Application for conversion and exercising an option

Sun Life

Policy number

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

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

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

Advisor instructions:

Use this application if applying for:

- conversion, group conversion or exercising an option (without an increase in coverage) of all eligible Sun Life life insurance products offered by Sun Life Assurance Company of Canada, a member of the Sun Life group of companies, or
- conversion or exercising an option (without an increase in coverage)
  - on critical illness insurance, the only benefits being added are Return of premium on death (ROPD), Return of premium on cancellation (ROPC) or Return of premium on cancellation or expiry (ROPC/E), or
  - on life insurance, the only benefits being added are Plus premium, Child term (CTB) or Guaranteed return of premium death benefit

You may also apply for non-smoking status on this new application for any of the above transactions.

Use the Application for life and/or critical illness insurance, instead of this application, if applying for:

- conversion or exercising an option with an increase in coverage (amount of insurance applied for exceeds the amount available for conversion/exercising option), or
- conversion or exercising an option (without an increase in coverage) and adding a benefit that was not on the original policy (This does not apply to adding ROPD, ROPC, ROPC/E, Plus premium or CTB.).

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

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

These may include:

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

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

Ensure the Important information you should know page, containing the Sun Life Privacy Statement of Canada **is given to the proposed insured.**

Notes:

- If there are more than 2 people to be insured under this policy number, complete a second form and attach it to this application**.**
- Advisors must refer to our illustration software to determine if a signed illustration is required for this application.

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

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

AAPPE

General information

In this section, *you*, *your*, *Person 1* and *Person 2*, refer to the proposed insured and/or the applicant(s).

a) Information about Person 1 (proposed insured)

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Former surname (if any)	City of birth	Country of birth		
Residential address (street number and name)				Apartment or suite
City	Province/State	Country		Postal/Zip code
Phone number	Business phone number			

Proof of age (Complete only if not provided on the original application.)

Document (indicate type)	Requirement
☐ Canadian, U.S.A., U.K. or Bermuda driver's licence ☐ Change to Canadian, U.S.A., U.K. or Bermuda birth certificate ☐ Canadian citizenship ☐ Indian status card ☐ Register of civil status in Quebec ☐ Provincial identification card ☐ Military card	Registration number
☐ Current valid Canadian passport ☐ Current valid passport (other country) ☐ Current Nexus card	Expiry date (dd-mm-yyyy)
☐ Baptismal certificate ☐ Hospital certificate of birth	Issue date (dd-mm-yyyy)
☐ Provincial ID health insurance card (if date of birth is indicated) Includes: RAMQ, Medicare and BC medical care card (may say MSP card)	Expiry date (dd-mm-yyyy) ***or*** Registration number
☐ Permanent resident card	Expiry date (dd-mm-yyyy) ***or*** ID number

Is the proposed insured also an applicant? ☐ Yes ☐ No

If you are also an applicant, are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', what is your Social Insurance Number? _____ **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN) _____

CRS - If '**yes**', are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

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

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

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

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

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

☐ Other: Specify the reason _____

Does the applicant want to retain age? ☐ Yes ☐ No

Note: Age may be retained up to 10.5 months for par and Universal Life (UL) policies, 12 months for all other non-par or non-UL life policies and 6 months for critical illness policies.

Information about Person 2 (proposed insured)

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

Policy number

General information

Residential address (street number and name)			Apartment or suite
City	Province/State	Country	Postal/Zip code
Phone number	Business phone number		

Proof of age (Complete only if not provided on the original application.)

Document (indicate type)	Requirement
☐ Canadian, U.S.A., U.K. or Bermuda driver's licence ☐ Change to Canadian, U.S.A., U.K. or Bermuda birth certificate ☐ Canadian citizenship ☐ Indian status card ☐ Register of civil status in Quebec ☐ Provincial identification card ☐ Military card	Registration number
☐ Current valid Canadian passport ☐ Current valid passport (other country) ☐ Current Nexus card	Expiry date (dd-mm-yyyy)
☐ Baptismal certificate ☐ Hospital certificate of birth	Issue date (dd-mm-yyyy)
☐ Provincial ID health insurance card (if date of birth is indicated) Includes: RAMQ, Medicare and BC medical care card (may say MSP card)	Expiry date (dd-mm-yyyy) ***or*** Registration number
☐ Permanent resident card	Expiry date (dd-mm-yyyy) ***or*** ID number

Is the proposed insured also an applicant? ☐ Yes ☐ No

If you are also an applicant, are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', what is your Social Insurance Number? _____ **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN) _____

CRS - If '**yes**', are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

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

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

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

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

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

☐ Other: Specify the reason _____

Does the applicant want to retain age? ☐ Yes ☐ No

Note: Age may be retained up to 10.5 months for par and Universal Life (UL) policies, 12 months for all other non-par or non-UL life policies and 6 months for critical illness policies.

Is there an applicant who is not a proposed insured? ☐ Yes ☐ No If '**no**' proceed to c).

b) Information about the applicant(s) who are not a proposed insured

i) Individual (not a corporation, trust or other entity) applicant information
Complete the following for all Individual (not a corporation, trust or other entity) applicants.

Applicant's first name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Occupation	Residential address (street number and name)			Apartment or suite
City	Province/State	Country		Postal/Zip code

Policy number

General information

Relationship to the proposed insured

Are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', what is your Social Insurance Number? _____ **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN) _____

CRS - If '**yes**', are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

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

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

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

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

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

☐ Other: Specify the reason _____

Applicant's first name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

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

City	Province/State	Country	Postal/Zip code

Relationship to the proposed insured

Are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', what is your Social Insurance Number? _____ **Note:** Required for tax reporting for life insurance.

FATCA - If **'yes'**, are you a U.S. resident for tax purposes (which includes a U.S. citizen)? ☐ Yes ☐ No

If you are a U.S. resident for tax purposes, provide a U.S. Taxpayer Identification Number (TIN) _____

CRS - If '**yes**', are you a resident of any other jurisdiction other than Canada and the U.S. for tax purposes? ☐ Yes ☐ No

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

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

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

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

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

☐ Other: Specify the reason _____

ii) Corporation, trust or other entity applicant information

Complete the following for all corporation, trust or other entity applicants.

Name of corporation, trust or entity

Title of person to whom all notices and correspondence about this policy are to be sent

Mailing address (street number and name)	Apartment or suite

City	Province/State	Country	Postal code/Zip

Policy number

General information

Are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', forms *4831 (Identity verification and third party determination for entity owners)* and *4545 (International tax classification for an entity)* must be completed for this applicant.

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

Are you applying for universal or permanent life insurance? ☐ Yes ☐ No

If '**yes**', forms *4831 (Identity verification and third party determination for entity owners)* and *4545 (International tax classification for an entity)* must be completed for this applicant.

c) Information about contingent owner(s)

Note: You should name a contingent owner if:

- there is only one applicant and the policy will continue after that owner's death (where the applicant is not the proposed insured person), or
- there is more than one applicant.

Is there a contingent owner? ☐ Yes ☐ No If '**no**', proceed to the Beneficiary information section.

