Filing at a Glance

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

Product Name: UND 14-200 and UND 14-271	SERFF Tr Num: SUNL-126312855	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43605
Sub-TOI: L08.000 Life - Other	Co Tr Num: UND 14-200 AND UND 14-271	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Margaret Carvalho, Thomas Miele, Christopher McAuliffe, Pat Squillacioti	Disposition Date: 09/29/2009
	Date Submitted: 09/25/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UND 14-200 and UND 14-271
Project Number: UND 14-200 and UND 14-271
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 09/29/2009

Deemer Date:
Submitted By: Margaret Carvalho

Filing Description:
NAIC # 549-79065
FEIN # 04-2461439

Re: UND 14-200 – Application

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: Pending with our state of domiciliary of Delaware.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 09/29/2009
Created By: Pat Squillacioti
Corresponding Filing Tracking Number: UND 14-200 and UND 14-271

UND 14-271 – Application

Dear Sir or Madam:

We submit the above listed forms for your review and approval. These form are new and do not replace any other forms previously approved by your Department. They are submitted in final printed form and subject only to minor modifications in paper stock, ink, and adaptation to computer printing.

These forms are intended to comply with all laws, rules, bulletins and published guidelines applicable to these forms. They have been filed and are pending with our domiciliary state of Delaware.

UND 14-200 – Application for Reinstatement & Contractual Policy Changes
This application will be used along with our previously approved life insurance policies by existing policyholders who elect to reinstate their policy or to make a change to one of their previous designations.

UND 14-271 – Certificate of Insurability Application Supplement
This application will be used to update an applicant's insurability when the Application Part II (Medical Evidence) is older than 90 days.

The enclosed forms include brackets around the items that may vary. The bracketed items shown are the values that will currently print for each respective form. The use of variability in the enclosed forms will be administered as described in the enclosed Memorandums of Variability and in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

The enclosed forms will also be used by our Sun life Assurance Company of Canada company for which a separate filing is being made under SERFF #: SUN-12631286.

Please do not hesitate to contact me if you have any questions regarding this submission. Thank you for your attention to this matter.

Sincerely,

Margaret Carvalho

Company and Contact

Filing Contact Information

Margaret Carvalho, Compliance Consultant margaret.carvalho@sunlife.com

One Sun Life Executive Park 781-446-1811 [Phone]

Wellesley Hills, MA 02481 781-237-3327 [FAX]

Filing Company Information

Sun Life Assurance Company of Canada (U.S.)	CoCode: 79065	State of Domicile: Delaware
One Sun Life Executive Park	Group Code: 549	Company Type:
State Filings, SC2175	Group Name:	State ID Number:
Wellesley Hills, MA 02481	FEIN Number: 04-2461439	
(800) 432-1102 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada (U.S.)	$40.00	09/25/2009	30840581

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/29/2009	09/29/2009

Disposition

Disposition Date: 09/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SUNL-126312855*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada (U.S.)*	*State Tracking Number:*	*43605*
Company Tracking Number:	*UND 14-200 AND UND 14-271*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*UND 14-200 and UND 14-271*		
Project Name/Number:	*UND 14-200 and UND 14-271/UND 14-200 and UND 14-271*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statements of Variability		Yes
Supporting Document	Readability Certification		Yes
Form	Application for Reinstatement & Contractual Policy Changes		Yes
Form	Certificate of Insurability		Yes

Form Schedule

Lead Form Number: UND 14-200

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	UND 14-200	Application/Enrollment Form	Application for Reinstatement & Contractual Policy Changes	Initial		0.000	UND 14-200 Reinstatement Application.pdf
	UND 14-271	Application/Enrollment Form	Certificate of Insurability	Initial		0.000	UND 14-271 Certificate of Insurability.pdf

☐ **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

Sun Life Financial℠

Application for Reinstatement & Contractual Policy Changes

Policy Number _____

☐ Reinstatement* ☐ Rating Reduction ☐ Change Death Benefit Option from___ to ___

☐ Increase Face Amount to _____ ☐ Smoker Change ☐ Business Exchange

*Reason for policy lapse: _____

Section A: Insured

First Insured

1a. Ms.__ Mr.__ Dr. __ Miss __Mrs.__	1b. Name (first, middle initial, last)	1c.Male__ Female__	1d.Birth Date (m/d/y)
1e. Birthplace (country/state)	1f. Social Security/Tax ID Number	1g. Home Phone Number	1h. Work Phone Number
1i. Address (street, city, state, zip code, country) (If mailing address differs, provide in Section H.)			

