

Sun application (for SunTerm and Sun Critical Illness Insurance)

Use this application to apply for new insurance on proposed insured(s) age 18 or over where:

- a paramedical or medical evidence of insurability is required or a tele-interview will be conducted, and
- an application is being made for SunTerm or Sun Critical Illness Insurance.

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

This application may be used for up to 2 proposed insureds for the life insurance product or for the same proposed insured and proposed owner for one life insurance product and one critical illness insurance product.

If you wish to apply for a Child term or Owner waiver disability, you must complete the Application for life and/or critical illness insurance (810-2799).

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

Complete for all applications.

Are you applying for a multi-life application with more than 2 proposed insureds? Yes No

If 'yes', you must complete the Additional proposed insureds section, found on page 2.

Will you be using tele-interviewing to gather evidence requirements on the proposed insured(s) listed below? Yes No

If 'yes', please complete the appropriate sections on pages 7 - 10.

1 General information

Information about the first proposed insured (Person 1)

| | | | | | | | | |
|---|---------|----------------------------------|-------------|-----------------------------------|--|----------------------------|---------------------------|-------------------------|
| First name | | Middle initial | Last name | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Former last name (if any) | |
| Residential address (street number and name) | | | | | | Apartment or suite | City | |
| Province | Country | | Postal code | Home phone number | | Business phone number | | |
| Driver's licence number | | | Province | Place of birth (city and country) | | | | |
| Occupation (please specify job title and duties) | | | | Name and address of employer | | | | |
| Annual income from salary, bonuses and dividends \$ | | Amount of any other income \$ | | Source of any other income | | Canadian net worth \$ | | Foreign net worth \$ |
| <input type="checkbox"/> Canadian citizen or <input type="checkbox"/> Permanent resident status or <input type="checkbox"/> Other (give details) Note: If Permanent resident status or Other, include number of years in Canada. | | | | | | | | |

Do you want to retain age? Yes No **Note:** Age may be retained up to 90 days.



1 General information (continued)**Information about the second proposed insured (Person 2)**

| | | | | | |
|---|----------------------------------|----------------------------|--|----------------------------|---------------------------|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Former last name (if any) |
| Residential address (street number and name) | | | | Apartment or suite | City |
| Province | Country | Postal code | Home phone number | | Business phone number |
| Driver's licence number | | Province | Place of birth (city and country) | | |
| Occupation (please specify job title and duties) | | | Name and address of employer | | |
| Annual income from salary, bonuses and dividends \$ | Amount of any other income \$ | Source of any other income | | Canadian net worth \$ | Foreign net worth \$ |
| <input type="checkbox"/> Canadian citizen or <input type="checkbox"/> Permanent resident status or <input type="checkbox"/> Other (give details) Note: if Permanent resident status or Other, include number of years in Canada. | | | | | |

Do you want to retain age? Yes No **Note:** Age may be retained up to 90 days.**Additional proposed insureds (Separate applications must be submitted.)**

For all multi-life applications, provide the names of any additional proposed insureds for whom a separate application will be submitted.

| | | | | |
|------------|----------------|-----------|--|----------------------------|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) |

Information about proposed owner 1 (if not a proposed insured)

| | | | | | |
|--|----------------|-----------|--|----------------------------|--------------------------------------|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Relationship to the proposed insured |
| Occupation (please specify job title and duties) | | | Residential address (street number and name) | | Apartment or suite |
| City | Province | Country | Postal code | | |

Information about proposed owner 2 (if not a proposed insured)

| | | | | | |
|--|----------------|-----------|--|----------------------------|--------------------------------------|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Relationship to the proposed insured |
| Occupation (please specify job title and duties) | | | Residential address (street number and name) | | Apartment or suite |
| City | Province | Country | Postal code | | |

1 General information (continued)**Proposed contingent owner(s)****Notes:**

- Complete 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 | | | |

Corporation, trust or other entity

| | | | |
|---|----------|---------|--------------------|
| 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 |

Language choice

What language would the proposed owner like the policy to be in?

- Issue the policy in English
 Établir le contrat en français

Purpose of insurance

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 below)

| |
|---------|
| Details |
|---------|

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 \$ | |

2 Beneficiary information

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

Note: 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 the beneficiary designation sections a) and b).

