

SUBMISSION CHECKLIST FOR NEW BUSINESS

Sun Life Assurance Company of Canada Singapore Branch ("Sun Life Singapore")

IMPORTANT NOTES

- The Application Form is valid for 6 months from the earlier signature date of the Proposed Insured or Proposed Owner
- Proposed Insured's health details are valid for 6 months
- Any changes made on this form must be initialed and dated by the individual completing the section
- Sun Life Singapore reserves the right to seek further clarification or request additional documents in relation to any information provided in the Application Form

MANDATORY DOCUMENTS

- Application Form
- Policy Illustration including Product Summary
- Accredited Investor Form / Fact Find Form
- Please submit a certified true copy of the following documents for Proposed Insured, Proposed Owner, Third Party Payor and Beneficial Owner
 - Government issued proof of identity; and
 - Proof of Residential Address ("PORA") dated within the past 6 months matching the residential address stated on this form
- [Declaration of Corporation Form](#) or [Declaration of Trustee Form](#) (if applicable)

SUPPLEMENTARY DOCUMENTS

Please refer to the last [page](#) of this packet.

APPLICATION FORM

Sun Life Assurance Company of Canada Singapore Branch ("Sun Life Singapore")

WARNING

UNDER SECTION 23(5) OF THE INSURANCE ACT 1966, OR ANY FUTURE AMENDMENT TO IT, YOU ARE TO DISCLOSE IN THIS PROPOSAL FORM FULLY AND FAITHFULLY ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

Distributor name
Financial Advisory Representative's full name ("Representative")

SECTION A PROPOSED INSURED – PERSONAL DETAILS

1	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Mdm <input type="checkbox"/> Miss <input type="checkbox"/> Other	Family Name / Surname / Last Name (including Suffix) as appears on ID / Passport
	Given Name / First Name as appears on ID / Passport	
2	Are you / have you been known by any former name, maiden name, alias, or western name? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the other name(s)	
3	Name as you wish it to appear in future correspondence (if different from above)	
4	Date of Birth (dd-mmm-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
5	Country of Birth	Nationality
6	List all countries where you hold a current passport, long term visa, national ID, permanent resident status or work permit	
7	Email Address (mandatory – This email address will be the email address through which we accept instructions and signed documents, as relevant, from you, without further reference to you, unless you instruct us otherwise in writing.)	
8	Contact Number (mandatory) Country Code + Area Code Mobile Number	

SECTION A PROPOSED INSURED – PERSONAL DETAILS (continued)

9	Residential Address	
	City	State / Province
	Country	Postal Code
10	Mailing Address (if different from Residential Address)	
	City	State / Province
	Country	Postal Code
11	Have you lived in your current country of residence for the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please provide all your countries of residence for the past 10 years	
	Country	Length of Residence (mm/yyyy to mm/yyyy)
		to
		to
		to
12	Do you plan to live outside your current country of residence within the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details	
	City	
	Country	
	Reason for your change in residence	
	Planned length of stay in the new country (mm/yyyy to mm/yyyy) to	
	Do you plan to return to your current country of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please provide the City and Country you plan to live in	
	City	
	Country	

SECTION B PROPOSED OWNER (INDIVIDUAL) – IF DIFFERENT FROM PROPOSED INSURED

1	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Mdm <input type="checkbox"/> Miss <input type="checkbox"/> Other	Family Name / Surname / Last Name (including Suffix) as appears on ID / Passport
	Given Name / First Name as appears on ID / Passport	
2	Are you / have you been known by any former name, maiden name, alias, or western name? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the other name(s)	
3	Name as you wish it to appear in future correspondence (if different from above)	
4	Date of Birth (dd-mmm-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
5	Country of Birth	Nationality
6	List all countries where you hold a current passport, long term visa, national ID, permanent resident status or work permit	
7	Email Address (mandatory – This email address will be the email address through which we accept instructions and signed documents, as relevant, from you, without further reference to you, unless you instruct us otherwise in writing.)	
8	Contact Number (mandatory)	
	Country Code +	Area Code Mobile Number
9	Residential Address	
	City	State / Province
	Country	Postal Code
10	Mailing Address (if different from Residential Address)	
	City	State / Province
	Country	Postal Code

SECTION B PROPOSED OWNER (INDIVIDUAL) – IF DIFFERENT FROM PROPOSED INSURED (continued)

11	Have you lived in your current country of residence for the past 10 years? If "No," please provide all your countries of residence for the past 10 years		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Country	Length of Residence (mm/yyyy to mm/yyyy)	
		to	
		to	
		to	
12	Name of Business / Employer	Location of Business / Employer	
13	Job Title	Job Duties	
14	Nature of Business / Industry (e.g. Manufacturing, Hospitality, etc.)		
15	For Private Investor/Shareholder of Single Family Office, please indicate your investment portfolio includes which of the following:		
	<input type="checkbox"/> Equities and/or bonds <input type="checkbox"/> Cryptocurrencies <input type="checkbox"/> Real estate including rental income		
	<input type="checkbox"/> Venture capital funding into company(ies). Please provide name of company(ies) and type of industry:		

	<input type="checkbox"/> If others, please provide details:		

16	Are you a Business Owner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
17	In the past 5 years, have you been subject to any bankruptcy order or proceedings? If "Yes," please provide details		<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Source of Wealth		
	<input type="checkbox"/> Business or Trade Income <input type="checkbox"/> Inheritance and Gifts <input type="checkbox"/> Investment <input type="checkbox"/> Salary <input type="checkbox"/> Sales of Assets		
	<input type="checkbox"/> Others _____		
19	Annual Income		
	US\$		
20	Relationship with Proposed Insured		
	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Others _____		

SECTION C PROPOSED OWNER (CORPORATION / ENTITY/ TRUST)

If the Proposed Owner is a legal entity, please complete this section and the Declaration of Corporation Form (for Corporation / Entity) or Declaration of Trustee Form (for Trust).