1j. Permanent U.S. Resident Yes__ No__	1k. Years in U.S.	1l. U.S. Citizen Yes__ No__	1m. If No: Valid Green Card or Visa Number	1n. Driver's License State of Issue

1o. Driver's License Number	1p. Occupation, Employer Name and Address
1q. Personal Income $	1r. Net Worth $

Second Insured (or New Insured for Business Exchange)

2a. Ms.__ Mr.__ Dr. __ Miss __Mrs.__	2b. Name (first, middle initial, last)	2c.Male__ Female__	2d. Birth Date (m/d/y)
2e. Birthplace (country/state)	2f. Social Security/Tax ID Number	2g. Home Phone Number	2h. Work Phone Number
2i. Address (street, city, state, zip code, country) (If mailing address differs, provide in Section H.)			

2j. Permanent U.S. Resident Yes__ No__	2k. Years in U.S.	2l. U.S. Citizen Yes__ No__	2m. If No: Valid Green Card or Visa Number	2n. Driver's License State of Issue

2o. Driver's License Number	2p. Occupation, Employer Name and Address
2q. Personal Income $	2r. Net Worth $

Section B: Owner

If the Owner is the same as the Insured, specify: First Insured __ Second Insured__ Both__ and **ONLY complete question 1g- Email Address.** Specify: Company__ Individual__ Trust__

1a. Owner Name		1b. Relationship to Insured	
1c. Social Security/Tax ID Number	1d. Birth/Trust Date (m/d/y)	1e. Permanent U.S. Resident: Yes__ No__	1f. U.S. Citizen: Yes__ No__
1g. Email Address		1h. Phone Number	
1i. Name(s) Authorized Company Representative(s)/Trustee(s)			1j. State Trust Established
1k. Address (street, city, state, zip code, country)			
1l. Contingent Owner: Name, Relationship to Insured			

Section C: Premium Plan and Fund Information

Ensure the information matches the illustration.

1a. Planned Periodic Premium Amount
1b. Frequency __Annual __Semi-Annual __Quarterly (for VUL only) __Monthly (pre-authorized checking) __List Bill (If existing list bill, provide number:_____) 1c. Will the premium for this policy be financed through single or multiple loan(s) from a private or public lender now or in the future? Yes____ No_____ If yes, complete the Life Insurance Source of Premium Eligibility Questionnaire.

Section D: Beneficiary

1a. Primary Name	1b. Relationship	1c. %
2a. Primary Name	2b. Relationship	2c. %
3a. Primary Name	3b. Relationship	3c. %
4a. Contingent Name	4b. Relationship	4c. %
5a. Contingent Name	5b. Relationship	5c. %

Note: Unless otherwise specified: The surviving beneficiaries within a class (primary or contingent) will share equally.

Section E: Other Insurance

1. For each Insured, provide details below for all insurance in-force and/or pending, on either a formal or an informal basis, with the Company and any other companies. Include those policies or applications owned personally or by a third party, including but not restricted to individuals(s), business, charity, life settlement or viatical company. **If none, Individual or First Insured initial here _____, Second Insured initial here_____.**

Insured	Insurance Company	Business/ Personal/ Settlement	Issue Year/Pending	Formal/ Informal	Total Face Amount	Policy Number
a.						
b.						
c.						
d.						
e.						

