Sun Life Assurance Company of Canada
Sun Life Assurance Company of Canada (U.S.)

(Hereinafter referred to as "the Company")
One Sun Life Executive Park, Wellesley Hills, MA 02481

Part II of Application for Life Insurance

Sun Life Financial℠

1. Name of Proposed Insured	Application Number

Please provide full details for all "Yes" answers on Page 2.

2. Are you being treated by diet, drugs or other means? ☐ Yes ☐ No

3. Have you ever had, been told you have or been treated by a physician for:
   a. High blood pressure, chest discomfort, stroke, circulatory or heart disorder? ☐ Yes ☐ No
   b. Diabetes, sugar in the urine, thyroid, or other glandular (endocrine) disorder? ☐ Yes ☐ No
   c. Kidney, bladder, urinary, reproductive organ or prostate disorder? ☐ Yes ☐ No
   d. Protein (albumin), blood or pus in the urine, sexually transmitted disease or venereal disease? ☐ Yes ☐ No
   e. Cancer, tumor, polyp, or disorder of the skin or breast? ☐ Yes ☐ No
   f. Asthma, pneumonia, emphysema, or any other respiratory or lung disorder? ☐ Yes ☐ No
   g. Seizure, convulsion, fainting, loss of consciousness, tremor, paralysis, or other disorder of the nervous system? ☐ Yes ☐ No
   h. Anxiety, depression, stress or any psychological or emotional condition or disorder? ☐ Yes ☐ No
   i. Colitis, hepatitis, ulcers, or other disorders of the stomach, liver or digestive system? ☐ Yes ☐ No
   j. Arthritis, gout, back or joint pain, bone fracture, or muscle disorder? ☐ Yes ☐ No
   k. Anemia, bleeding, or blood disorder? ☐ Yes ☐ No
   l. Have you ever been told by a physician that you have, or have you been treated by a physician for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
   m. A positive blood test for antibodies to the AIDS (HIV) virus? ☐ Yes ☐ No

4. Have you:
   a. Regularly used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician? ☐ Yes ☐ No
   b. Been treated or counseled for alcoholism or drug abuse? ☐ Yes ☐ No
   c. Been advised to reduce your consumption of alcohol? ☐ Yes ☐ No

5. Do you have any health symptoms for which a physician has not been consulted or treatment received? For example, persistent fever, unexplained weight loss, loss of appetite, pain or swelling? ☐ Yes ☐ No

6. Other than previously stated, have you within the past five years:
   a. Consulted a physician or any other practitioner, had a checkup, illness, surgery or been hospitalized? ☐ Yes ☐ No
   b. Had an electrocardiogram, stress or exercise test, x-ray, blood test or other diagnostic test? ☐ Yes ☐ No
   c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed? ☐ Yes ☐ No

7. Have any of your parents, brothers or sisters had diabetes, heart disease or high blood pressure? ☐ Yes ☐ No

8. Family History

	Age(s) if Living	Age(s) at Death	State of Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Please provide full details for all "Yes" answers. (Include the dates, the results and the names and addresses of all attending physicians and medical facilities.)

Question	Details

I declare that I have made no statement to the medical examiner, agent, or any other person connected with the Company which in any way qualifies or modifies the above answers which I have read and confirm to be full and true to the best of my knowledge and belief. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

Signed at

City/State	Date (m/d/y)

Signature of Person proposed for Insurance	in presence of (Medical or paramedical examiner will please sign here)
X	X

Medical Report on Proposed Insured

Name	Birth Date (m/d/y)	Age

Name of Agent	Sales Office

Place of examination: ☐ My office ☐ Applicant's place of business Time _____ ☐ A.M. ☐ P.M.
☐ Applicant's residence ☐ Elsewhere

Please answer all questions as fully and carefully as possible and mail or deliver the report as indicated on Page 4.

9. Have you attended the applicant professionally? If so, for what and when? (Details on Page 4) ..... ☐ Yes ☐ No

10. Height: (In shoes) _____ ft. _____ ins. Weight: (In clothing) _____ lbs.
Have you measured him/her? ..... ☐ Yes ☐ No
Have you weighed him/her? ..... ☐ Yes ☐ No
Change in weight: ☐ No change ☐ Gain ☐ Loss _____ lbs. Reason for change: _____
Circumference of chest. In full inspiration: _____ In forced expiration: _____ Measure around abdomen: _____

11. Blood pressures. If the initial reading exceeds 140/90, read it again later and record all the readings in the order they were taken.