1	Full Legal Name	
2	Registered Address	
	City	State / Province
	Country	Postal Code
3	Mailing Address (if different from Registered Address)	
	City	State / Province
	Country	Postal Code
4	Email Address (mandatory – This email address will be the email address through which we accept instructions and signed documents, as relevant, from you, without further reference to you, unless you instruct us otherwise in writing.)	
5	Contact Number (mandatory)	
	Country Code +	Area Code Mobile Number
6	Relationship with Proposed Insured <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Others _____	

SECTION D BENEFICIAL OWNER DETAILS

For the avoidance of doubt, this is NOT a nomination of beneficiary(ies) under the Policy.

A beneficial owner is defined as the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established, and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

Is there a Beneficial Owner(s) associated with this application? Yes No

If "Yes," please complete the questions below. If there is more than one Beneficial Owner associated with this application, please complete and submit a copy of this page for all additional Beneficial Owners.

1	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Mdm <input type="checkbox"/> Miss <input type="checkbox"/> Other	Family Name / Surname / Last Name (including Suffix) as appears on ID / Passport
	Given Name / First Name as appears on ID / Passport	
2	Are you / have you been known by any former name, maiden name, alias, or western name? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the other name(s)	
3	Date of Birth (dd-mmm-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
4	Country of Birth	Nationality
5	List all countries where you hold a current passport, long term visa, national ID, permanent resident status or work permit	
6	Residential Address	
	City	State / Province
	Country	Postal Code
7	Source of Wealth <input type="checkbox"/> Business or Trade Income <input type="checkbox"/> Inheritance and Gifts <input type="checkbox"/> Investment <input type="checkbox"/> Salary <input type="checkbox"/> Sales of Assets <input type="checkbox"/> Others _____	
8	Relationship with Proposed Insured / Owner	

SECTION E THIRD PARTY PAYOR DETAILS

Complete if not the Proposed Insured / Proposed Owner.

1	<input type="checkbox"/> The Third Party Payor is an Individual <input type="checkbox"/> The Third Party Payor is a legal Entity / Trust Name of Entity / Trust: _____
2	Relationship with Proposed Insured / Owner
3	Reason for making payment for Proposed Insured / Owner

Individual Payor

4	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Mdm <input type="checkbox"/> Miss <input type="checkbox"/> Other	Family Name / Surname / Last Name (including Suffix) as appears on ID / Passport
	Given Name / First Name as appears on ID / Passport	
5	Are you / have you been known by any former name, maiden name, alias, or western name? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the other name(s)	
6	Date of Birth (dd-mmm-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
7	Country of Birth	Nationality
8	List all countries where you hold a current passport, long term visa, national ID, permanent resident status or work permit	
9	Residential Address	
	City	State / Province
	Country	Postal Code
10	Name of Business / Employer	Location of Business / Employer
11	Job Title	Job Duties

SECTION E THIRD PARTY PAYOR DETAILS (continued)

12	Nature of Business / Industry (e.g. Manufacturing, Hospitality, etc.)		
13	<p>For Private Investor/Shareholder of Single Family Office, please indicate your investment portfolio includes which of the following:</p> <p><input type="checkbox"/> Equities and/or bonds <input type="checkbox"/> Cryptocurrencies <input type="checkbox"/> Real estate including rental income</p> <p><input type="checkbox"/> Venture capital funding into company(ies). Please provide name of company(ies) and type of industry:</p> <p>_____</p> <p><input type="checkbox"/> If others, please provide details:</p> <p>_____</p>		
14	Are you a Business Owner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
15	In the past 5 years, have you been subject to any bankruptcy order or proceedings? If "Yes," please provide details		<input type="checkbox"/> Yes <input type="checkbox"/> No
16	<p>Source of Wealth</p> <p><input type="checkbox"/> Business or Trade Income <input type="checkbox"/> Inheritance and Gifts <input type="checkbox"/> Investment <input type="checkbox"/> Salary <input type="checkbox"/> Sales of Assets</p> <p><input type="checkbox"/> Others _____</p>		
17	Annual Income US\$		

Entity Payor

18	Name of Entity		
19	Incorporation/Registration Number	Date of Formation (dd-mmm-yyyy)	
20	Country of Incorporation / Registration		
21	Registered Address		
	City	State / Province	
	Country	Postal Code	
22	Nature of Business Activity ((Manufacturing, Hospitality, Family Office, Investment Holding Company, etc.)		

SECTION E THIRD PARTY PAYOR DETAILS (continued)

23	For Family Offices, please indicate your investment portfolio includes which of the following: <input type="checkbox"/> Equities and/or bonds <input type="checkbox"/> Cryptocurrencies <input type="checkbox"/> Real estate including rental income <input type="checkbox"/> Venture capital funding into company(ies). Please provide name of company(ies) and type of industry: _____ <input type="checkbox"/> If others, please provide details: _____
24	Source of Wealth (This refers to the origin of the entire body of wealth i.e. total assets. How are the assets being accumulated?) <input type="checkbox"/> Operating Income <input type="checkbox"/> Investments <input type="checkbox"/> If others, please provide details: _____