2. For each Insured, state the ultimate amount of life insurance coverage that will be in place on each life (excluding group life or corporate owned life insurance) with the issue of this policy and any other pending application with another company.
Individual or First Insured $_____ Second Insured $_____

3. Is the policy applied for through this application being purchased for the purpose of being assigned or sold to a third party or will it replace a policy whose ownership has been assigned or sold to a third party? __Yes __No
If yes, complete Part 2 of the Life Insurance Source of Premium Eligibility Questionnaire.
4. Has an Application for insurance on the life/lives of the Insured(s) been declined or offered on a basis other than applied? __Yes __No
If yes, provide details:

Section F: Insured(s) Lifestyle Information

	Insured 1	Insured 2
1. Have you used tobacco, (cigarettes, cigars, chewing tobacco, etc.) or products containing nicotine (nicorette gum, nicotine patch, etc.) within the past 12 months?	__Yes __No	__Yes __No
1a. If yes, please indicate quantity and frequency of tobacco use _____		
2. Have you used tobacco or nicotine products in the past and stopped?	__Yes __No	__Yes __No
If yes, date stopped: _____		

3. Do you plan to travel or reside outside of the U.S. and Canada in the next two years? . . . . . __Yes __No __Yes __No
If yes, submit the required Foreign Travel/Residence/Citizenship Questionnaire.
4. Do you hold an active pilot's license?. . . . . __Yes __No __Yes __No
5. Have you flown as a pilot or co-pilot in any type of aircraft, within the past two years? . . . . . __Yes __No __Yes __No
If yes, submit the required Aviation Questionnaire.
6. Have you participated in scuba diving, parachuting, hang gliding, motorized racing
or any hazardous sport? If yes, indicate the sport: _____ . . __Yes __No __Yes __No
7. While operating a motor vehicle, boat or aircraft, in the last five years, have you:
a. Been charged with any moving violations?. . . . . __Yes __No __Yes __No
b. Had an operator's license restricted, suspended or revoked? . . . . . __Yes __No __Yes __No
c. Been charged with operating under the influence of alcohol or drugs? . . . . . __Yes __No __Yes __No
If yes, provide details: _____

Section G: Medical Contact Information

First Insured		**Second Insured**	
1a. Name, Phone Number and Address of Primary Physician/Health Care Provider		2a. Name, Phone Number and Address of Primary Physician/Health Care Provider	
1b. Reason for Last Visit	1c. Date (m/d/y)	2b. Reason for Last Visit	2c. Date (m/d/y)
1d. Name, Phone Number and Address of Medical Specialist Last Seen		2d. Name, Phone Number and Address of Medical Specialist Last Seen	
1e. Reason for Last Visit and Results	1f. Date (m/d/y)	2e. Reason for Last Visit	2f. Date (m/d/y)

1g. Height: ___ ft. ___ in Weight: _____ lbs	1h. Have you lost 10 lbs or more in the past two years? If "Yes", loss of _____ lbs. Reason?	2g. Height: ___ ft. ___ in Weight: _____ lbs	2h. Have you lost 10 lbs or more in the past two years? If "Yes", loss of _____ lbs. Reason?

	Insured 1	**Insured 2**
1. Within the past five years (or since the date of application for this policy, if more recent) have you		
a. Been examined or treated by, or consulted a physician or other practitioner?	__Yes __No	__Yes __No
b. Had an electrocardiogram, X-ray or other diagnostic test? ……	__Yes __No	__Yes __No
c. Been treated or counseled for alcoholism or drug abuse?	__Yes __No	__Yes __No
d. Been diagnosed or received treatment by a qualified physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other disorders of the immune system? ……	__Yes __No	__Yes __No
e. Had a positive blood test for antibodies to the AIDS (HTLV – III) virus? ……	__Yes __No	__Yes __No
2. Are you aware of any symptom or complaint regarding your health for which you have not yet consulted a physician or received treatment? ……	__Yes __No	__Yes __No

Give complete details of all "Yes" answers. Reason for examination: nature of symptoms, disease or injury	Dates, duration, treatment, surgery, results of tests, etc.	Names and addresses of physicians and medical facilities.

Section H: Additional Information/Special Requests

_____

_____

_____

Section I: Signature Section

Declarations

I/We understand and agree that:

1. The information provided in this Application (Part I and Part II Medical, if required) is the basis for and becomes part of the insurance contract issued as a result of this Application.

2. No broker/registered representative or medical examiner has the authority to make or modify the Company's guidelines, to decide whether anyone proposed for insurance is an acceptable risk or to waive any of the Company's rights or requirements.