Multiple owners outside 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.

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 applicant and their contingent owner in the space provided below.

Applicant (owner)	Contingent owner	Relationship to the applicant (owner)
Applicant (owner)	Contingent owner	Relationship to the applicant (owner)

d) Preferred language

What language would the applicant like their policy and future correspondence in? Check one box:

☐ English **Note:** For Quebec residents, you will receive a French and an English copy of your policy.

☐ French

Beneficiary information

In this section, *you* and *your* refer to the applicant(s). If not completed, the beneficiary will be the applicant or the estate of the applicant.

Notes:

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

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

Note: 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 the cases of unequal shares, the predeceased beneficiary's share will revert to you or your estate.

Are you applying for critical illness insurance? ☐ Yes ☐ No If **'yes'**, proceed to c).

Policy number

Beneficiary information

Do you want to name a primary beneficiary(ies) for Person 1? ☐ Yes ☐ No

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
				%

Do you want to name a primary beneficiary(ies) for Person 2? ☐ Yes ☐ No

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
				%

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

Do you want to name a contingent beneficiary(ies) for Person 1? ☐ Yes ☐ No

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
				%

Do you want to name a contingent beneficiary(ies) for Person 2? ☐ Yes ☐ No

First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name		
Relationship to proposed insured (In Quebec, relationship to applicant)			☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
				%

Policy number

Beneficiary information

c) Critical illness insurance designations

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

i) Critical illness benefit payee beneficiary

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
			%

ii) Return of premium on death beneficiary

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
			%

iii) Return of premium on cancellation or expiry beneficiary

Note: If not completed, we pay any Return of premium on cancellation or expiry benefit to the applicant or the estate of the applicant.

First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
First name	Middle initial	Last name	
Relationship to proposed insured (In Quebec, relationship to applicant)		☐ Revocable ☐ Irrevocable	% shared of benefits to be paid
			%

d) Trustee for a minor beneficiary (Complete when a minor beneficiary has been named in beneficiary designations a) - c).)

Have you named a minor beneficiary anywhere in a) – c) and want to name a trustee for that beneficiary? ☐ Yes ☐ No

Notes:

- 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.

i) Primary beneficiaries: I appoint

ii) Contingent beneficiaries: I appoint

iii) Critical illness benefit payee beneficiary: I appoint

Policy number

Beneficiary information

iv) 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.

Transaction type and plan details

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

1. What type of transaction are you applying for? ☐ Conversion ☐ Group conversion ☐ Exercising option

Notes:

- Question 1 must be answered by the applicant(s).
- Questions 2 and 3 must be answered by the applicant(s) and the proposed insured(s) if other than applicant. If a proposed insured is under age 16 (18 in Quebec), the question must be answered by their parent or legal guardian.
- Questions 2 and 3 are only to be answered if applying for a conversion or exercising an option. Do not answer if applying for a group conversion.

2. On the original policy, was there a Waiver of Premium/Risk, Disability Waiver or Owner Waiver - Disability benefit on either the insured person or owner? ☐ Yes ☐ No

   If "**yes**" complete question 3.

3. Is the proposed insured or the applicant currently disabled or have they made a claim or are intending to make a claim to a disability benefit on any policy being converted or from which an option is being exercised? ☐ Yes ☐ No

Complete for conversions only:

Notes:

- Changes to policies issued prior to 2017 may result in the loss of legacy protection which may result in a negative tax consequence.
- All conversions must meet current product minimums and are subject to the terms and conditions of the policy being converted and our administrative rules.
- If converting more than 1 policy, the conversion will result in only 1 new policy being produced.

Policy number

☐ Full conversion ☐ Partial conversion

Amount not being converted is to: ☐ remain in force ☐ be cancelled

Policy number

☐ Full conversion ☐ Partial conversion

Amount not being converted is to: ☐ remain in force ☐ be cancelled

Policy number

☐ Full conversion ☐ Partial conversion

Amount not being converted is to: ☐ remain in force ☐ be cancelled

a) Conversion of:

☐ Term plan
☐ Critical illness (term only)
☐ Critical illness attached term (on proposed insured or additional insured person)
☐ Term insurance on additional insured person
☐ Universal life coverage
☐ Spousal term
☐ Other

Policy number

Transaction type and plan details

b) Convert to:

☐ Sun Par Protector II $ _____ *or* ☐ Sun Par Accumulator II $ _____

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

Indicate: ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die

☐ premiums payable to first death (Available on Life pay only.)

☐ premiums payable to last death

Note: The Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II section must also be completed.

☐ Sun Par Accelerator $ _____ (Base insurance amount + Enhanced amount)

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

Request to receive mailing

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

Do you want to receive notice of these meetings and related information? ☐ Yes ☐ No

If not completed, we will assume response as '**yes**'.

☐ Non-participating permanent life $ _____

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

Indicate: ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die

☐ premiums payable to first death (Available on Life pay only.)

☐ premiums payable to last death

☐ SunUniversalLife II $ _____

Indicate: ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die

☐ COI payable to first death

☐ COI payable to second death

Note: The Additional information required if converting or exercising option to SunUniversalLife II section must also be completed.

☐ SunUniversalLife (Bermuda only) $ _____

Indicate: ☐ Single life ☐ Joint first-to-die ☐ Joint last-to-die

Note: The Additional information required if converting or exercising option to SunUniversalLife (Bermuda only) section must also be completed.

☐ Sun Lifetime Alternative (Only available if converting from Sun 1 Year Term or Sun Term to 65.) $ _____

☐ Term (Only available on term conversions.) $ _____

☐ 20 year ☐ 30 year

Indicate: ☐ Single life ☐ Joint first-to-die ☐ Multi-life (Complete for person 2) $ _____

☐ 20 year ☐ 30 year

☐ Sun Critical Illness Insurance $ _____

☐ Term 75 *or* ☐ Lifetime

Guaranteed payment period — Guaranteed payment period

☐ 15 years ☐ To age 75 — ☐ 10 years ☐ 15 years ☐ To age 100

Policy number _____

Transaction type and plan details

☐ Existing universal life policy | Policy number | Amount of increase $

☐ Other

c) Benefit details:

i) On new policy

☐ Carry over these benefit(s) (describe):

If carrying over CTB, provide the name(s) and date(s) of birth of children covered under the CTB.

Child **1**	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
Child **2**	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
Child **3**	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
Child **4**	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
Child **5**	First name	Middle initial	Last name	Date of birth (dd-mm-yyyy)

Are you reducing the CTB benefit amount? ☐ Yes ☐ No

If **'yes'**, indicate the new CTB amount. $

☐ Add the following benefit(s):

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

☐ CTB $

☐ ROPD

☐ ROPC (Lifetime only.)

Adult	Child
☐ 15 years	☐ Advanced
☐ age 65	☐ age 35
☐ age 75	

☐ ROPC/E (Term 75 only.)