SECTION F PRODUCT AND PREMIUM PAYMENT DETAILS

Product										
Applicable to Non-Participating Whole Life Product										
Sum Assured US\$	Premium* US\$	Premium Payment Term <input type="checkbox"/> Multi Pay 5 Pay <input type="checkbox"/> Multi Pay 10 Pay <input type="checkbox"/> Single Pay <input type="checkbox"/> Single Pay - Split Pay								
*Premium Payment Term of Multi Pay 5 Pay and Multi Pay 10 Pay – please state the annual premium amount. Premium Payment Term of Single Pay and Single Pay - Split Pay – please state the total premium amount.										
Number of Yearly Installment of Legacy Plus Death Benefit Option <input type="checkbox"/> Single Payout <input type="checkbox"/> Yearly Installment If "Yearly Installment" is checked, the number of years must be selected: _____										
Applicable to Indexed Universal Life Product										
Sum Assured US\$	Initial Premium US\$									
Premium Allocation <ul style="list-style-type: none"> Allocation must total 100% and be stated in whole percentages. This premium allocation will remain in effect for the initial premium and all future premiums until we receive further instructions from you to change your premium allocation. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:70%;">Applicable to SunBrilliance IUL II</th> <th style="width:30%;">% (must total 100%)</th> </tr> </thead> <tbody> <tr> <td>Optimum Indexed Account</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Multiplier Indexed Account</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Fixed Account</td> <td style="text-align: center;">%</td> </tr> </tbody> </table>			Applicable to SunBrilliance IUL II	% (must total 100%)	Optimum Indexed Account	%	Multiplier Indexed Account	%	Fixed Account	%
Applicable to SunBrilliance IUL II	% (must total 100%)									
Optimum Indexed Account	%									
Multiplier Indexed Account	%									
Fixed Account	%									
Dollar Cost Averaging (DCA) <input type="checkbox"/> No <ul style="list-style-type: none"> Automatically enrolled unless opt out This DCA option will remain in effect for the initial premium and all future premiums until we receive further instructions from you to change your DCA option 										
Enhanced Cash Value (ECV) Option <input type="checkbox"/> Yes <input type="checkbox"/> No										
Number of Yearly Installment of Legacy Plus Death Benefit Option <input type="checkbox"/> Single Payout <input type="checkbox"/> Yearly Installment If "Yearly Installment" is checked, the number of years must be selected: _____										
Backdate to Save Age <input type="checkbox"/> Yes										
Payment Method <input type="checkbox"/> Cheque or Bank Draft <input type="checkbox"/> Telegraphic Transfer ("TT")										
Source of Funds (please check the relevant box(es)) <input type="checkbox"/> Self <input type="checkbox"/> Spouse / Other Individuals <input type="checkbox"/> Corporations / Entity / Trust										
Purpose of Insurance <input type="checkbox"/> Protection <input type="checkbox"/> Savings <input type="checkbox"/> Investment <input type="checkbox"/> Others _____										

SECTION G PROPOSED INSURED – LIFESTYLE DETAILS

1	Do you participate in hazardous avocations such as auto racing, hang gliding, mountain climbing, scuba diving or other hazardous activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you participate in aviation activities other than as a passenger on scheduled commercial airlines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "Yes" to questions #1 and/or #2, please complete the appropriate questionnaire(s).		
3	Do you have any pending charges, or have you ever been charged with or convicted of any criminal offense, or are you currently on probation, parole or statutory release? If "Yes," please provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you travelled over the past 12 months or plan to travel in the next 12 months? If "Yes," please provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No
Past / Next 12 months		
Period of Visit <input type="checkbox"/> Past 12 months <input type="checkbox"/> Next 12 months		
City / Cities		
Country		
Length of Visit		Frequency of Visits
Period of Visit <input type="checkbox"/> Past 12 months <input type="checkbox"/> Next 12 months		
City / Cities		
Country		
Length of Visit		Frequency of Visits
Period of Visit <input type="checkbox"/> Past 12 months <input type="checkbox"/> Next 12 months		
City / Cities		
Country		
Length of Visit		Frequency of Visits

SECTION H RESIDENCY DETAILS (INDIVIDUAL)

Please complete only <u>one</u> of the columns to the right and only <u>one</u> of the rows below.		Proposed Insured	Proposed Owner (only if Individual)
Singapore Citizen	I confirm that I am currently residing in Singapore <u>AND</u> I have not continuously resided outside of Singapore for the past 5 years preceding the date of this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Permanent Resident, Work Pass or Permit under the Employment of Foreign Manpower Act (Cap. 91A)	I confirm that I have resided in Singapore for 183 days or more in the 12 months preceding the date of this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pass or Permit under the Immigration Act (Cap. 133)	I confirm that my pass / permit has a duration longer than 90 days <u>AND</u> I have continuously resided in Singapore for at least 90 days in the past 12 months preceding the date of this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
None of the Above		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

SECTION I PROPOSED INSURED – HEALTH DETAILS

1	Height centimetres	Weight kilograms
2	Has your weight changed over the past 12 months? If "Yes," please provide details <input type="checkbox"/> Loss of <input type="checkbox"/> Gain of kilograms	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Reason	
3	Have you ever been treated for or had any symptoms or indication of	
a	High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	Anemia, hemophilia, or any other blood or bleeding disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c	Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d	Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e	Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn's disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f	Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g	Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h	Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i	Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION I PROPOSED INSURED – HEALTH DETAILS (continued)

	<p>j Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson’s disease, tremor, Alzheimer’s disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>k Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4</p>	<p>Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5</p>	<p>Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6</p>	<p>Have you ever had a blood transfusion?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7</p>	<p>Other than for conditions already disclosed, in the past 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8</p>	<p>Have you been hospitalized or had any surgery in the past 10 years?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9</p>	<p>Do you have any symptoms for which you have not yet consulted a physician or received treatment?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>10</p>	<p>Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>11</p>	<p>Do you have a deformity or an amputation?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>12</p>	<p>Are you taking any prescribed or non-prescribed medications?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>13</p>	<p>For Adult Females only</p>	
<p>a</p>	<p>Are you now pregnant? If “Yes,” please state: No. of months: _____ Estimated Date of Delivery: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>b</p>	<p>Have you ever had any complications of pregnancy during gestation (e.g. ectopic pregnancy, abortion, disseminated intravascular coagulation, gestational diabetes, hypertension, protein in urine, etc.)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>14</p>	<p>For Minors below 5 years old, please answer these questions</p>	
<p>a</p>	<p>Was the child born prematurely (less than 37 weeks of gestation) or with birth / congenital defects?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>b</p>	<p>Has the child failed to meet any neurological or developmental milestones?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>c</p>	<p>Has the child required any follow up or investigation for birth defects, congenital disorders or deformities, physical impairment, or delayed development?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>d</p>	<p>In the past 5 years, has the child used any medication on a daily basis for over 21 days?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION I PROPOSED INSURED – HEALTH DETAILS (continued)

15	If you answered "Yes" to <u>any</u> of the above questions #3 through #14, please provide details		
Question Number	Date of Occurrence (mm/yyyy)	Details (diagnosis, tests, treatment, frequency/severity of symptoms, date of last symptoms)	Name and Address of Doctors, Medical Clinics or Hospitals

16	Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vaping, marijuana, nicotine patches, nicotine gum, hookah or shisha)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Product(s)	Amount(s)	Frequency of Use

17	In the past 10 years, have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Product(s)	Amount(s)	Frequency of Use

18	Do you currently drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Average Frequency of Consumption <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once per month		
	On those days when you drink alcohol, how many drinks do you typically have?		

