

Please PRINT Clearly

Use this form to apply for Portable Optional Group Term Life and Accidental Death and Dismemberment (AD&D) insurance. Please complete sections 1 through 5, read the acknowledgment, and sign and date the form. Mail the completed form, a copy of your Portability Notice, and a check for the first premium, in the envelope provided in the Portability Kit (if available) to: Sun Life Assurance Company of Canada, Group Life Portability, SC 1219, One Sun Life Executive Park, Wellesley Hills, MA 02481. Questions about Portability? Please call our Customer Service Center at 1-800-247-6875.

## 1 General Information

Rates will increase when you reach a new age band. See page 5 of the Portability Kit for rates and age bands.

### Information about the person being insured

Your name (first, middle initial, last)			Date of birth (m/d/y)		
Residence address (street number & name, apartment or suite) City				State	Zip
Social Security Number		Work phone number		Home phone number	

### Information about the qualifying group policy

Name of group policyholder (i.e. your employer or plan administrator)	Policy number
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## 2 Coverage Amounts

See Section 3 of the Portability Notice for the amount of Life Insurance you are eligible to apply for.\* You may keep the current amount of Optional coverage you had with your prior employer, or decrease coverage.

If your prior coverage included an Accidental Death and Dismemberment (AD&D) benefit, your selections at right will apply to Optional AD&D as well.

To apply for spouse and child coverage, you must apply for continued coverage for yourself.

\*Subject to a policy maximum of \$500,000.

### For yourself

Employee coverage amount (check one and write in amount):

<input type="checkbox"/> Current amount: \$	<input type="checkbox"/> Decrease to: \$
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### For your spouse

During your employment with your prior employer, did you purchase Optional Life coverage for your spouse? If yes, you are eligible to apply for spouse coverage. Please provide your spouse's information below and write in the amount of spouse coverage you wish to apply for:

Spouse coverage amount (check one and write in amount)		
<input type="checkbox"/> Current amount: \$	<input type="checkbox"/> Decrease to: \$	
Spouse name (first, middle initial, last)	Social Security number	Date of birth (m/d/y)

### For your children

During your employment with your prior employer, did you purchase Optional Life coverage for your eligible dependent child(ren)? If yes, and you want to apply for coverage, please provide their names and dates of birth below. Write in the amount of coverage you wish to apply for. If you need additional space, check here  and attach a separate sheet.

Child coverage amount (Check one & write in amount. All children receive the same amount of coverage.)		
<input type="checkbox"/> Current amount: \$	<input type="checkbox"/> Decrease to: \$	
Child name (first, middle initial, last)	Social Security Number	Date of birth (m/d/y)
Child name (first, middle initial, last)	Social Security Number	Date of birth (m/d/y)

### Premium payment

\$	How would you prefer to pay premiums?		
	<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-annually	<input type="checkbox"/> Quarterly

**3 Health Questions**

Please complete the questions at right. If you answer "yes" to any, please provide details in the comments section. If you need additional space, check here  and attach a separate sheet.

	Employee	Spouse	Child
1. In the last 12 months, have you been refused life insurance? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past five years, have you had, or been treated by a member of the medical profession for, any of the following?			
a) Cancer .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Heart disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past five years, have you been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been hospitalized in the last 3 years? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Comments:	<div style="border: 1px solid black; height: 30px;"></div>		

**4 Beneficiary Designation**

If you do not name a beneficiary or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

Proceeds for the loss of a covered family member will be paid to you.

Under Secondary Beneficiaries, list the individuals who should receive proceeds only if ALL of your Primary Beneficiaries are not living at the time of your death.

On the lines below, list the individual(s) who you want to receive Portable Optional Life Insurance proceeds in the event of your death. You may specify as many individuals as you like, but the total shares must equal 100% for your Primary Beneficiaries and 100% for your Secondary Beneficiaries. If you need additional space, check here  and attach a separate sheet.

**Primary Beneficiaries**

Name (first, middle initial, last)	Address (street, city, state, zip)	Social Security Number	Relationship to the person being insured	Percent share of proceeds
1.				%
2.				%
<b>Total = 100%</b>				

**Secondary Beneficiaries**

Name (first, middle initial, last)	Address (street, city, state, zip)	Social Security Number	Relationship to the person being insured	Percent share of proceeds
1.				%
2.				%
<b>Total = 100%</b>				

**5 Acknowledgment and Signature**

To begin processing of your portable coverage, Sun Life Assurance Company of Canada must receive this signed Application, any other required documentation, and your first premium payment within 60 days of your termination date.

**You must read and sign to apply for coverage.**

I/We understand and agree that: (1) The answers and statements in this Application will be the basis for and become part of any insurance certificate issued as a result of this Application. (2) The certificate issued will replace the coverage provided by the qualifying group policy indicated in Section 1 of this Application. (3) No insurance requested in this Application will be effective until Sun Life Assurance Company of Canada approves this Application.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I/We declare that the information provided in this Application is complete and true to the best of my/our knowledge and belief.

Signature of employee X	Today's date
Signature of spouse (if also applying for coverage) X	Today's date