Adult	Child
☐ 15 years	☐ Advanced
☐ age 65	☐ age 35
☐ age 75	

☐ Guaranteed return of premium death benefit (Available on 15 or 20 pay non-participating permanent life only.)

ii) On original policy

☐ Cancel these benefit(s) (describe):

d) Statement of smoking status

Note: In the following question, *you* refers to the applicant(s).

	Person 1	**Person 2**
Are you applying for non-smoker rates on this new application?	☐ Yes ☐ No	☐ Yes ☐ No
If '**yes**', does the existing policy have non-smoker rates?	☐ Yes ☐ No	☐ Yes ☐ No

If '**no**', you must answer the Smoking declaration questions in the Additional evidence section.

Complete for group conversions only:

Notes:

- All conversions must meet current product minimums and are subject to the terms and conditions of that policy and our administrative rules.
- Include a copy of the Client's termination notice with this application.

a) Convert to:

☐ Sun Lifetime Alternative

Policy number

Transaction type and plan details

☐ Carry over Accidental death benefit from original group policy

☐ Sun One year term

☐ Sun Term to 65

Group policy number	Certificate number

Group company name	Eligible amount	Amount being converted
	$	$

Date the group insurance was terminated, the last day worked or the benefit's expiry date: Date (dd-mm-yyyy)

Is this a group spousal conversion? ☐ Yes ☐ No If '**yes**', complete the following spousal information:

First name	Last name	SIN (required for tax reporting for life insurance)	Date of birth (dd-mm-yyyy)

The spouse must also sign the Acknowledgement and agreement section of this application.

b) Statement of smoking status

In the **last 12 months**, has the proposed insured smoked or used cigarettes, cigarillos, small or large cigars, pipes, vapor products, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ☐ Yes ☐ No

Complete for exercising options only:

Note: All options must meet current product minimums and are subject to the terms and conditions of that policy and our administrative rules.

a) New plan:

☐ Sun Par Protector II $ _____ *or* ☐ Sun Par Accumulator II $ _____

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

Note: The Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II section must also be completed.

☐ Sun Par Accelerator $ _____ (Base insurance amount + Enhanced amount)

Request to receive mailing

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

Do you want to receive notice of these meetings and related information? ☐ Yes ☐ No

If not completed, we will assume response as '**yes**'.

☐ Non-participating permanent life $ _____

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

☐ SunUniversalLife II $ _____

Note: The Additional information required if converting or exercising option to SunUniversalLife II section must also be completed.

☐ SunUniversalLife (Bermuda only) $ _____

Note: The Additional information required if converting or exercising option to SunUniversalLife (Bermuda only) section must also be completed.

☐ Term $ _____

☐ 10 year ☐ 10 year with renewal protection ☐ 15 year ☐ 20 year ☐ 30 year

☐ Other _____

Policy number

Transaction type and plan details

b) Option being exercised:

☐ Guaranteed insurability

☐ Age ☐ Date of marriage (dd-mm-yyyy) ☐ Child's date of birth (dd-mm-yyyy)

☐ Date of legal adoption (dd-mm-yyyy) ☐ Other

☐ Child term

In the **last 12 months**, has the proposed insured smoked or used cigarettes, cigarillos, small or large cigars, pipes, vapor products, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ☐ Yes ☐ No

☐ Business value protection

Note: Complete and attach a *Financial questionnaire (E96)* and 2 years of financial statements on the business named on the application for the new policy.

☐ Partner protection (Only available on term plans.)

First name of deceased	Last name	Amount of coverage on the deceased (Basic insurance amount)
		$

Indicate policy number:

Policy number exercising option from

i) On new policy

☐ Carry over these benefit(s) (describe):

☐ Add the following benefit:

☐ CTB $

☐ Guaranteed return of premium death benefit (Available on 15 or 20 pay non-participating permanent life only.)

ii) On original policy

☐ Cancel these benefit(s) (describe):

c) Statement of smoking status (Do not complete if exercising a Child term option.)

Note: In the following question, *you* refers to the applicant(s).

Person 1

Are you applying for non-smoker rates on this new application? ☐ Yes ☐ No

If '**yes**', does the existing policy have non-smoker rates? ☐ Yes ☐ No

If '**no**', you must answer the Smoking declaration questions in the Additional evidence section.

Additional information required if converting or exercising option to Sun Par Protector II or Sun Par Accumulator II

i) **Dividend options (If not completed, default will be PUA.)**

☐ Paid-up additional insurance (PUA) **Note:** If adding PUA and it exceeds the maximum insurance amount, the Additional evidence section must also be completed.

☐ Annual premium reduction (Only available if premiums are payable on an annual basis.)

☐ Cash payment

☐ Dividends on deposit

☐ Enhanced insurance **Note:** If adding enhanced insurance and it exceeds the maximum insurance amount, the Additional evidence section must also be completed.

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

Do you want to add the Plus premium benefit (PPB)? ☐ Yes ☐ No

Policy number

Transaction type and plan details

ii) **Plus premium benefit (PPB)** (Not available on **10 pay**. Only available if PUA or Enhanced insurance selected in i) Dividend options.)

Note: If adding PPB, the Additional evidence section must also be completed.

Payment option for PPB

Scheduled (regular monthly or annual payments): ☐ Monthly $ ☐ Annual $

iii) **Premium offset (If not completed, we will assume response as 'yes'.)**

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

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

iv) **Request to receive mailing (If not completed, we will assume response as 'yes'.)**

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

Do you want to receive notice of these meetings and related information? ☐ Yes ☐ No

If not completed, we will assume response as '**yes**'.

Additional information required if converting or exercising option to SunUniversalLife II

Note: If an investment mix change is required on an existing universal life policy, complete a Investment account change and allocation form.

i) **Death benefit options (If not completed, default will be Insurance amount plus policy fund.)**

Choose one of the following:

☐ Insurance amount plus policy fund

☐ Level insurance amount

ii) **Cost of insurance (If not completed, default will be Level.)**

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

iii) **Investment account options (If not completed, default will be Daily interest account 100%.)**

You must allocate your payments to any of the following Investment account options. Your choices must be in multiples of 5% and they must add up to 100% for a maximum of ten accounts. Each of your investment account options must have a minimum amount of $100.00.

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

Policy number

Transaction type and plan details

Interest rate accounts	Percentage
Daily interest account	%
Guaranteed interest accounts (GIAs) 1 year	%
3 year	%
5 year	%
10 year	%
Sun Life Diversified Account	%

Managed accounts	Percentage
BlackRock Global Equity Index	%
BlackRock US Equity Index	%
CI Cambridge Canadian Equity Corporate Class	%
CI Signature Income & Growth	%
Sun Life BlackRock Canadian Equity Index	%
Sun Life BlackRock Canadian Universe Bond Fund	%
Sun Life Dynamic Strategic Yield	%
Sun Life Granite Balanced Portfolio	%
Sun Life Granite Balanced Growth Portfolio	%
Sun Life Granite Conservative Portfolio	%
Sun Life Granite Enhanced Income Portfolio	%
Sun Life Granite Growth Portfolio	%
Sun Life Granite Income Portfolio	%
Sun Life Granite Moderate Portfolio	%
Sun Life MFS Canadian Bond	%
Sun Life MFS Canadian Equity Growth	%
Sun Life MFS Global Value	%
Sun Life MFS US Equity	%
+ Sub total	%
= 100%	%

Sub total %

Your GIA earnings will automatically compound until the account matures.