SECTION I PROPOSED INSURED – HEALTH DETAILS (continued)

19 Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counselling or medical advice or participated in any organizations / support groups due to your use of drugs or alcohol? Yes No
If "Yes," please provide details

Type of Counselling, Treatments, and/or Participation in Organizations / Support Groups	Start Date (mm/yyyy)	End Date (mm/yyyy)

20 Please complete the following table

Relationship to You	Current Age	Or Age at Death	Cause of Death
Father			
Mother			
Sibling(s)			
Sibling(s)			
Sibling(s)			

21 Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder not recorded in question #20? Yes No
If "Yes," please provide details

Relationship to You	Condition (if cancer include type)	Age at Onset	Age if Living	Age at Death

SECTION I PROPOSED INSURED – HEALTH DETAILS (continued)

22	Do you have any regular doctor, attending physician and / or specialist doctor? If "Yes," please provide details below	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Doctor / Attending Physician		
Name of Medical Clinic or Hospital		
Full Address of Medical Clinic or Hospital		
Your Name on the Record (if different from name on ID / Passport)		Date of Last Consultation (dd-mmm-yyyy)
Reason for Last Medical Consultation		
Treatment or Medication Prescribed		
Tests Performed and Results of All Tests		
If you do not have a regular doctor or any health care advisor, please provide the details regarding your last consultation with any doctor, health care provider at a medical clinic, or hospital		
Name of Doctor / Health Care Provider		
Name of Medical Clinic or Hospital		
Full Address of Medical Clinic or Hospital		
Your Name on the Record (if different from name on ID / Passport)		Date of Last Consultation (dd-mmm-yyyy)
Reason for Last Medical Consultation		
Treatment or Medication Prescribed		
Tests Performed and Results of All Tests		

SECTION J PROPOSED INSURED – LIFE INSURANCE DETAILS

1	Do you have any inforce life insurance, pending applications or plan to apply for additional life insurance in <input type="checkbox"/> Yes <input type="checkbox"/> No Singapore and any country? If "Yes," please provide details	
Name of Insurer		
Status of Policy / Application <input type="checkbox"/> Inforce Policy <input type="checkbox"/> Future Application <input type="checkbox"/> Pending Application		
Type of Policy / Application <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____		
Amount of Coverage	Policy Issued Year (Inforce Only) (yyyy)	
US\$		
Name of Insurer		
Status of Policy / Application <input type="checkbox"/> Inforce Policy <input type="checkbox"/> Future Application <input type="checkbox"/> Pending Application		
Type of Policy / Application <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____		
Amount of Coverage	Policy Issued Year (Inforce Only) (yyyy)	
US\$		
Name of Insurer		
Status of Policy / Application <input type="checkbox"/> Inforce Policy <input type="checkbox"/> Future Application <input type="checkbox"/> Pending Application		
Type of Policy / Application <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____		
Amount of Coverage	Policy Issued Year (Inforce Only) (yyyy)	
US\$		
Name of Insurer		
Status of Policy / Application <input type="checkbox"/> Inforce Policy <input type="checkbox"/> Future Application <input type="checkbox"/> Pending Application		
Type of Policy / Application <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____		
Amount of Coverage	Policy Issued Year (Inforce Only) (yyyy)	
US\$		

SECTION J PROPOSED INSURED – LIFE INSURANCE DETAILS (continued)

2	Is this insurance application meant to replace any inforce life insurance with any Sun Life company or any other insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details
Name of Insurer	Location of Insurer <input type="checkbox"/> Singapore <input type="checkbox"/> Overseas _____
Type of Policy <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____	
Premium Type <input type="checkbox"/> Regular Pay <input type="checkbox"/> Single Pay <input type="checkbox"/> Flexible Pay	
Amount of Coverage US\$	Year of Issue (yyyy)
Name of Insurer	Location of Insurer <input type="checkbox"/> Singapore <input type="checkbox"/> Overseas _____
Type of Policy <input type="checkbox"/> Term Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Others _____	
Premium Type <input type="checkbox"/> Regular Pay <input type="checkbox"/> Single Pay <input type="checkbox"/> Flexible Pay	
Amount of Coverage US\$	Year of Issue (yyyy)
<p>WARNING</p> <p>Please consult your representative <u>before</u> making a decision to replace an inforce life insurance policy with a new policy.</p> <p>Some disadvantages of replacing an inforce life insurance policy may be:</p> <ul style="list-style-type: none"> a) the new insurance policy may not be granted on standard terms, b) the new insurance policy may result in a lower level of benefit and / or higher cost, c) you may lose financial benefits on your inforce policy built up over the years. <p>The above are non exhaustive. Please make your own assessment and / or refer to your Representative, as relevant, before making a decision.</p>	
3	What is the ultimate total amount to be insured with all companies (include inforce, pending or planning to apply)? US\$

IMPORTANT NOTICE: Full disclosure of all existing life insurance exposure and concurrent applications is a material fact and would influence a prudent Underwriter in accepting or declining a risk or in determining the premium or terms and conditions of the contract. The insurance company reserves the right to void the policy or to decline a claim at all times if:

1. The applicant fails to make full disclosure under Section J Question (1) and (2); or
2. An amount exceeding the declared amount under Section J Question (3) is ultimately placed with all companies at the date of issue of this policy.