3. In accepting coverage, I/we also accept any corrections and amendments made by the Company. No change in plan, amount, benefits, age at issue or classification can be made without my/our written consent. However, the Company may change non-guaranteed elements of the coverage at its sole discretion.

4. In connection herewith, it is expressly acknowledged that the insurance, as applied for, is suitable for the insurance needs and financial objectives of the undersigned.

5. Sales illustrations are used to assist in understanding how the coverage could perform over time, under a number of assumptions. I/we acknowledge that rates of return or credited interest rates assumed in sales illustrations are hypothetical only and are not estimates or guarantees. The actual performance of any such coverage, including account values, cash surrender values, death benefit and duration of coverage, will be different from what may be illustrated because the hypothetical assumptions used in an illustration may not be indicative of actual future performance. I/we also understand that any sales illustration used is not a contract and will not become part of any coverage issued by the Company.

I/we declare that the statements and answers in this Application are complete and true to the best of my/our knowledge and believe that they are correctly recorded.

I/we 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who Knowingly provides false incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

District of Columbia: I/we understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida: I/we understand that 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Virginia: I/we 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 may have violated state law.

For Variable Universal Life applications, I/we also hereby understand and agree that values and benefits provided by the life insurance coverage applied for are based on the investment experience of a separate account and are not guaranteed, such that:

- **The death benefit amount may increase or decrease to reflect the investment experience of the variable sub-accounts.**
- **The duration of coverage may increase or decrease due to the investment experience of the variable sub-accounts.**
- **The account value and cash surrender value may increase or decrease to reflect the investment experience of the variable sub-accounts.**
- **With respect to the variable sub-accounts, there is no guaranteed minimum coverage value nor are any coverage values guaranteed as to dollar amount.**

The Owner acknowledges receipt of a current prospectus from the Company for variable universal life insurance.

Authorization

I/we, hereby authorize any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility, that has provided payment, treatment or services to me or on my behalf; (b) insurance company; (c) state department of motor vehicles; (d) consumer reporting agency; or the Medical Information Bureau, Inc., to disclose or furnish to the Underwriting Department of the Company, their subsidiaries, affiliates, third party administrators and reinsurers, any and all non-health information relating to me.

I/we understand that the Company will use the information it obtains to: (a) underwrite my Application for coverage, (b) make eligibility, risk rating, coverage issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I/we have or have applied for with the Company.

I/we hereby authorize the Company to disclose any information it obtains about me to the Medical Information Bureau, Inc., or any other life insurance company with which I/we do business. I/we understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I/we may further authorize. I/we understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to my dependents if they are to be insured under the life insurance coverage applied for.

I/we understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I/we may revoke it at any time by providing written notice to the Underwriting Department of the Company at the address shown on page 1 of this form, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I/we are entitled to receive a copy of the Authorization upon request. A copy of this Authorization shall be as valid as the original.

Signature of Proposed Insured (not required if under age 15)	Signature of 2nd Proposed Insured (not required if under age 15)
Signature of Personal Representative of Proposed Insured	Signature of Personal Representative of Proposed Insured
Relationship to Proposed Insured	Relationship to Proposed Insured
Signature of Owner (if other than Proposed Insured)	Signature of Owner (if other than Proposed Insured)
Signature of Co-Owner	Signature of Co-Owner
Signature of Assignee	Signature of Assignee
Signature of Broker/Registered Representative	

Signed at:	City/State	Date (m/d/y)

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☐ **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]

Sun Life Financial℠

Application Supplement - Certificate of Insurability

(This form MUST be completed to update insurability when [Medical Evidence] is older than [90 days])

All questions must be completed. If any of the questions are answered "Yes" then do not collect money, do not deliver a policy, and return the policy to New Business & Underwriting. No coverage will be in effect.