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

☐ Rollover to a new account of the same term

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

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

or ☐ **Alternate order 1:**
Funds are withdrawn in the following order:
- DIA
- Managed accounts in proportion to the balance of each managed account
- GIAs (taken first from layers closest to maturity)
- Sun Life Diversified Account

or ☐ **Alternate order 2:**
Funds are withdrawn in the following order:
- DIA
- GIAs (taken first from layers closest to maturity)
- Managed accounts in proportion to the balance of each managed account
- Sun Life Diversified Account

iv) **Maintaining your policy's tax-exempt status**

Note:

Check one of the boxes below. (**Note**: If not completed, default is Retain insurance amount.

☐ Retain insurance amount

☐ Increase insurance amount as required (to a maximum of 8%) but reverse the increase when this can be done without losing tax-exempt status (note the cost of insurance will be changed accordingly).

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

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

☐ Daily interest account

☐ Guaranteed interest account – 1 year

Policy number

Transaction type and plan details

Additional information required if converting or exercising option to SunUniversalLife (Bermuda only)

Note: If an investment mix change is required on an existing universal life policy, complete a Universal Life Client service request form.

i) **Death benefit options (If not completed, default will be Insurance amount plus your policy fund.)**

Choose one of the following:

☐ Level insurance amount
☐ Indexed insurance amount
☐ Insurance amount plus your policy fund value

For multiple life coverage, the fund value will be paid as a proportion of each insurance amount to the total, unless you tell us your fund value is to be paid with the ☐ first ***or*** ☐ last settlement of basic benefits under the policy.

ii) **Cost of insurance (If not completed, default will be Guaranteed level rates.)**

☐ Guaranteed yearly term ***or*** ☐ Guaranteed level term

iii) **Investment bonus (If not completed, we will assume response as 'no'.)** ☐ Yes ☐ No

iv) **Investment account options (If not completed, default will be Daily interest account 100%.)**

You must allocate your payments to any of the following Investment account options. Your choices must be in multiples of 5% and they must add up to 100%. Each of your investment accounts must also have a minimum amount of $100.00.

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

Interest rate accounts	Percentage
Daily interest account	%
Guaranteed interest accounts (GIAs)	
1 year	%
3 year	%
5 year	%
10 year	%
20 year	%

Sub total %

Accounts based on indices	Percentage
American Equity	%
Canadian Bond	%
Canadian Equity	%
Foreign Equity	%

\+ Sub total %

= 100% %

Your GIA earnings will automatically compound until the account matures.

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

☐ Rollover to a new account of the same term

In what order do you want your investment account withdrawals and transfers processed? If not specified, your withdrawal order will be Standard. (A change to this section is not available after the policy is issued. Check one.)

☐ Standard order:
- Activity account
- Daily interest account
- Accounts based on the performance of indices
- Accounts based on the performance of managed funds
- GIAs (nearest to maturity)

or ☐ Alternate order:
- Activity account
- Daily interest account
- GIAs (nearest to maturity)

Policy number

Acknowledgement of variability

I refers to the applicant(s).

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

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

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

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

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

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

Policy number

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

Completion of this section is mandatory if:

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

Notes:

- In this section, *you* and *your* refer to the applicant(s), which includes sole proprietors.
- The questions must be answered by the applicant(s).

If any applicant is **not an individual** *(ie Corporation or other entity)*, forms 4831 *(Identity verification and third party determination for entity owners)* and 4545 *(International tax classification for an entity)* must be completed for that applicant.

Always verify the identity of Clients and find out whether any third parties are involved. This helps Sun Life to manage risk and to comply with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and other relevant legislation/regulations.

If additional space is required for any part of this section, complete form 4830 for each applicant.

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

Identity verification
Applicant 1 (Information on an individual applicant)

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

Detailed occupation/pre-retired occupation/principal business

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

City	Province/State	Country	Postal/Zip code

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

☐ a) Photo identification

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

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

☐ b) Dual process

Refer to information from 2 different independent and reliable source documents that are valid and current. Must collect all information from 2 out of 3 options listed below and confirm that this matches the information provided by the person;

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

Note: Detailed information is required in the Source field (e.g., Province of Ontario, Hydro-Québec, CIBC, Bell Canada etc.). Financial entities, utility providers, federal, provincial, territorial, and municipal levels of government are considered reliable sources of information.

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

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

Identity verification
Applicant 2 (Information on an individual applicant)

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

Detailed occupation/pre-retired occupation/principal business

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

City	Province/State	Country	Postal/Zip code

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

☐ a) Photo identification

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

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

☐ b) Dual process

Refer to information from 2 different independent and reliable source documents that are valid and current. Must collect all information from 2 out of 3 options listed below and confirm that this matches the information provided by the person;

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

Note: Detailed information is required in the Source field (e.g., Province of Ontario, Hydro-Québec, CIBC, Bell Canada etc.). Financial entities, utility providers, federal, provincial, territorial, and municipal levels of government are considered reliable sources of information.

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

Third party determination

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

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

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

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

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

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

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

City	Province/State	Country	Postal/Zip code

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

Policy number

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

Name (If individual, first name, middle initial, last name.)			If individual, date of birth (dd-mm-yyyy)
Type of third party	Relationship to applicant	Detailed occupation/pre-retired occupation/principal business	
Address/residential address (street number and name) **Note**: PO Box and General Delivery addresses are not acceptable		Apartment or suite	Phone number
City	Province/State	Country	Postal/Zip code
If an entity, registration number	Province/State of registration	Country of registration	

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

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

To the best of every applicant's knowledge, has any applicant, their family members or close associates held any of the positions indicated in a), b) and c) below? Indicate **Yes** or **No** beside a), b) and c) below. Record all that apply in the charts below.

Notes:

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

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

1. member of the executive council of government
2. president (head) of a state-owned company
3. president (head) of a state-owned bank
4. deputy minister (or equivalent rank) in government
5. ambassador
6. counsellor of an ambassador
7. attaché
8. leader (or president) of a political party represented in a legislature
9. head of state
10. head of government
11. head of a government agency
12. judge of a supreme court, constitutional court or other court of last resort
13. military officer with a rank of general or above
14. member of a legislature

Applicant's first name	Middle initial	Last name	
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name	Middle initial	Last name	
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Policy number

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

Applicant's first name	Middle initial	Last name	
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name	Middle initial	Last name	
First name (PEFP) If not applicant	Middle initial	Last name	Relationship to applicant (PEFP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

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

1. governor general
2. lieutenant governor
3. member of the senate
4. member of the house of commons
5. member of a legislature
6. deputy minister (or equivalent rank) in government
7. ambassador
8. counsellor of an ambassador
9. attaché
10. military officer with a rank of general or above
11. president of a corporation that is wholly owned directly by Her Majesty in right of Canada or a province
12. head of a government agency
13. judge of an appellate court in a province
14. judge of the federal court of appeal
15. judge of the supreme court of Canada
16. leader (or president) of a political party represented in a legislature
17. holder of any prescribed office or position
18. mayor