SECTION J PROPOSED INSURED – LIFE INSURANCE DETAILS (continued)

4	Have you ever had any inforce policy or prior applications for critical illness, disability, health, life or long term care insurance cancelled, declined, offered with alternate terms / conditions, postponed or premium increased by any insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details
Name of Insurer	
Type of Policy <input type="checkbox"/> Critical Illness <input type="checkbox"/> Disability <input type="checkbox"/> Health <input type="checkbox"/> Life <input type="checkbox"/> Long Term Care	
Decision <input type="checkbox"/> Cancelled <input type="checkbox"/> Declined <input type="checkbox"/> Offered with Alternate Terms / Conditions <input type="checkbox"/> Postponed <input type="checkbox"/> Premium Increased	
Reason for Decision	
Year (yyyy)	
Name of Insurer	
Type of Policy <input type="checkbox"/> Critical Illness <input type="checkbox"/> Disability <input type="checkbox"/> Health <input type="checkbox"/> Life <input type="checkbox"/> Long Term Care	
Decision <input type="checkbox"/> Cancelled <input type="checkbox"/> Declined <input type="checkbox"/> Offered with Alternate Terms / Conditions <input type="checkbox"/> Postponed <input type="checkbox"/> Premium Increased	
Reason for Decision	
Year (yyyy)	
If you are an adult student or minor, please complete Question #5 and #6.	
5	Father Full Name
Amount of Individual Life Insurance Coverage US\$ _____ (Inforce) US\$ _____ (Pending)	
Mother Full Name	
Amount of Individual Life Insurance Coverage US\$ _____ (Inforce) US\$ _____ (Pending)	
6	Are all your siblings equally insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please provide details (amount and reason)

SECTION J PROPOSED INSURED – LIFE INSURANCE DETAILS (continued)

If you are a non-wage earner or homemaker, please complete Question #7.

7	Spouse Full Name		
	Amount of Individual Life Insurance Coverage		
	US\$	(Inforce)	US\$ (Pending)

SECTION K PROPOSED INSURED – FINANCIAL STATEMENT

1	Name of Business / Employer		
2	Job Title	Job Duties	
3	Nature of Business / Industry (e.g. Manufacturing, Hospitality, etc.)		
4	Registered Business Address		
	City	State / Province	
	Country	Postal Code	
5	<p>For Private Investor/Shareholder of Single Family Office, please indicate your investment portfolio includes which of the following:</p> <p><input type="checkbox"/> Equities and/or bonds <input type="checkbox"/> Cryptocurrencies <input type="checkbox"/> Real estate including rental income</p> <p><input type="checkbox"/> Venture capital funding into company(ies). Please provide name of company(ies) and type of industry: _____</p> <p><input type="checkbox"/> If others, please provide details: _____</p>		
6	Business Website Address (please provide website URL)		
7	Are you a Business Owner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8	In the last 5 years, have you been subject to any bankruptcy order or proceedings? If "Yes," please provide details		<input type="checkbox"/> Yes <input type="checkbox"/> No
9	<p>Source of Wealth</p> <p><input type="checkbox"/> Business or Trade Income <input type="checkbox"/> Inheritance and Gifts <input type="checkbox"/> Investment <input type="checkbox"/> Salary <input type="checkbox"/> Sales of Assets</p> <p><input type="checkbox"/> Others _____</p>		

SECTION K PROPOSED INSURED – FINANCIAL STATEMENT (continued)

For Question #10 to #12, if the Proposed Insured is a non-wage earner, homemaker, adult student, or minor, please provide the financial information for their wage earner, spouse or parent.

10	Please provide your annual income details			
	Earned Annual Income	US\$	Unearned Annual Income	US\$
	Salary		Investments (Bonds, Dividends, Interest, etc.)	
	Bonus		Real Estate (Profit from sales of properties, Rental income, etc.)	
	Others		Business (Directorship, LLP, Partnership, Sole-proprietorship, etc.)	
	Others		Others (Gift, Inheritance, etc.)	
	Total Annual Income (Earned + Unearned)			
11	Please provide your assets and liabilities details			
	Assets	US\$	Liabilities	US\$
	Cash and Savings		Personal Loans	
	Stocks and Bonds		Margin Account	
	Value of Business Interest		Loan Guarantees	
	Real Estate		Mortgages	
	Others		Others	
	Total Assets		Total Liabilities	
	Net Worth (Total Assets – Total Liabilities)			

SECTION K PROPOSED INSURED – FINANCIAL STATEMENT (continued)

12	Please provide your financial reference
	Name of Bank / Financial Institution
	Country
	Name of Contact
	Name of Bank / Financial Institution
	Country
	Name of Contact
	Name of Bank / Financial Institution
	Name of Contact

SECTION L FINANCIAL STATEMENT FOR BUSINESS INSURANCE

If the purpose of the insurance is related to business, please complete this section.

1	Purpose of Insurance <input type="checkbox"/> Buy –Sell Agreement <input type="checkbox"/> Credit Coverage <input type="checkbox"/> Key Person <input type="checkbox"/> Others _____
2	Business Structure <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Partnership <input type="checkbox"/> Private Limited Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Others _____
3	Ownership Share in the Business (%)
4	For purpose of Key Person, are other key employees insured or to be insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide their insurance details If "No," please explain why they are not insured

SECTION L FINANCIAL STATEMENT FOR BUSINESS INSURANCE (continued)

5	In the last 5 years, has the business been subject to any bankruptcy order or proceedings? If "Yes," please provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Please provide your balance sheet details	
	Current Year (US\$)	Previous Year (US\$)
	Assets	
	Liabilities	
	Net Worth	
	Gross Income	
	Net Income	
	Market Value	

SECTION M POLITICAL EXPOSED PERSON (PEP) DETAILS

Politically Exposed Person (PEP) is a natural person who is or has been entrusted with prominent public functions in Singapore, a foreign country or an international organisation. Prominent public functions include the roles held by a head of state, a head of government, government ministers, senior civil or public servants, senior judicial or military officials, senior executives of state owned corporations, senior political party officials, members of the legislature and senior management of international organisations.

Is Proposed Insured, Proposed Owner, Payor, Beneficial Owner, Beneficiary or any of your Family member¹ ever been a PEP or a close associate² of a PEP? Yes No

If "Yes," please provide details

Name of PEP
Role of PEP <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Proposed Owner <input type="checkbox"/> Payor <input type="checkbox"/> Beneficial Owner <input type="checkbox"/> Family Member ¹ <input type="checkbox"/> Beneficiary
Designation of PEP
Employer of PEP
Country of PEP
Period Held (yyyy) Start Year End Year
If you are a Family Member, what is your relationship to any of the other role

SECTION M POLITICAL EXPOSED PERSON (PEP) DETAILS (continued)

Name of PEP	
Role of PEP <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Proposed Owner <input type="checkbox"/> Payor <input type="checkbox"/> Beneficial Owner <input type="checkbox"/> Family Member ¹ <input type="checkbox"/> Beneficiary	
Designation of PEP	
Employer of PEP	
Country of PEP	
Period Held (yyyy)	
Start Year	End Year
If you are a Family Member, what is your relationship to any of the other role	

¹ "Family member" means a parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling and adopted sibling.