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

- If not completed, the 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) | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable | |
| | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable | |
| (for Person 2) | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable | Total 100% |
| | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> 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) | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable | |
| (for Person 2) | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable | |

c) Benefit payee beneficiary (Complete when critical illness insurance has been applied for.)**Notes:**

- If you designate a payee, you will not receive the **critical illness** benefit payment.
- If not completed, the beneficiary is the applicant or the estate of the applicant.

| First name | Middle initial | Last name | Relationship to proposed insured (In Quebec, relationship to proposed owner.) | Beneficiary designation |
|------------|----------------|-----------|--|--|
| | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable |

d) Return of premium on death beneficiary (Complete when Return of premium on death has been applied for.)**Notes:**

- If not completed, the beneficiary will be the proposed owner or the estate of the proposed owner.
- A beneficiary cannot be appointed for Return of premium on cancellation or expiry.
- We pay any Return of premium on cancellation or expiry benefit 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 |
|------------|----------------|-----------|--|--|
| | | | | <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable |

2 Beneficiary information (continued)**e) Trustee for a minor beneficiary****Notes:**

- Complete when a minor beneficiary has been named in beneficiary designations a) to d).
- 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 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.

3 Plan information

In this section:

- *you* and *your* refer to the proposed owner(s).
- Person 1 and Person 2 refer to the first and second proposed insureds.

Is this application being used to apply for one life insurance and one critical illness insurance policy for the same proposed insured and proposed owner? Yes No

Are you applying for primary as well as optional coverage for the same proposed insured(s) and proposed owner(s)? Yes No

If 'yes', what is the amount of optional coverage being applied for? \$

SunTerm \$ 10 year 15 year 20 year 30 year

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

Risk classification applied for on Person 1

1 non-smoker 2 non-smoker 3 non-smoker 4 smoker 5 smoker

Risk classification applied for on Person 2

1 non-smoker 2 non-smoker 3 non-smoker 4 smoker 5 smoker

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

4 Optional benefits

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

SunTerm

- Total disability waiver Person 1 Person 2
- Accidental death benefit Person 1 Person 2
- Guaranteed insurability Person 1 Person 2
- Business value protection Person 1 Person 2
- Renewal protection (SunTerm 10 only) Person 1 Person 2
- Partner protection (SunTerm only with 3 or more proposed insureds.)
- Other

| | | |
|----------|----|--------------|
| Person 1 | \$ | Benefit name |
| Person 2 | \$ | Benefit name |

Sun Critical Illness Insurance

Note: Optional benefits cannot be added after a Sun CII policy has been issued.

- Total disability waiver
- Long term care conversion option
- Return of premium on
 - Death
 - Cancellation or expiry (Term 10 or Term 75)
 - 15 years
 - age 65
 - age 75
 - Cancellation (Lifetime only)
 - 15 years
 - age 65
 - age 75

Person 1

Evidence number (for H.O. use only)

E#

Person 2

Evidence number (for H.O. use only)

E#

5 Personal and medical history

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

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:

- All questions to be answered by the proposed insured(s).
If more space is required for any question below, use a separate sheet signed and dated by the proposed insured.

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

Complete (a - c) if applying for temporary insurance.

Notes:

- If you answer 'yes' to questions a), b), or c), or if you choose not to answer them, you are not eligible for temporary insurance coverage.
Please carefully review the Certificate of temporary insurance to understand the terms, conditions and exclusions that apply to temporary insurance.

Form with three questions (a, b, c) regarding medical history for Person 1 and Person 2, with Yes/No checkboxes.

Underwriting requirements

Who will be making arrangements for all the applicable requirements?

- Advisor Back office Head office (Available only if using tele-interview.)

If advisor or back office will be making arrangements for the applicable requirements, please indicate which requirements have been arranged. (Select all that apply.)

Table with 3 columns: Requirement, Person 1, Person 2. Rows include None, Tele-interview, Paramedical, Vitals, Blood profile.

Table with 3 columns: Requirement, Person 1, Person 2. Rows include Inspection report, Other (specify), Provide name of insurance company.

Form with three text input fields: Name of insurance company, Name of the service provider, Additional comments or special instructions.

EAPPE

Policy number input field



Person 1

Evidence number (for H.O. use only)

E#

Person 2

Evidence number (for H.O. use only)

E#

5 Personal and medical history (continued)

All applications: Complete questions 1 - 4.

1. 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? ... If 'yes', provide details below.

Person 1

Person 2

Yes No Yes No

Table with 4 columns: Proposed insured, Product(s), Amount(s) and frequency of use, Date(s) last used (dd-mm-yyyy). Rows for Person 1 and Person 2.

2. Do you have any existing life and/or critical illness insurance coverage in force on your life? ... If 'yes', provide details below. Note: If replacing insurance, complete and attach the required applicable replacement form.

Person 1

Person 2

Yes No Yes No

Table with 6 columns: Proposed insured, Date(s) issued (mm-yyyy), Plan type(s), Amount(s) (including benefits), Company name(s), Replacing, Business or personal. Rows for Person 1 and Person 2.

3. a) Do you have any applications for life, disability, critical illness or long term care insurance currently pending or contemplated? ... If 'yes', provide details below.

Person 1

Person 2

Yes No Yes No

Table with 5 columns: 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. Rows for Person 1 and Person 2.

b) Have you ever had any application 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.