Applicant's first name	Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name	Relationship to applicant (PEDP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name	Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name	Relationship to applicant (PEDP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name	Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name	Relationship to applicant (PEDP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Applicant's first name	Middle initial	Last name	
First name (PEDP) if not applicant	Middle initial	Last name	Relationship to applicant (PEDP)
Country where position held	Organization or institution	Position held (indicate all applicable numbers from list)	

Policy number

c) Head of an international organization (HIO) – (living or deceased, current or in the last 5 years) ☐ Yes ☐ No

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

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

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

Applicant's first name	Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name	Relationship to applicant (HIO)
Country where position held	Organization or institution	Position held	

Applicant's first name	Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name	Relationship to applicant (HIO)
Country where position held	Organization or institution	Position held	

Applicant's first name	Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name	Relationship to applicant (HIO)
Country where position held	Organization or institution	Position held	

Applicant's first name	Middle initial	Last name	
First name (HIO) If not applicant	Middle initial	Last name	Relationship to applicant (HIO)
Country where position held	Organization or institution	Position held	

Source of payment, purpose of product and source of wealth

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

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

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

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

Policy number

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

Complete the question below if any applicant has answered "***yes***" to any of the questions in the Politically exposed (PEP)/Head of international organization (HIO) sub section relating to PEFP/PEDP/HIO determination.

Record the accumulation of the applicant's source of wealth. This is the origin of a person's total assets that can be reasonably explained, rather than what might be expected. For example, a person's wealth could originate from an accumulation of activities and occurrences.

Provide your accumulated source of wealth (Select all that apply.)

Applicant 1

- ☐ family wealth
- ☐ inheritance
- ☐ divorce settlement
- ☐ income from purchase or sale of investments (e.g. from real estate, securities, royalties, patents)
- ☐ gifts
- ☐ payments from pension or retirement plans
- ☐ casino or lottery wins
- ☐ other personal assets (e.g. sales of residential properties, artwork)
- ☐ business income
- ☐ sales of business property
- ☐ salaries, bonuses, commissions
- ☐ other (provide details below):

Applicant 2

- ☐ family wealth
- ☐ inheritance
- ☐ divorce settlement
- ☐ income from purchase or sale of investments (e.g. from real estate, securities, royalties, patents)
- ☐ gifts
- ☐ payments from pension or retirement plans
- ☐ casino or lottery wins
- ☐ other personal assets (e.g. sales of residential properties, artwork)
- ☐ business income
- ☐ sales of business property
- ☐ salaries, bonuses, commissions
- ☐ other (provide details below):

Policy number

Person 1 Evidence no. (for H.O. use only) E#

Person 2 Evidence no. (for H.O. use only) E#

Additional evidence

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.

Note: In a), *you* refers to the applicant(s).

a) **Are you:**

Note: In this section *you* refers to the applicant(s).

1) adding ROPD to a Sun Critical Illness Insurance product? ☐ Yes ☐ No

2) adding paid-up additional insurance or enhanced insurance that exceeds the maximum insurance amounts? ☐ Yes ☐ No

3) adding paid-up additional insurance or enhanced insurance, where the original policy(converting policy) exceeds the maximum insurance amounts? ☐ Yes ☐ No

4) adding a Guaranteed return of premium on death benefit on Non-particiipating permanent life product? ☐ Yes ☐ No

5) adding the Plus premium benefit, regardless of face amount? ☐ Yes ☐ No

6) adding a Child term benefit? ☐ Yes ☐ No

b) **Information about proposed insured(s)**

Notes: • In this section *you* refers to the proposed insured(s).
- This section must be answered for any '**yes**' answers above by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian who has full knowledge of the proposed insured's personal or medical history.
- If more space is required, use a separate sheet signed and dated by the proposed insured.

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

i) heart attack or any other heart disease or disorder, stroke/TIA, cancer or any other growth(s) or malignancy, diabetes or kidney, lung or liver disease or disorder

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

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.
If '**yes**', provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

ii) AIDS, HIV infection or any other disease or disorder of the immune system ☐ Yes ☐ No ☐ Yes ☐ No

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.
If '**yes**', provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

2) Are you aware of any symptoms for which you have not yet consulted a physician or received treatment? ☐ Yes ☐ No ☐ Yes ☐ No

Provide details including symptoms, date of onset and any other relevant information.
If '**yes**', provide details including symptoms, date of onset and any other relevant information.

Person 1 details

Additional evidence

Person 2 details

3) Have you **ever** had any medical conditions, not already mentioned, for which you have been or are being investigated, under observation or treated for, or for which you are currently awaiting investigation or test results? **(Do not tell us about genetic testing or genetic test results.)** ☐ Yes ☐ No ☐ Yes ☐ No

Provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.
If '**yes**', provide details including diagnosis, date of diagnosis, type of treatment and any other relevant information.

Person 1 details

Person 2 details

4) Have you **ever** had any applications for life, disability, critical illness or long term care insurance declined, rated, postponed, cancelled or modified in any way? ☐ Yes ☐ No ☐ Yes ☐ No

Provide details including date of application, plan type, decision and reason, and name of company.
If '**yes**', provide details including date of application, plan type, decision and reason, and name of company.

Person 1 details

Person 2 details

c) **Smoking declaration** (To be completed if converting or exercising an option (not CTB) and applying for a change to non-smoker rates on the new policy.)

Notes: • In the following questions, *you* refers to the proposed insured(s).
- The following questions must be answered by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian **who has full knowledge of the proposed insured's personal or medical history**.
- If you have answered the Statement of smoking status question in the Transaction type and plan details section as '**yes**', the following questions must also be answered.

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

Proposed insured	Daily	Occasionally (socially)	Used within the last 5 years	Last used more than 5 years ago	Never smoked or used tobacco or nicotine products
Person 1	☐	☐	☐ Date last used (dd-mm-yyyy):	☐	☐
Person 2	☐	☐	☐ Date last used (dd-mm-yyyy):	☐	☐

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

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

2. **Person 1:** Height ____ ☐ cm ☐ ft & in Weight ____ ☐ kg ☐ lb
Person 2: Height ____ ☐ cm ☐ ft & in Weight ____ ☐ kg ☐ lb

	Person 1	Person 2
3. In the **last 12 months**, have you had a weight loss of more than 4.5kg or 10lbs?	☐ Yes ☐ No	☐ Yes ☐ No

Person 1: If '**yes**' complete the chart below.

Amount of change: ____ ☐ lb ☐ kg	Reason for change: ☐ diet ☐ exercise ☐ surgery ☐ other
If '**other**', provide details below.	

Policy number

Additional evidence

Person 2: If '**yes**' complete the chart below.

Amount of change: _____ ☐ lb ☐ kg	Reason for change: ☐ diet ☐ exercise ☐ surgery ☐ other
If '**other**', provide details below.	