² "Close associate" means a natural person who is closely connected to a PEP, either socially or professionally.

SECTION N PROPOSED OWNER (INDIVIDUAL) – FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) AND COMMON REPORTING STANDARDS (CRS)

If the Proposed Owner is not an Individual, please complete the U.S. FATCA and OECD CRS Entity Self-Certification Form and do not complete this section.

1	Are you a U.S. Citizen (born or naturalized), a U.S. tax resident based on the substantial presence test, or a U.S. green card holder? <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Do you have a U.S. tax identification number (SSN or ITIN)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide that number
3	Are you a tax resident of Singapore? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide your Singapore tax identification number (TIN)
4	Are you a tax resident of other country(ies) / jurisdiction(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please go to question #6.
5	Please list ALL the country(ies), excluding Singapore, in which you are a tax resident and the associated tax identification number (TIN).
	Country / Jurisdiction of Tax Residency
	TIN
	If TIN is unavailable, provide reason A, B, C or D. If reason D is selected, provide an explanation

SECTION N PROPOSED OWNER (INDIVIDUAL) – FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) AND COMMON REPORTING STANDARDS (CRS) (continued)

	Country / Jurisdiction of Tax Residency
	TIN
	If TIN is unavailable, provide reason A, B, C or D. If reason D is selected, provide an explanation
	Country / Jurisdiction of Tax Residency
	TIN
	If TIN is unavailable, provide reason A, B, C or D. If reason D is selected, provide an explanation
	<p>Reason A – The country where you are liable to pay tax does not issue TINs to its residents.</p> <p>Reason B – You have applied for a TIN or equivalent number. If you select Reason B, you agree to provide Sun Life with your TIN or equivalent number within 30 days of receiving it from the applicable tax authority.</p> <p>Reason C – A TIN is not required to be provided on this form. Note: Select Reason C only if the tax authority of the jurisdiction of tax residence entered on the table has enacted local law which does not require a TIN to be provided for purposes of OECD CRS.</p> <p>Reason D – You have not applied for a TIN or equivalent number, or is unable to obtain a TIN or equivalent number.</p>
6	Please explain if the country of your residential / mailing address or contact number differs from your declared county(ies) /jurisdictions of tax residency
7	Please confirm that the tax residence(s) provided above include all jurisdictions of tax residence applicable to you. <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION O CONSENT AND AUTHORISATION

Each of the Policy Owner and Life Insured ("I") acknowledge and confirm the following, as relevant:

- (i) I have received a copy of the Financial Needs Analysis (if applicable), Cover Page, Policy Illustration, Product Summary and Guide to Life Insurance, (collectively, the "**Documents**") read and understood the Documents, and their contents have been explained to me by my Representative to my satisfaction.
- (ii) I understand and agree that any life insurance coverage provided by Sun Life Assurance Company of Canada Singapore Branch ("**Company**") based on the information contained herein will not become effective until and unless: (a) the Policy is issued during the lifetime of the proposed insured; (b) the relevant Premium is received in good order by the Company; and (c) the statements made in this Application, Medical Questionnaire and any other relevant forms (collectively, the "**Forms**") remain complete and true as of the date the Policy is delivered.
- (iii) No Premium or other consideration has been paid with this application.
- (iv) I understand and agree that the Forms shall be a part of any Policy issued by the Company.
- (v) All information provide by me are accurate and true to the best of my knowledge and belief, represents full disclosure from me of the facts I know or ought to know, and I have the requisite authority to sign the Forms, as relevant.
- (vi) I understand and agree that the Policy will be issued in and governed by the laws of Singapore, construed in accordance with Singapore law and the courts of Singapore shall have exclusive jurisdiction with respect to any and all issues and disputes arising in connection with this application and the Policy.
- (vii) I am not an undischarged bankrupt, have not been served with any bankruptcy application (including statutory demand) nor subjected to any bankruptcy order or similar adjudication by a court of law within the last 12 months.
- (viii) I understand that if I am not a Singapore resident, it is my sole responsibility to ensure that, and by completing and submitting this application I confirm that, I am not in breach or violation of any laws or regulations of the jurisdiction where I am resident (the "Foreign Laws"). I hereby fully indemnify and hold harmless the Company and its officers, employees and representatives against all claims, penalties, losses, damages, expenses (including reasonable legal fees) that may be suffered by any of them in connection with any breach or violation on my part of the Foreign Laws.
- (ix) To the best of my knowledge, any funds to be used for any payment of Premium are not the proceeds of crime and are not intended to facilitate terrorist activities.

SECTION O CONSENT AND AUTHORISATION (continued)

