and amount, frequency of use and date last used.

Product	Amount consumed in an average week	Frequency of use	Date last used (dd-mm-yyyy)
			– –

16. In the **last 10 years**, have you been charged with or convicted of any criminal offence or are you currently on probation, parole or statutory release? ☐ Yes ☐ No
If '**yes**', provide details below.

17. In the **last 5 years**, have you received a disability income benefit (for example, Worker's Compensation (WCB), Canada Pension Plan (CPP), long or short term disability) because of illness or injury for a period **exceeding 2 weeks**? ☐ Yes ☐ No
If '**yes**', provide details in the box below.

6 Medical information

Note: If more space is required for any question in section 6, please provide additional details in section 7.

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

Name				
Address (street number and name)	Apartment or suite	City	Province	Postal code
Date and reason for last visit to **any** medical advisor or clinic (dd-mm-yyyy). If other than usual medical advisor, please provide the name and address of the doctor consulted.				
Any treatments/medications prescribed and any tests requested or completed.	Results of any completed tests.			

2. In the **last 3 years**, have you had a complete physical examination? ☐ Yes ☐ No
3. Have you **ever** been treated for or had any indication of:w

	Yes	No
a) stroke or cerebrovascular accident (CVA), aneurysm, transient ischemic attack (TIA), mini-stroke, numbness or weakness of an arm or leg, paralysis, visual disturbance, optic neuritis, permanent or temporary loss of vision in either eye, dizziness, fainting, imbalance, loss of sensation, neuropathy, tremors or any other neurological disease or disorder	☐	☐
b) abnormal blood sugar, impaired glucose tolerance or diabetes	☐	☐
c) hepatitis (including hepatitis carrier state), jaundice or any other liver disease or disorder	☐	☐
d) high blood pressure	☐	☐
e) enlarged glands or lymph nodes, hemophilia, anemia or any other blood or bleeding disease or disorder	☐	☐
f) cancer, tumour, cysts, polyps, abnormal pap smear or any other growth or malignancy	☐	☐
g) kidney, bladder or prostate disease or disorder, including protein or red blood cells in the urine, abnormal PSA or urinary incontinence	☐	☐
h) Crohn's disease, ulcerative colitis, peptic or gastric ulcer, bowel incontinence, rectal or intestinal bleeding, persistent diarrhea or any other disease or disorder of the bowel, stomach or pancreas	☐	☐
i) epilepsy, cerebral palsy, concussion, fainting, loss of consciousness, dizziness, severe headaches or any other disease or disorder of the brain or nervous system	☐	☐
j) depression, anxiety, burnout, nervous breakdown or any other mental, emotional or nervous disease or disorder	☐	☐
k) fibromyalgia, fatigue, chronic fatigue syndrome, chronic pain syndrome or temporomandibular joint disorder (TMJ)	☐	☐

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6 Medical information (continued)

l) arthritis, osteopenia, osteoporosis or amputation ☐ ☐

m) heart attack, angina, chest pain, congestive heart failure (CHF), arteritis, coronary artery disease (CAD), irregular pulse, peripheral vascular disease (PVD) or any other disease or disorder of the heart or blood vessels ☐ ☐

n) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, sleep apnea, shortness of breath or any other lung problems or breathing conditions **(exclude colds and flu)** ☐ ☐

4. In the **last 2 years**, have you been treated for or had any indication of:
   a) hyperthyroidism, hypothyroidism or any other thyroid or endocrine disease or disorder ☐ ☐
   b) blindness or deafness, or any other disease or disorder of the eye, ear, nose, throat or mouth **(exclude routine check-ups where no follow-up required, such as tonsillectomy, adenoidectomy, sinusitis or any other disease or disorder requiring eye-glasses, contact lenses or ear tubes)** ☐ ☐
   c) skin disease, skin lesions, chronic skin infections, abnormal moles or dysplastic nevi **(exclude poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema)** ☐ ☐

5. In the **last 5 years**, have you had any falls? ☐ Yes ☐ No

Give details for any '**yes**' answers to questions 3, 4 or 5.

Question number	Symptoms/conditions	Details including diagnosis, treatment and current status, and relevant dates for each	Names/addresses of physicians, medical facilities and hospitals consulted for symptoms/conditions

6. In the **last 12 months**, have you taken any prescribed or non-prescribed medications? ☐ Yes ☐ No
   If '**yes**', complete the following.