4. a) In the **last 5 years**, have you used marijuana or hashish? ☐ Yes ☐ No ☐ Yes ☐ No

If '**yes**' to a), indicate which of the following best describes you average frequency of use.

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

b) If '**yes**' to a), do you mix the marijuana or hashish with tobacco? ☐ Yes ☐ No ☐ Yes ☐ No

c) If '**yes**' to a), do you use it for medicinal purposes? ☐ Yes ☐ No ☐ Yes ☐ No

d) If '**yes**' to c), did a physician prescribe it? ☐ Yes ☐ No ☐ Yes ☐ No

If '**yes**', is this your usual physician or health care professional? ☐ Yes ☐ No ☐ Yes ☐ No

e) If '**yes**' to d), what condition is being treated? ☐ Yes ☐ No ☐ Yes ☐ No

f) In the **last 10 years**, have you used any drugs or narcotics that weren't prescribed to you (such as cocaine, LSD, ecstasy, heroin, fentanyl, anabolic steroids or amphetamines)? ☐ Yes ☐ No ☐ Yes ☐ No

If '**yes**' provide details.

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

g) Have you **ever** been treated, counselled or gone to meetings for alcohol or drug abuse? ☐ Yes ☐ No ☐ Yes ☐ No

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

h) If '**no**' to g), has a doctor or health care professional ever recommended you get treatment or counselling or limit the amount alcohol or drugs you use? ☐ Yes ☐ No ☐ Yes ☐ No

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

5. Have you **ever** been treated for or had any symptoms or indication of:

i) AIDS or HIV infection ☐ Yes ☐ No ☐ Yes ☐ No

ii) chest pain, high blood pressure, irregular pulse or heart disease or disorder ☐ Yes ☐ No ☐ Yes ☐ No

iii) stroke or cerebrovascular accident (CVA), aneurysm, transient ischemic attack (TIA) or paralysis ☐ Yes ☐ No ☐ Yes ☐ No

iv) asthma, persistent cough or any other lung disease or disorder ☐ Yes ☐ No ☐ Yes ☐ No

v) diabetes, abnormal blood sugar or kidney disease or disorder ☐ Yes ☐ No ☐ Yes ☐ No

vi) cancer, tumour or any other growth or malignancy ☐ Yes ☐ No ☐ Yes ☐ No

vii) ulcer (peptic or gastric), ulcerative colitis or Crohn's disease ☐ Yes ☐ No ☐ Yes ☐ No

viii) hepatitis (including hepatitis carrier state) or any other liver disease or disorder ☐ Yes ☐ No ☐ Yes ☐ No

ix) any other medical history not previously mentioned ☐ Yes ☐ No ☐ Yes ☐ No

Policy number

Additional evidence

Give details for all '**yes**' answers in question 5.

Proposed insured	Question number	Date (mm-yyyy)	Indicate all related treatments, durations, dates, tests and results. Include names and addresses of all attending physicians, medical facilities and hospitals.
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			
☐ Person 1 ☐ Person 2			

6. Provide additional details for any question in this section.

Person 1

Person 2

7. Do you have a usual medical advisor or medical clinic? ☐ Yes ☐ No ☐ Yes ☐ No

Person 1

a) If '**yes**' to question 7, name of usual medical or health care professional or medical clinic.			
Address (street number and name)	City		Province/State
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
b) If '**yes**' to question 7, in the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No		If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).	
c) If '**no**' to question 7, in the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No		If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).	
If '**yes**', to c), name and address of doctor consulted.			

Person 2

a) If '**yes**' to question 7, name of usual medical or health care professional or medical clinic.			
Address (street number and name)	City		Province/State
Phone number	Date first consulted (mm-yyyy)	Date last consulted (mm-yyyy)	Name on file (if different than legal name)
b) If '**yes**' to question 7, in the **last 5 years**, did you see this doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No		If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).	
c) If '**no**' to question 7, in the **last 5 years**, did you see any doctor or clinic for a routine physical exam or checkup? ☐ Yes ☐ No		If '**yes**', date of most recent exam or checkup (dd-mm-yyyy).	
If '**yes**', to c), name and address of doctor consulted.			

Policy number

Additional evidence

d) **Family history** (To be completed if converting to critical illness and applying for change to non-smoker rates on new policy.)

Note: In the following question, *you* refers to the applicant(s).

1. Are you applying for a conversion to critical illness insurance? ☐ Yes ☐ No

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

Notes:

- In the following questions, *you* refers to the proposed insured(s).
- These questions must be answered by the proposed insured(s) or if under age 16 (18 in Quebec), by the parent or legal guardian who has full knowledge of the proposed insured's personal or medical history.
- The following questions do not need to be completed for proposed insured(s) over the age of 65. **Do not tell us about genetic testing or genetic test results.**

2. Have any of your parents, brothers or sisters been diagnosed **before age 65** with heart disease, stroke/TIA, cancer (including leukemia, lymphoma and Hodgkin's disease), diabetes or Parkinson's disease? ☐ Yes ☐ No

3. Have any of your parents, brothers or sisters **ever** been diagnosed with Huntington's disease, polycystic kidney disease (PKD), multiple sclerosis (MS), muscular dystrophy, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or any other hereditary disease or disorder? ☐ Yes ☐ No

If '**yes**' to 2) or 3), complete the following chart.

Relationship to family member	Age at onset	Age if living	Age at death
Condition (if cancer include type)			
Relationship to family member	Age at onset	Age if living	Age at death
Condition (if cancer include type)			
Relationship to family member	Age at onset	Age if living	Age at death
Condition (if cancer include type)			
Relationship to family member	Age at onset	Age if living	Age at death
Condition (if cancer include type)			

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

Notes:

- In this section, *you* refers to the proposed insured.
- The proposed insured's biological, adopted or step-children may be covered under a child term benefit.

If there is more than 1 proposed insured, who's child(ren) are being insured? ☐ Person 1 ☐ Person 2

Does the proposed insured currently have any children? ☐ Yes ☐ No

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

Notes:

- If more than 3 children are to be insured, print off an additional copy of the CTB pages and submit those pages with this application.
- The information below must be provided by the Person who's children are being insured.

Information about Child 1 to be insured

Child's first name	Middle initial	Last name		
Relationship to proposed insured ☐ Child ☐ Step child ☐ Adopted child			☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Policy number

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

Does this child live with you? ☐ Yes ☐ No

If '**yes**', who does this child live with? ☐ Person 1 ☐ Person 2

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

First name of person the child lives with	Middle initial	Last name

Relationship to child	Residential address (street number and name)	Apartment or suite

City	Province/State	Postal/Zip code

Do you have full knowledge of this child's medical history? ☐ Yes ☐ No

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

Note: If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children

Information about Child 2 to be insured

Child's first name	Middle initial	Last name

Relationship to proposed insured ☐ Child ☐ Step child ☐ Adopted child	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Does this child live with you? ☐ Yes ☐ No

If '**yes**', who does this child live with? ☐ Person 1 ☐ Person 2

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

First name of person the child lives with	Middle initial	Last name

Relationship to child	Residential address (street number and name)	Apartment or suite

City	Province/State	Postal/Zip code

Do you have full knowledge of this child's medical history? ☐ Yes ☐ No

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

Note: If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children

Information about Child 3 to be insured

Child's first name	Middle initial	Last name

Relationship to proposed insured ☐ Child ☐ Step child ☐ Adopted child	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Does this child live with you? ☐ Yes ☐ No

If '**yes**', who does this child live with? ☐ Person 1 ☐ Person 2

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

First name of person the child lives with	Middle initial	Last name

Relationship to child	Residential address (street number and name)	Apartment or suite

City	Province/State	Postal/Zip code

Policy number

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

Do you have full knowledge of this child's medical history? ☐ Yes ☐ No

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

Note: If not present, this child may not apply for this benefit at this time.