- (x) I am not, and I undertake to ensure that any of my beneficiary and assignee is not, subject to any laws, regulations and/or sanctions administered by any governmental or regulatory bodies, including that which requires the Company to cease to provide any insurance coverage, transact business with or otherwise offer any service or give any economic benefits to me or any beneficiary or assignee or refuse to deal or transact with you, your beneficiary or assignee in any way including but not limited to making payments or receiving payments.
- (xi) I confirm I am not acting on behalf of or at the direction of an undisclosed party.
- (xii) I am responsible for my own tax affairs and acknowledge that I should take advice from a tax expert in the jurisdiction of my tax residence in the event of any doubt or as I deem fit. I hereby declare that I have not been convicted of any serious tax crimes. Serious tax crimes include omissions, falsifications or fraudulent conduct perpetrated with willful intent to evade tax or to assist others in evading tax.
- (xiii) If I am a U.S. person, including U.S. tax resident, pursuant to FATCA and CRS, I acknowledge and agree that the Company makes no representation with respect to the tax compliance and policyholder taxation of the policy under sections 7702 (definition of life insurance) and 7702A (Modified Endowment Contract) of the Code, and I acknowledge and agree that I shall be liable for reporting and remitting the 1% U.S. excise tax that is imposed on policies issued by a non-U.S. insurer under section 4371(2) of the Code.
- (xiv) I acknowledge if the Proposed Insured is classified as a U.S. person pursuant to FATCA and CRS, I agree to report and remit the 1% excise tax imposed under section 4371(2) of the U.S. Internal Revenue Code ("Code") to the Internal Revenue Service in a timely manner.
- (xv) I acknowledge that the Company may request from me further information and/or documents as it deems fit and I agree to provide the same upon request.
- (xvi) I understand that for non-Singapore-dollar policy, the Singapore-dollar return will depend on prevailing exchange rates which may be highly volatile. I acknowledge that the Company does not bear the loss resulting from any currency conversion or the cost of charges incurred on any transaction pertaining to currency conversions.
- (xvii) I understand and agree that the Policy Owner shall be and remain responsible for the payment of the Premiums for the Policy notwithstanding that the Premiums may be paid by another person or entity pursuant to an arrangement between the Policy Owner and such person or entity. Where the Premiums are paid by another person or entity for the Policy Owner, the Company has the right to accept or reject such payment, and require details and documentation relating to such person or entity to be provided.
- (xviii) Where any proceeds under this Policy is paid out by the Company when the Policy Owner is below the age of 18 years, the parent or Legal Guardian's receipt of such proceeds for the Policy Owner shall be a full and sufficient discharge of the Company's obligations. The Company shall have no duty whatsoever now or at the time of payment of any proceeds to (a) see or review any documentation evidencing the parental relationship or guardianship, or (b) make any inquiry concerning the continued existence of any guardianship. I hereby fully indemnify and hold harmless the Company and its officers, employees and representatives against all claims, losses, damages, expenses (including reasonable legal fees) that may be suffered by any of them in this regard.
- (xix) I understand and agree that the Policy applied for shall not take effect unless and until my application is approved and the initial premium specified is received in full. I acknowledge that the Company will rely on the information I have provided when considering whether to accept this Application and the approval of my application is within the sole discretion of the Company. The Company is not obliged to provide any reason or justification in rejecting my application, and such decision of the Company shall be final. Amongst other things, the Company is entitled not to accept or process this application should I be found to be a Prohibited Person, meaning a person or entity (including any director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my behalf or my beneficial owners or beneficiaries' beneficial owners therein) subject to any laws, regulations and/or sanctions administered by any regulatory authorities in any country, which have the effect of prohibiting the Company from providing insurance coverage, transacting business with or otherwise offering any economic benefits to me or any other beneficiary under the relevant Policy, and the decision of the Company shall be final.
- (xx) I further agree that in the event that the Company becomes aware subsequently that I or my assignee have become a Prohibited Person, the Company may block and/or terminate the relevant Policy, including but not limited to, making or receiving any payments under the relevant Policy. As an ongoing obligation, I will immediately inform the Company if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons.
- (xxi) Any document or communication from the Company will be deemed to have been received by me: (i) in the case of personal delivery or courier, at the time of acknowledgement of receipt; (ii) in the case of delivery by registered mail, the third (3rd) Business Day following the evidence of sending; (iii) in the case of post mail, on the seventh (7th) Business Day following sending if the recipient is located locally and the thirtieth (30th) Business Day following sending if the recipient is located overseas; and (iv) in the case of electronic mail or facsimile, at the time of transmission provided the timestamp on the part of the sender shows that such notice has been successfully transmitted, and for this clause, "Business Day" refers to a day when banks in Singapore are open for a full day of business (excluding Saturdays, Sundays and public holidays).
- (xxii) I will notify the Company immediately if there is any change to any of my declarations above.

By signing below, I acknowledge and agree that (i) to the extent required or permitted by laws or regulations applicable to the Company or its corporate parent(s), subsidiaries, or affiliates, the Policy and any person's interest therein may be reported to tax and regulatory authorities in Singapore or other applicable jurisdictions; and (ii) consent for the Company to collect, use, store, disclose and/or transfer my Personal Data (as defined in the Personal Data Protection Act 2012 ("PDPA")) to its corporate parent(s), head office, subsidiaries or affiliates, agents, independent contractors or service providers, actual or potential assignees, novatees, transferees, successors, reinsurers, professional advisors, auditors, courts, tribunals, regulators, supervisory or governmental bodies or authorities, police, banks, financial institutions, credit reference agencies, nominees, stock exchanges, trade repositories, clearing houses, fund managers or administrators, issuers, underwriters, distributors or brokers, any person or entity who or which is entitled to demand or request for the Company to make a disclosure under laws and regulations or to whom it is in the Company's interests to make disclosure to perform its functions or meet its legal regulatory or other obligations, and/or any person or entity that the Company is required by a court or tribunal or regulator or governmental authority to make disclosure, whether in Singapore or elsewhere, for any of the following purposes (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service that the Company may offer; (b) to underwrite an

SECTION O CONSENT AND AUTHORISATION (continued)

application for any such product or service; (c) to administer and/or determine claims, coverage, benefits, and other features of such products or services; (d) to obtain reinsurance; (e) for any other purpose in connection with provision or enhancement of products or services which the Company may provide; (f) in connection with matching any Personal Data with other information in the Company's possession that relates to me; (g) to ensure compliance by the Company of its contractual, legal and regulatory obligations; (h) in connection with legitimate business interest of the Company, including but not limited to market analysis, management reporting, and risk management purposes. I authorise the Company to obtain my medical records (including any document or information arising from or referred to in such records) from any relevant medical source, and to provide my Personal Data to such medical source, as relevant, for the purposes of considering my insurability, whether or not the Company would eventually insure me. I understand that my medical records are a part of my Personal Data. Where I provide the Company with Personal Data of any other individual, I consent that I have obtained the consent(s) from the individual(s) concerned to provide the same to the Company. I shall procure all relevant consents from the individual(s) concerned in respect of the persons to whom his/her Personal Data may be shared and the purposes for which his/her Personal Data may be collected, used, stored, transferred or disclosed, as stated above. I acknowledge and agree that the Company's rights in relation to my Personal Data as set out above shall continue notwithstanding any termination or cessation of any product or service by the Company. I recognise that Personal Data may be transferred out of the jurisdiction from where it was supplied, and that the standard of confidentiality and data protection in different jurisdictions may differ. I hereby waive any rights I may have that would prevent the Company from meeting any of the Company's legal or regulatory requirement. The Company's privacy statement is accessible at <https://www.sunlife.com.sg>

Where the Policy Owner is a Trustee of a trust ("Trust") and the Proposed Insured is a beneficiary or Settlor of the Trust, by signing below, the Proposed Policy Owner confirms that it has satisfied the relevant requirements relating to insurable interest under the Insurance Act 1966 and the Proposed Insured confirms that (s)he agrees to the effecting of the Policy, amongst other things.