Medication	Reason for taking	Date first taken (dd-mm-yyyy)	Dosage	Most recent dosage change (dd-mm-yyyy)	Date last taken (dd-mm-yyyy)
		– –		– –	– –
		– –		– –	– –
		– –		– –	– –
		– –		– –	– –

7. In the **last 5 years**, have you consulted a medical or health care professional or been treated for or had any indication of any disease or disorder of the bones, joints, tendons, muscles or limbs, including knees, hips, shoulders, neck or back? ☐ Yes ☐ No

8. In the **last 2 years**, have you been treated for or had any pain that lasted **more than one week** or has recurred **more than once** in the same location of your body (regardless of the duration)? ☐ Yes ☐ No
   If '**yes**', complete and attach the required **Pain questionnaire – Long term care insurance (E298)**.

9. In the **last 5 years**, have you had any medical or diagnostic tests, such as X-rays, ECGs, scans, MRIs, ultrasounds, biopsies, blood or urine? ☐ Yes ☐ No If '**yes**', complete the following.

Test/reason for test	Date of test (mm-yyyy)	Test results	Details of any abnormalities
	–	☐ Normal ☐ Abnormal	
	–	☐ Normal ☐ Abnormal	
	–	☐ Normal ☐ Abnormal	
	–	☐ Normal ☐ Abnormal	

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6 Medical information (continued)

10. Are you aware of any symptoms or complaints, regarding your health, for which you have not yet consulted a physician or received treatment? ☐ Yes ☐ No

11. In the **last 5 years**, have you had any medical condition, not already mentioned, for which you have been or are being investigated, under observation or treated for, or are there any medical consultations for which you are currently awaiting investigations or test results? ☐ Yes ☐ No

12. Has any surgery, diagnostic test or medical treatment been discussed, recommended or planned? ☐ Yes ☐ No

13. In the **last 12 months**, have you received any physiotherapy, chiropractic treatment, massage therapy, acupuncture or any other treatment for any condition or symptom? ☐ Yes ☐ No
If '**yes**', provide details.

Type of treatment	Date treatment started (mm-yyyy)	Date of most recent treatment (mm-yyyy)	Condition/symptom that prompted treatment and current status	Details including frequency of treatment, if ongoing or completed, and final treatment date if completed
	–	–		
	–	–		
	–	–		
	–	–		

14. In the **last 5 years**, have you consulted any other physicians or health care professional or been a patient in a hospital, clinic or other medical facility or had any surgery or other treatment? ☐ Yes ☐ No

Give details for any '**yes**' answers to questions 7, 9, 10, 11, 12 or 14.

Question number	Date (mm-yyyy)	Details including conditions/symptoms, complaint, event, what was discussed, recommended and completed, as well as the results of all tests/treatments	Details including name/addresses of attending physicians and their specialties, all medical facilities/hospitals, dates consulted, seen and treated
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7 Additional details

Use this chart to provide additional details for any questions in sections 4 - 6, where enough space was not provided.

Question number	Details

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8 Special instructions

9 Authorization to disclose information to your advisor

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

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 conditions 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.

Do you agree to the disclosure of your information? ☐ Yes ☐ No (If not indicated, answer is '**no**'.)

PAPRSIGE

10 Payments

Please do not submit any payment with the application. The full required payment must be provided when the policy is delivered.

Please make the cheque payable to Sun Life Assurance Company of Canada.

Note: We do not accept cash payments.

1. Payment on delivery information

Please indicate how the initial payment will be made:
☐ cheque on delivery for full annual payment
☐ cheque on delivery for initial monthly payment with subsequent payments based on pre-authorized chequing (PAC) information provided in section 2 below
☐ PAC withdrawal based on PAC information provided in section 2 below, or
☐ PAC withdrawal with PAC information/payment instructions to be provided on delivery

2. Pre-authorized chequing (PAC) authorization

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

All PAC payors agree:
- Sun Life Assurance Company of Canada may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from their bank account indicated in this application for insurance,
- all pre-authorized debits will be processed as personal under the Canadian Payments Association 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 Canadian Payments Association 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 11 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.**

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

10 Payments (continued)

b) 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 c).)

c) Sun Life Assurance Company of Canada (company) will withdraw funds to pay all payments, including the initial payment if selected in section 1 above, 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 13. For a joint account requiring more than one signature to withdraw funds, all the depositors must sign the authorization on page 13.