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

Name of person answering questions for this child	Relationship to the children

Note: Provide details for each child answering '**yes**' to any question in numbers 1 - 4. If any child is age 16 (18 in Quebec) or over, they must answer the following questions and sign the Acknowledgement and agreement section of this application.

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

Child to be insured	Details

2. Has any child **ever** been treated for or had any symptoms or indication of:

a) heart murmur or any other disease or disorder of the heart or blood vessels ☐ Yes ☐ No

Child to be insured	Details

b) cancer, leukemia or any other growths or malignancy ☐ Yes ☐ No

Child to be insured	Details

c) diabetes or any other thyroid or endocrine disease or disorder ☐ Yes ☐ No

Child to be insured	Details

d) hemophilia, bleeding disorder or any other blood disease or disorder ☐ Yes ☐ No

Child to be insured	Details

Policy number

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

e) Crohn's disease, ulcerative colitis, hepatitis or any other disease or disorder of the bowel, stomach or liver ☐ Yes ☐ No

Child to be insured	Details

f) asthma, cystic fibrosis, tuberculosis or any other respiratory disease or disorder ☐ Yes ☐ No

Child to be insured	Details

g) depression, anxiety, attention deficit disorder or any other psychological, emotional or nervous disease or disorder ☐ Yes ☐ No

Child to be insured	Details

h) disease or disorder of the kidney or urinary tract ☐ Yes ☐ No

Child to be insured	Details

i) muscular dystrophy, multiple sclerosis or any other neurological disease or disorder ☐ Yes ☐ No

Child to be insured	Details

j) Down syndrome, developmental delay, autism, cerebral palsy or any other congenital disease or disorder ☐ Yes ☐ No

Child to be insured	Details

Policy number

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

k) epilepsy, seizure or any other disease or disorder of the brain ☐ Yes ☐ No

Child to be insured	Details

Child to be insured	Details

Child to be insured	Details

3. Has any child **ever** been tested for exposure to the HIV (AIDS) virus? ☐ Yes ☐ No

Child to be insured	Details

Child to be insured	Details

Child to be insured	Details

4. Are there any medical conditions, not already mentioned, for which any child had or is awaiting investigation, treatment or is under observation? **(Exclude routine check-ups where no follow-up is required, colds, flu, tonsillectomy, adenoidectomy, appendectomy, hernia repair and tubes in ears. Do not tell us about genetic testing or genetic test results.)** ☐ Yes ☐ No

Child to be insured	Details

Child to be insured	Details

Child to be insured	Details

Policy number

Authorization to disclose information to your advisor

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

Purpose

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

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

Sharing of information

The information we may share with your advisor could include:

- medical testing and laboratory results
- other confidential personal information about illness, including mental illness, infectious diseases, other medical 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
- this authorization remains valid until 30 days after the later of the day we:
  (a) issue a new insurance policy, or
  (b) mail you a notice telling you that we have declined your application.

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

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

PAPRSIGE

Policy number

Payments

Method of payment information

Notes:

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

What is the method of payment?

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

☐ Payment on delivery: If selected, the Payment on delivery and Pre-authorized chequing (PAC) authorization (if applicable) must also be completed.

☐ Pre-authorized chequing (PAC): If selected, the Pre-authorized chequing (PAC) authorization section must also be completed.

☐ Future periodic payment (only applicable for universal life applications): If selected, the Future periodic payment section must also be completed.

☐ Bermuda only

Frequency: ☐ Quarterly ☐ Annual **Note**: If not indicated, default will be Annual.

Currency: ☐ Bermuda funds ☐ U.S.A. funds **Note**: If not indicated, default will be Bermuda funds.

Future periodic payment amount $

Payment on delivery

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 PAC information provided in the Pre-authorized chequing (PAC) authorization section

☐ PAC withdrawal based on PAC information provided in the Pre-authorized chequing (PAC) authorization section, or

☐ PAC withdrawal with PAC information/payment instructions to be provided on delivery

Pre-authorized chequing (PAC) authorization

Are all PAC payors also a proposed insured and/or applicant? ☐ Yes ☐ No If '**no**' provide the PAC payor name(s).

PAC payor's first name	Middle initial	Last name
PAC payor's first name	Middle initial	Last name

Notes:

- All PAC payors must agree to the following terms to use the PAC payment option.
- We will withdraw all payments, including the initial payment, from the account indicated.

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 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 applicant/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 the Acknowledgement and agreement section as a PAC payor,

Policy number

Payments

- 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) Do the payors want us to withdraw funds to pay the initial payment? ☐ Yes ☐ No

If '**yes**', there could be a premium credit transferred to the new application to help pay the initial payment if this is a full conversion. If there is a premium credit, would you still like us to withdrawal the initial payment? ☐ Yes ☐ No

If '**no**', ensure the total initial payment has been submitted to the advisor upon completion of this application.

b) Does the payor want to add to an existing PAC? ☐ Yes ☐ No

If '**yes**', what is the policy number the existing PAC is paying for? Policy number

If '**yes**', regular PAC withdrawals for this policy will be withdrawn on the same day each month for the policy number indicated unless a different day is indicated here: Monthly withdrawal day for this application

c) Does the payor want to start a new PAC? ☐ Yes ☐ No If '**yes**', complete 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 Acknowledgement and authorization section. For a joint account requiring more than one signature to withdraw funds, all the account holders must sign the Acknowledgement and authorization section.

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
PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5
1-877-SUN-LIFE (1-877-786-5433)
Fax # 1-866-487-4745
www.sunlife.ca

Policy number

Payments

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

Account holder name 1	Account holder name 2		
Name of financial institution			
Address of financial institution (street number and name)			
City	Province	Postal code	
Branch/Transit number	Bank/Institution number	Account number	

This sample cheque shows the information that you need to provide.