Case ID or Policy Number _____

Proposed Life Insured (Life One)	Proposed Life Insured (Life Two)
Name (First/Middle Initial/Last) _____	**Name** (First/Middle Initial/Last) _____
Date of Birth _____	**Date of Birth** _____

Section 1

	Life One	Life Two
1. Since the date of application for this policy (_ _ / _ _ / _ _ _ _) have you:		
a. Been examined or treated by, or consulted by a physician or other practitioner?	☐Yes ☐No	☐Yes ☐No
b. Had an electrocardiogram, x-ray or other diagnostic test?	☐Yes ☐No	☐Yes ☐No
c. Been treated or counseled for alcoholism or drug abuse?	☐Yes ☐No	☐Yes ☐No
2. Are you aware of any symptom or complaint, regarding your health, for which you have not yet consulted a physician or received treatment?	☐Yes ☐No	☐Yes ☐No
3. Do you have any office visit, test, or other appointment scheduled with any health care facility or practitioner?	☐Yes ☐No	☐Yes ☐No
4. Since the date of application for this policy have you:		
a. Been in any accident or received any injury that required medication attention?	☐Yes ☐No	☐Yes ☐No
b. Received treatment for hypertension, heart or vascular disease, cancer, diabetes, pulmonary, kidney or any other disease?	☐Yes ☐No	☐Yes ☐No
Section 2		
5. Have you submitted an application to any other life insurance company or have you been declined or offered at other than standard rates by any other company?	☐Yes ☐No	☐Yes ☐No
6. Has there been any change in your aviation, motor vehicle or power boat, skydiving/parachuting, skin or scuba diving or any other hazardous activities? [If Yes, please complete the aviation and/or avocation questionnaire(s).]	☐Yes ☐No	☐Yes ☐No
7. Has there been any change in your tobacco or nicotine use?	☐Yes ☐No	☐Yes ☐No

Give full details of any Yes answers.

Life One

Question No:	Details

Life Two

Question No:	Details

Signatures

I/We declare that the above answers are full and true to the best of my/our knowledge and belief.

Proposed Insured Life One _____

Signed at _____ Date _____

Proposed Insured Life Two _____

Signed at _____ Date _____

Broker/Registered Rep _____

Signed at _____ Date_____

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Certificate of Complaince Rule & Reg 19 _U.S. Co._.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: See Form Schedule.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Statements of Variability

Comments:

Attachments:

SOV UND 14-200 U.S. Co.pdf

SOV UND 14-271 U.S. Co.pdf

Item Status: **Status Date:**

Satisfied - Item: Readability Certification

Comments:

Attachment:

Readability Certification _U.S._.pdf

STATE OF ARKANSAS
INSURANCE DEPARTMENT

CERTIFICATE OF COMPLIANCE WITH RULE AND REGULATION 19

RE: Form Numbers: 14-200 & 14-271

We hereby certify that the guidelines established in Arkansas Rule and Regulation 19 have been reviewed and the policy form(s) designated above comply(ies) with these guidelines.

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

Thomas Miele, Assistant Vice President, Annuities

September 24, 2009
Date

AR

SUN LIFE OF COMPANY OF CANADA (U.S.)
STATEMENT OF VARIABILITY

Revision Date: 9/21/2009
Form Number: UND 14-200

Page No.	Field	Scope of Variation
1	One Sun Life Executive Park ...	Address is bracketed to denote such may change in the future.
1	Reinstatement … Business Exchange	Reasons bracketed to denote such may change in the future.
4-5	Fraud Warnings	Variability to accommodate changes to comply with future state requirements.

SUN LIFE OF COMPANY OF CANADA (U.S.)
STATEMENT OF VARIABILITY

Revision Date: 9/21/2009
Form Number: UND 14-271

Page No.	Field	Scope of Variation
1	One Sun Life Executive Park, Wellesley Hills, MA 02481	Address is bracketed to denote such may change in the future.
1	Medical Evidence	Text is bracketed to denote term may change in the future.
1	90 days	Number of days is bracketed to denote period may change in the future ranging from 30 days to 180 days.
1	If Yes, please complete … avocation questionnaire(s).	Instruction is bracketed to denote names of questionnaire(s) or instruction may change in the future.

READABILITY CERTIFICATION

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

I hereby certify, that the form(s) listed below has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test.

Form Number	Score
UND 14-200*	50.1
UND 14-271*	50.3

* When calculated with Policy, this application supplement scores 50+.

Thomas Miele
Assistant Vice President

September 25, 2009
Date