Person 1

Person 2

Yes No Yes No

Table with 2 columns: Person 1, Person 2. Rows for details of declined applications.

Policy number

Person 1

Evidence number (for H.O. use only)

E#

Person 2

Evidence number (for H.O. use only)

E#

5 Personal and medical history (continued)

4. In the last 5 years, have you declared or been petitioned into personal or corporate bankruptcy?.. [] Yes [] No | [] Yes [] No
If 'yes', provide details below.

Table with 3 columns: Proposed insured, Date discharged (dd-mm-yyyy), Circumstances of bankruptcy. Rows for Person 1 and Person 2.

Tele-interview applications: Complete question 5 only. Do not complete questions 6 - 8.

5. Language interview should be conducted in [] English [] French [] Other (specify language)
Best time to call for interview [] Morning (8 a.m. - 12 noon) [] Afternoon (12 noon - 5 p.m.) [] Evening (5 p.m. - 9 p.m.)
Preferred phone number for interview [] Home [] Cell [] Business

Additional information for the tele-interviewer (If no comments, leave blank.)

Large empty box for additional information for the tele-interviewer.

Paramedical or medical evidence of insurability applications: Complete questions 6 - 8 only. Do not complete question 5.

6. Have you been charged with or convicted of:
a) in the last 10 years, an alcohol or drug related driving offence or refusing a breathalyzer test? [] Yes [] No | [] Yes [] No
b) in the last 3 years, any other driving offences? [] Yes [] No | [] Yes [] No
(Exclude tickets for parking and failure to provide insurance or ownership cards.)

If 'yes' to a) or b), provide details below. For speeding convictions, include the number of kilometres per hour over the speed limit.

Table with 4 columns: Proposed insured, Date(s) of offence(s) (dd-mm-yyyy), Type(s) of offence(s), Details. Rows for Person 1 and Person 2.

Policy number

Person 1

Evidence number (for H.O. use only)

E#

Person 2

Evidence number (for H.O. use only)

E#

5 Personal and medical history (continued)

7. a) In the last 12 months, have you travelled or resided outside of Canada? Yes No | Yes No
 (Exclude travel or residence of less than 6 months in the United States.)
 If 'yes', provide details below.

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

- b) In the next 12 months, do you intend to travel or reside outside of Canada? Yes No | Yes No
 (Exclude travel or residence of less than 6 months in the United States.)
 If 'yes', provide details below.

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

8. 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 | Yes No
 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 | Yes No
 If 'yes', complete and attach the appropriate questionnaire.
- 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
 If 'yes', provide details below.

| Proposed insured | Details |
|------------------|---------|
| Person 1 | |
| Person 2 | |

Policy number

6 Payments

Did the proposed owner apply for temporary insurance? Yes No If 'yes', submit a payment. Provide 1/12th of the required annual payment to secure temporary insurance.

If this payment is to be made by PAC, complete section 2 a).

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

\$

Note: If temporary insurance has been applied for, we must receive the cheque within 7 calendar days for temporary insurance to be in effect.

1. Method of payment information**Notes:**

- We do not accept cash payments.
- If a method of payment is not selected, we will proceed on a Payment on delivery basis, assuming PAC with payment instruction to be provided upon delivery.
- Payments will not be taken from the payor's account until the policy is in effect unless initial payment in section 2 has been selected.

Pre-authorized chequing (PAC) If **PAC**, complete section 2.

Notes:

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

Annual

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.

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 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

Is the PAC payor also a proposed owner? Yes No If 'no', please provide PAC payor name(s).

Note: All PAC payors must agree to 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 in e) have signed section 8 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.

PAPRSIGE



6 Payments (continued)

- a) Withdraw funds to pay the initial payment Yes No
(If 'yes', complete b) or c). 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 required initial payment.
- b) Start a new PAC Yes No
(If 'yes', complete d) and e). Regular PAC withdrawals for this policy will start one month from the policy date, unless otherwise indicated in d).)
- c) Add to existing PAC that is paying for policy Yes No
(Regular PAC withdrawals for this policy will be withdrawn on the same day each month as the existing PAC for the policy number listed above, unless otherwise indicated in d).)
- d) Sun Life Assurance Company of Canada will withdraw funds to pay all payments, including the initial payment if selected, on this policy each month from the bank account shown on the sample cheque attached or any account designated.
All persons whose signatures are required to sign on this account must sign the authorization on page 14. For a joint account requiring more than one signature to withdraw funds, all the account holders must sign the authorization on page 14.
We will withdraw the initial payment immediately.
Regular PAC withdrawals will start one month from the policy date or on (dd-mm-yyyy)
The payor may cancel this authorization at any time, subject to providing the company with 10 days notice. Payors should contact their financial institution about their rights regarding cancellation. A sample cancellation form is available at www.payments.ca.
Payors have certain recourse rights if any debit does not comply with this agreement. For example, payors have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAC Agreement. To obtain more information on recourse rights, payors should contact their financial institution or visit www.payments.ca.
Contact us at any time, at:
Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5
1-877-SUN-LIFE (1-877-786-5433)
Fax 1-866-487-4745
www.sunlife.ca
- e) Attach a sample cheque marked void to the signature booklet **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 | | |

7 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).