Notes:

Branch/Transit numbers are normally 4-5 digits

Bank/Institution numbers are always 3 digits long:

BMO 001

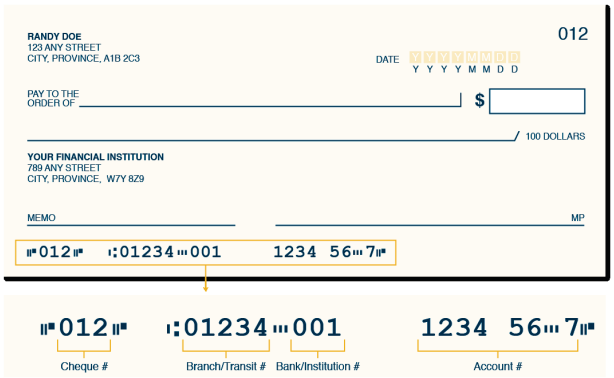
Scotiabank 002

RBC 003

TD 004

CIBC 010

Account numbers can be up to 12 digits long



Special instructions

Policy number

Translation agreement and declaration

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

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

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

a) Proposed insured(s) and/or applicant(s) agreement

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

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

Translator's first name	Middle initial	Last name

5. Translator's relationship to person translation was provided for:

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

6. In what language were the questions translated?

Person 1		Person 2	
Applicant 1		Applicant 2	

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

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

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

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

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

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

Policy number

Acknowledgement and agreement

By signing below, the applicants confirm they've received, read and agree to the Guide to critical illness definitions, if critical illness insurance was applied for.

By signing below, the applicants and proposed insureds (if other than applicant) confirm they've received, read and agree to the Sun Life Privacy Statement for Canada.

By signing below, the applicants acknowledge:

- having received a French version of this application and having expressly chosen to complete the English version;
- having expressly chosen to receive all documents related to this contract in English, as per the application; and
- they understand Sun Life may still be required by law to provide them with the French version of the contract.

Declaration

By signing below, the applicants, proposed insureds and pre-authorized chequing (PAC) payors acknowledge, declare and confirm:

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

By signing below, the proposed insured(s) confirm the information described in the Authorization to disclose information to your advisor section, may be shared with their advisor if they checked '**yes**' in that section.

Policy number

Acknowledgement and agreement

Authorization of all proposed insureds

By signing below, the proposed insureds (parent or legal guardian, if proposed insured is under age 16 (18 in Quebec)) authorize:

- any health care professional, physician, hospital, clinic or medically-related facility, insurance company, investigation agencies, MIB, LLC or other organization, institution or person, including the members of the Sun Life group of companies, which includes this company, that have records or knowledge 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,
- Sun Life to disclose to their regular physician, health care professional or any other physician indicated by them, the underwriting decision on this application for insurance;
- the performance of such examinations, electrocardiograms, blood profiles, and tests for HIV (AIDS) antibody and hepatitis, if needed to underwrite this application, and
- the company to release only the necessary personal information obtained during the underwriting process to their personal physician, to MIB, LLC, 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.

Signed in	Signed on (dd-mm-yyyy)	Applicant (indicate title of signing officers if applicable) X
Signed in	Signed on (dd-mm-yyyy)	Applicant (indicate title of signing officers if applicable) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (if other than applicant) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (if other than applicant or if under 16 [18 in Quebec] signature of parent or guardian) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured (spouse covered under spousal group conversion) X
Signed in	Signed on (dd-mm-yyyy)	Proposed insured to be covered under CTB (if over 16 [18 in Quebec]) X
Signed in	Signed on (dd-mm-yyyy)	PAC payor (if other than applicant or proposed insured) X
Signed in	Signed on (dd-mm-yyyy)	PAC payor (if other than applicant or proposed insured) X

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

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Payment information

Payment made with this application	Future payment frequency	Amount of future periodic payments
$	☐ Yearly ☐ Monthly ☐ Quarterly (Bermuda only)	$

Mailing information

Is the mailing address different from the residential address? ☐ Yes ☐ No

Address (street number and name)			
City	Province/State	Country	Postal/Zip code

Advisor information

Note: Shares must be a minimum of 10%.

Is commission being shared? ☐ Yes ☐ No

First name of lead service advisor	Last name	Code	Share	Office
First name of advisor sharing commission	Last name	Code	Share	Office
		Total share	%	

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

Are you related to the people to be insured and/or applicant(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

About the proposed insured(s)

Person 1

Did you meet with the proposed insured in person? ☐ Yes ☐ No

If '**no**' provide details

How long have you known the proposed insured?

Person 2

Did you meet with the proposed insured in person? ☐ Yes ☐ No

If '**no**' provide details

How long have you known the proposed insured?

AGTSTMTE

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Advisor report

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

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

- if photo identification was used to verify identity, all of the identification details provided in this application match the authentic government photo identification document shown to me in person face-to-face;
- if dual process was used to verify identity, the information I referred to was valid and current and came from 2 different reliable sources. The information referred to matched that of the applicant/owner/ sole proprietor;
- I have disclosed to each applicant that I am an independent advisor that has a contract to sell products issued by Sun Life Assurance Company of Canada, and I have also identified any other companies I represent;
- I have disclosed to each applicant that I will receive compensation in the form of commissions or salary for the sale of life and health insurance products;
- I have disclosed to each applicant that I may also receive additional compensation in the form of bonuses or non-monetary benefits such as travel incentives or attendance at conferences;
- I have disclosed to each applicant any conflicts of interest that I may have with respect to this transaction; and
- I am licensed in the province in which this application was completed and this signature page was signed.

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

By signing below, if applicable (see the Licensed administrative assistant's declaration section). I the advisor, also confirm that:

- I have reviewed the details provided in this application with each applicant/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the Client face-to-face, or in a non-face-to-face meeting via video conference;
- it has all the facts material to the insurance applied for; and
- I saw every person sign this application or I initiated remote signing.

Advisor's first name	Middle initial	Last name

Office	Advisor code	E-mail address

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

Notes:

- If you are not able to make a third party determination but have reasonable grounds to suspect that a third party is involved, describe the reason(s) why you suspect a third party involvement by emailing *money.laundering@sunlife.com*.
- If there are reasonable grounds to suspect there is an undisclosed PEP or HIO involved, email details to *money.laundering@sunlife.com*.

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Licensed administrative assistant's declaration

Did a licensed administrative assistant complete the application (excluding the Identity verification section)? ☐ Yes ☐ No

By signing below, I the licensed administrative assistant, confirm that:

- I have reviewed the details provided in this application with each applicant/sole proprietor, proposed insured and PAC payor;
- to the best of my knowledge, all details in this application are complete, true and given to me by the Client face-to-face, or in a non-face-to-face meeting via video conference;
- it has all the facts material to the insurance applied for; and
- I saw every person sign this application or I initiated remote signing.

Licensed administrative assistant's first name	Middle initial	Last name

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

Note: Please only submit one copy of this document.

- Sun Life advisors: Original or fax toll-free to 1-866-487-4745.
- All others: Through your MGA or National Account.

Policy number

Important information you should know

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

Sun Life Privacy Statement for Canada

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

Access to your information

We or our reinsurers may also submit a brief report of our findings to the MIB, LLC (MIB), a not-for-profit organization which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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, upon request, will supply such company with the information in its file.

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, LLC, you may visit the website at *www.mib.com*, call **866-692-6901** or write to:
MIB, LLC
50 Braintree Hill Park
Suite 400
Braintree, MA 02184- 8734

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

About Sun Life

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

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

ADMIN1E

Policy number