We will withdraw the initial payment on the date the policy comes into effect.

Regular PAC withdrawals will start one month from the date the policy comes into effect 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.cdnpay.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.cdnpay.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

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

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

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11 Acknowledgement and agreement

Acknowledgement and agreement

The proposed owner confirms they've received, read and agree to the Information about your application for Sun Long Term Care Insurance.

The proposed owner and proposed insured (if other than proposed owner) confirm they've received, read and agree to the Sun Life Financial Privacy Statement for Canada and the MIB, Inc., (MIB) notice (found on the Important information you should know page).

Declaration

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

- they were present when their portion of this application with Sun Life Assurance Company of Canada (company) was completed,
- they reviewed all their answers and statements recorded in this application,
- that all the information they supplied in connection with this application is complete and true, and was provided by them to the advisor (or some other person authorized by the company) for underwriting, administration of insurance and claims paying purposes,
- they understand that if they do not completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements) the company may void the policy,
- they agree that their personal, medical and financial information, may be shared as set out in the Sun Life Financial Privacy Statement for Canada,
- they are satisfied with the level of product information they received before signing this application and are aware that additional product information is available to them under the "Products and services" section of the website at *www.sunlife.ca* or by calling our toll-free Customer Care Centre at 1-877-SUN-LIFE (1-877-786-5433), and
- PAC payors, by signing below, agree to the terms of the PAC authorization, as set out in section 10.

The proposed insured confirms the information described in section 9, may be shared with their advisor if they answered 'yes' in that section.

Authorization of the proposed insured

The proposed insured authorizes:

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

Location signed	Date (dd-mm-yyyy)	Signature
Province:	Signed on: – –	Proposed owner (indicate title of signing officers if applicable) X
Province:	Signed on: – –	Proposed insured (if other than proposed owner) X
Province:	Signed on: – –	PAC payor (if other than proposed owner or proposed insured) X
Province:	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 no.

12 Advisor report

Please attach a business card.

Advisor information

Shares must be a minimum of 10%.
Is there another referring advisor that should receive commissions on this application? ☐ Yes ☐ No. If **'yes'**, please provide details.

Lead service advisor

First name	Middle initial	Last name

Sun Life advisor code	Office	Share
		%

Advisor(s) 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.

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

With the understanding that Sun Life will rely on the information to conduct customer due diligence and to satisfy applicable regulatory requirements, I, the advisor, confirm that:

- I have disclosed to the 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 the 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 the 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 the 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 applicable (see section 13), I the advisor, also confirm that:

- I have reviewed with each proposed owner, proposed insured and PAC payor, all of their information in this application and, to the best of my knowledge, this information is complete and true, and has all the facts material to the insurance applied for, and
- I saw every person sign this application.

Advisor's first name	Middle initial	Last name

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

Office	Advisor's code	E-mail address

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

Did a licensed administrative assistant complete the application? ☐ Yes ☐ No

I, the licensed administrative assistant, confirm that:

- I have reviewed with each proposed owner, proposed insured and PAC payor, all of their information in this application and, to the best of my knowledge this information is complete and true, and has all 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

LTCSTMTE

Information about your application for Sun Long Term Care Insurance

Sun Life Financial

Policy no.

When this insurance comes into effect

Sun Life Assurance Company of Canada (company) and you, the proposed owner, agree your Sun Long Term Care Insurance comes into effect when:

- you have provided your advisor with the full required payment and any other outstanding delivery requirements, and
- your policy has been delivered to you by your advisor.

You do not have coverage until these conditions are met.

Our assessment of the proposed insured's health may include a telephone interview, a face-to-face interview, and a review of their medical records.

Coverage will begin on the date we indicate in the policy.

When you can expect to receive your policy

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

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

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

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

LTCAHANE

Please leave this page with the proposed owner.

Important information you should know

Sun Life Financial

Policy no.

Sun Life Financial Privacy Statement for Canada

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives, distribution partners (such as advisors and their companies) and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

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).

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