	(1)	(2)	(3)	Any history of hypertension? ☐ Yes ☐ No
Systolic				
Diastolic				Pulse Rate

12. a. Has the applicant used tobacco, (cigarettes, cigars, chewing tobacco, etc.) or products containing nicotine (nicorette gum, nicotine patch, etc.) within the past 12 months? ..... ☐ Yes ☐ No
b. Has the applicant used tobacco or nicotine products in the past and stopped? ..... ☐ Yes ☐ No
If yes, date stopped: _____

Questions 13-15 to be filled out only if exam is performed by a medical examiner.

Please give details of questions answered "Yes" on Page 4.

13. Is there any abnormality:
a. Of the oral cavity, eyes, ears, skin (including xanthelasma, xanthomata, arcus senilis)? ..... ☐ Yes ☐ No
b. Of the lymph nodes or the thyroid gland? ..... ☐ Yes ☐ No
c. Of chest, spine or extremities? ..... ☐ Yes ☐ No
d. Of lungs on percussion and auscultation? ..... ☐ Yes ☐ No
e. Of the heart with respect to size and sounds? ..... ☐ Yes ☐ No

14. Is there:
a. Edema of the ankles? ..... ☐ Yes ☐ No
b. Intra-abdominal abnormality (enlarged liver, palpable spleen, palpable mass)? ..... ☐ Yes ☐ No
c. Any surgical scar? ..... ☐ Yes ☐ No
d. A hernia? If so, describe. ..... ☐ Yes ☐ No
e. Abnormality of the nervous system (muscular power, reflexes, etc.)? ..... ☐ Yes ☐ No
f. Inequality or inadequacy of the pulsations of the femoral, dorsalis pedis and posterial tibial arteries? ... ☐ Yes ☐ No

15. a. Describe general appearance, e.g. vigorous and healthy, pale, sickly, etc.

b. Reviewing all the features, please give your medical diagnosis: ☐ Healthy and unimpaired ☐ Other (clarify)

Supplemental questions to be answered by examiner on applicants age 70 and over.

16. Did the Proposed Insured require any assistance, either by device (cane, walker, wheel chair, etc.) or third party, to arrive at and participate in this examination? ☐ Yes ☐ No

17. Did the Proposed Insured require any assistance from a third party to understand and answer the questions from this exam? ☐ Yes ☐ No

18. Does the Proposed Insured display any signs or symptoms of confusion, dementia or memory loss? ☐ Yes ☐ No

19. Does the Proposed Insured understand that this exam is related to the purchase of a life insurance policy on his or her life? ☐ Yes ☐ No

Please give details of questions answered "Yes."

Question	Details

N.B. If you are aware of any additional facts, please submit them by private letter to the Medical Director at Sun Life Financial's U.S. Headquarters. Your letter will be held in strict confidence.

N.B. If you are not a regular examiner for this company, please state:

Signed at

City/State	Date (m/d/y)

Signature of Medical or Paramedical Examiner X	My fee for this report is $
Medical School (if applicable)	
Your Address	

Identification To be filled out only if exam is performed by a paramedical examiner.

Proposed Insured Must Show Acceptable Form of Identification:

☐ Driver's License ☐ Employment I.D. ☐ Passport ☐ Green card ☐ Other picture/signature I.D.

In my opinion, the item checked is positive identification of proposed insured. ..... ☐ Yes ☐ No*

Proposed Insured speaks and understands the English language..... ☐ Yes ☐ No*

*If either question answered "No," give details of negative reply:

MAIL/DELIVER IN SEALED ENVELOPE TO GENERAL AGENT OR MEDICAL DIRECTOR, SUN LIFE FINANCIAL, WELLESLEY HILLS, MA 02481.

Sun Life Assurance Company of Canada
Sun Life Assurance Company of Canada (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481
(800) SUN-LIFE

Sun Life Financial℠

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (Sun Life of Canada) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result
The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result
If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address _____

In the event the test is positive and you are denied coverage because of the fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent
I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Name of Proposed Insured Signature of Proposed Insured or Parent/Guardian

_____
Date Signed:

_____
Address