7.1 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 | <input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate: _____ | Proposed owner 1 | <input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate: _____ |
| Person 2 | <input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate: _____ | Proposed owner 2 | <input type="checkbox"/> Advisor <input type="checkbox"/> Other Indicate: _____ |

6. In what language where the questions translated?

| | | | |
|--------------------|--|------------------|--|
| Proposed insured 1 | | Proposed owner 1 | |
| Proposed insured 2 | | Proposed owner 2 | |

7.2 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 7.1, 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 |
|-----------------|-------------------|-----------------------------|

8 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 their answers and statements recorded in the application,
- that all the information they supplied in connection with this application is complete and true, and was provided by them to the advisor (or some other person authorized by the company) for underwriting, administration of insurance and claims paying purposes,
- they understand that if they do not completely and truthfully answer all of their questions (if they misrepresent any of their answers or statements) the company may void the policy(ies),
- they agree that their personal, medical and financial information may be shared as set out in the Sun Life Financial Privacy Statement for Canada,
- they are satisfied with the level of product information they received before signing the 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 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 6.2.

Authorization of all proposed insured(s)

The proposed insured(s) 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 the 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) 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

9 Advisor's report

Please 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'.)

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.

[Empty text box for distribution partner name and address]

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.

[Empty text box for related details]

About the proposed insured(s)

Person 1

| |
|---|
| Did you meet with the proposed insured in person? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'no', provide details below. |
| Details |
| How long have you known the proposed insured? |

AGTSTMTE



9 Advisor's report (continued)**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 I have:

- disclosed to each proposed owner that I am an independent advisor who has a contract to sell products issued by Sun Life Assurance Company of Canada, and I have also identified any other companies I represent;
- 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;
- 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;
- disclosed to each proposed owner any conflicts of interest that I may have with 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.

If applicable (see section 10), I the advisor, also confirm that I:

- have reviewed with each proposed owner, proposed insured and PAC payor, all of their information in the 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
- saw every person sign this application.

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

10 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 the 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
- 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



Policy number

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

Sun Life Financial Privacy Statement for Canada

Respecting your privacy

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

Access to your information

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

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

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

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

ADMINIE



Tele-interviewing – what to expect

Policy number

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

Introduction

Thank you for choosing Sun Life Financial for your insurance needs.

To properly assess the application, our underwriters need to collect personal and medical information from you.

A tele-interviewer, representing Sun Life Financial, will phone you to obtain that information. The phone call may last approximately 20 minutes depending upon your medical history.

Preparing for the tele-interview

You can help speed up the process by being prepared. Please have the following information ready:

- The name, address and phone number of any doctors you've visited within the **last five years**, the reason for the visit, any tests performed and the results.
- The name and dosage of any medications you are taking and the reason for taking it.
- If you are answering questions on behalf of any children, please have their information ready.

Contacting you

If you are not available when the tele-interviewer calls:

- The tele-interviewer will leave a message.
- Until they hear from you, the tele-interviewer will continue to attempt to contact you for the **next ten days**.

Important highlights of the Sun Life Financial tele-interviewing process:

- If additional underwriting evidence is required, a nurse will call to arrange a suitable time to visit to obtain the necessary medical information.
- Once all evidence is received, we will continue to review the application. If approved, a policy will be issued.

We want to assure you that access to your personal information, including that collected by the tele-interviewer, is restricted to employees and representatives who are responsible for underwriting, administration of insurance and claims paying purposes with us.

ADMINIE



Certificate of temporary insurance

Policy number

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

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 8 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) we have received a payment of at least 1/12th of the annual premium for the base plan and any additional benefits you have applied for.

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 applicant asks us to cancel the application, or
- e) the date the applicant declines our offer of insurance.

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

When you can 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.

The following conditions and exclusions apply to life insurance.

1. Amount we pay under this certificate (Conditions)

If any of the proposed life 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 life 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.

ADMINIE



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) had 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:

3. Amount we pay under this certificate (Conditions)

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.

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

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

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

- a) the proposed insured person 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 millilitres 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 applicant 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.

Receipt – Received from:

| First name | Middle initial | Last name | Amount paid for initial payment for this application (Indicate 'Nil', if no payment.) \$ | Date (dd-mm-yyyy) |
|------------|----------------|-----------|--|-------------------|
| | | | | |

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

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

| |
|--------------------------|
| Advisor's signature X |
|--------------------------|