Where the Policy Owner and Life Insured are the same person, (s)he may execute the Form only once, on the basis that (s)he is signing below in his/her capacity as Policy Owner and also in his/her capacity as Life Insured, at the same time.

Marketing consent

The Company will send you marketing or promotional information **only if** you instruct us to do so by ticking one or more of the boxes below.

I wish to receive marketing or promotional information from the Company, via the following communication channels

Voice calls* SMS and/or other electronic messaging* Mail Email All of the channels

I do not wish to receive marketing or promotional information from the Company, but I am aware that if my position changes, I can give the Company subsequent written instructions accordingly at any time in the future.

* Where I choose to allow the Company to make voice calls, to provide me with marketing or promotional information, I agree that the Company may do so notwithstanding that I may have placed my telephone number on Singapore's Do Not Call Registry with PDPC, and in this regard I agree to indemnify and hold harmless the Company to the fullest extent permitted under law and regulations.

Signature# of Proposed Owner ¹	
Name of Proposed Owner	
ID / Passport Number	Date (dd-mmm-yyyy)
Signature# of Proposed Insured ²	
Name of Proposed Insured	
ID / Passport Number	Date (dd-mmm-yyyy)

The signature(s) provided on this document shall be taken as the specimen signature of the relevant person, and used for the purposes of our signature verification going forward, unless you instruct us otherwise.

¹ Required if Proposed Owner differs from Proposed Insured. Where the Proposed Owner is an incorporated entity, its authorised signatory(ies) should sign for and on its behalf.

² Where the Proposed Insured is below the age of 16 years, his/her parent/legal guardian should sign and provide identification and/or other documents as required by the Company.

SECTION O CONSENT AND AUTHORISATION (continued)

Signature of Representative	
Name of Representative	
RNF Number	Date (dd-mmm-yyyy)

Sun Life Assurance Company of Canada Singapore Branch
50 Raffles Place, #26-04, Singapore Land Tower
Singapore 048623

Tel: +65 6223 1102 | Website: www.sunlife.com.sg

Sun Life Assurance Company of Canada is an insurance company federally incorporated in Canada, with OSFI Institution Code F380 and its registered office at 1 York Street, Toronto, Ontario, Canada M5J 0B6. It is regulated by Office of the Superintendent of Financial Institutions, Canada. Sun Life Assurance Company of Canada Singapore Branch (UEN T19FC0132B) is registered with the Accounting and Corporate Regulatory Authority of Singapore as a foreign company, with its registered office at 50 Raffles Place, #26-04, Singapore Land Tower, Singapore 048623. It is licensed and regulated by the Monetary Authority of Singapore. Where Sun Life Assurance Company of Canada Singapore Branch is referred to as "Sun Life Singapore," this is strictly for marketing and branding purposes only, and no legal significance is expressed or implied. Sun Life Assurance Company of Canada is a member of the Sun Life group of companies. The Sun Life group of companies operates under the "Sun Life" name. Sun Life Financial Inc., the publicly traded holding company for the Sun Life group of companies, is not a product offering company and is not the guarantor of the obligations of its subsidiaries.

©2025 Sun Life Assurance Company of Canada. All rights reserved.

The name Sun Life and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada.

SUPPLEMENTARY DOCUMENTS FOR NEW BUSINESS

Sun Life Assurance Company of Canada Singapore Branch

Title of Form	When to Use the Form
Aerial Activities Questionnaire	Proposed Insured engages in aerial activities (parachuting, skydiving, paragliding etc.)
Amendment Form	Changes to Application Form, Confidential Medical Questionnaire and other related forms
Attending Physician Statement ("APS")	Retrieval of medical record from medical facility
Authorisation for Release and Disclosure of Health Related Information (HIPAA)	Retrieval of medical record from medical facility located in United States
Authorisation for Release and Disclosure of Psychotherapy Notes (HIPAA)	Retrieval of psychotherapy medical record from medical facility located in United States
Aviation Questionnaire	Proposed Insured engages in aviation activities
Canadian Residency Questionnaire	Proposed Insured with residential connection to Canada
Confidential Medical Questionnaire (CMQ)	Insurance medical examination at approved medical facility
Country Questionnaire	Parties with connection to countries of interest
Identity Verification for Repeat Examination or Tests	<ul style="list-style-type: none"> ▪ Repeat examination or additional tests resulting from Proposed Insured's insurance medical examination ▪ The Examining Physician must complete the form with the Proposed Insured
Insurability Verification	<ul style="list-style-type: none"> ▪ The medical evidence is over 6 months but less than 12 months ▪ A request to increase the sum assured after the offer is given
Interpreter Services Declaration	<ul style="list-style-type: none"> ▪ Proposed Insured requires assistance from an Interpreter ▪ The Interpreter must complete the form with Proposed Insured
Mature Age Questionnaire	<ul style="list-style-type: none"> ▪ Proposed Insured is age 71 years and over ▪ The Examining Physician must complete the form with the Proposed Insured
Motor Racing Questionnaire	Proposed Insured engages in automobile racing, motorcycle racing, powerboat racing activities
Mountain Climbing Questionnaire	Proposed Insured engages in climbing activities
Supplementary Form for Offshore Residents	Proposed Owner is an Offshore resident for Non-Face-to-Face/Remote Process
Underwater Diving Questionnaire	Proposed Insured engages in diving activities