

SERFF Tracking Number: SUNL-126536988 State: Arkansas
Filing Company: Sun Life Assurance Company of Canada (U.S.) State Tracking Number: 45158
Company Tracking Number: 14-750 PART I APPLICATION AND 14-272 APPLICATION SUPPLEMENT
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: 14-750 Part I Application and 14-272 Application Supplement
Project Name/Number: 14-750 Part I Application and 14-272 Application Supplement/14-750 Part I Application and 14-272 Application Supplement

Filing at a Glance

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

Product Name: 14-750 Part I Application and 14-272 Application Supplement SERFF Tr Num: SUNL-126536988 State: Arkansas

TOI: L06I Individual Life - Variable SERFF Status: Closed-Approved-Closed State Tr Num: 45158

Sub-TOI: L06I.002 Single Life - Flexible Premium Co Tr Num: 14-750 PART I APPLICATION AND 14-272 APPLICATION SUPPLEMENT State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird
Disposition Date: 03/16/2010
Authors: Margaret Carvalho, Thomas Miele, Christopher McAuliffe, Pat Squillacioti
Date Submitted: 03/14/2010

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 14-750 Part I Application and 14-272 Application Supplement

Status of Filing in Domicile: Pending

Project Number: 14-750 Part I Application and 14-272 Application Supplement

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Pending with our domiciliary state of Delaware.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/16/2010

Explanation for Other Group Market Type:

State Status Changed: 03/16/2010

Deemer Date:

Created By: Margaret Carvalho

Submitted By: Margaret Carvalho

Corresponding Filing Tracking Number: 14-750 Part I Application and 14-272 Application Supplement

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Filing Description:

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

NAIC # 549-79065

FEIN # 04-2461439

Re: 14-750 – Part I of Application for Life Insurance
14-272 – Application Supplement-Medical Certification

Dear Sir or Madam:

We submit the above referenced forms for your review and approval. These forms are new and do not replace any other forms previously approved by your Department. These forms are intended to comply with all applicable laws, rules, bulletins and published guidelines of your state. They are submitted in final printed form and subject only to minor modifications in paper stock, ink, and adaptation to computer printing.

These forms have been filed and are pending with our domiciliary state of Delaware.

14-750 – Part I of Application for Life Insurance Application

This application will be used to offer previously approved policies issued by Sun Life Assurance Company of Canada (U.S.).

14-272 – Application Supplement-Medical Certification

This form is completed when a medical exam from another company is being submitted instead of an exam by us and the Medical Certification section of the Part I of Application for Life Insurance is not completed.

The enclosed forms will also be used by Sun life Assurance Company of Canada for which a separate filing is being made under SERFF #: SUNL-126514836.

The enclosed forms include brackets around the items that may vary. The bracketed items shown are the hypothetical values for the representative sample provided. The use of variability in the enclosed forms will be administered as described in the enclosed statements of variable material and in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

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

Sincerely,

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Margaret Carvalho
 Telephone: 800-432-1102, x 1811
 Fax: 781-237-7149
 Email: margaret.carvalho@sunlife.com

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: \$100.00
 Retaliatory? Yes
 Fee Explanation: 2 x 50.00 = 100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada (U.S.)	\$100.00	03/14/2010	34845377

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/16/2010	03/16/2010

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Disposition

Disposition Date: 03/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	14-750 SOV Part I of Application		Yes
Supporting Document	14-272 SOV Application Supplement-Medical Certification		Yes
Form	Part I of Application for Life Insurance		Yes
Form	Application Supplement-Medical Certification		Yes

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Form Schedule

Lead Form Number: 14-750

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	14-750	Application/	Part I of Application Enrollment for Life Insurance Form	Initial		50.000	14-750 Part I of Application 2-25-10.pdf
	14-272	Application/	Application Enrollment Supplement-Medical Form Certification	Initial		50.000	14-272 Application Supplement-Medical Certification 2-25-10.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]



Part I of Application for Life Insurance

Section A: Proposed Insured Information

Proposed Insured 1

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 M.)					
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			

Proposed Insured 2 (Survivorship only)

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 M.)					
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			

Section B: Primary Owner

If the Primary Owner is the same as the Proposed Insured(s), specify: First Insured ___ Second Insured ___ Both ___ and **proceed to Section C.**

If the Primary Owner is not the Proposed Insured(s) then the Primary Owner is a: Company ___ Individual ___ Trust ___

1a. Full Legal Name			
1b. Social Security/Tax ID Number	1c. Birth/Trust Date (m/d/y)	1d. Relationship to Proposed Insured(s)	
1e. Mailing Address (street, city, state, zip code, country)			
1f. Permanent U.S. Resident: Yes ___ No ___		1g. U.S. Citizen: Yes ___ No ___	1h. State Trust Established
1i. Name(s) Authorized Company Representative(s)/Trustee(s)			
1j. Contingent Owner: Name and Relationship to Insured			

For additional owners complete and submit the Multiple Owner Supplement.

Section C: Coverages

1a. Face Amount (excluding Riders) \$ _____	1b. Death Benefit Compliance Test (select one) <input type="checkbox"/> GPT <input type="checkbox"/> CVAT
1c. Death Benefit Option (select one) <input type="checkbox"/> Option A – Level <input type="checkbox"/> Option B – Increasing <input type="checkbox"/> Option C – Return of Premium	

<p>1d. Product and Rider Selection</p> <p>[Universal Life (UL)]</p> <p>[Sun Universal Protector] _____</p> <p><input type="checkbox"/> Accidental Death Benefit Rider Amount: \$ _____</p> <p><input type="checkbox"/> Exchange of Insured Rider</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Charitable Giving Benefit Rider**</p> <p><input type="checkbox"/> Payment of Stipulated Amount Rider Amount: \$ _____</p> <p><input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70]</p> <p>[Sun Universal Protector PLUS] _____</p> <p><input type="checkbox"/> Enhanced Surrender Value Rider</p> <p><input type="checkbox"/> Supplemental Insurance Rider Amount: \$ _____</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Charitable Giving Benefit Rider**</p> <p><input type="checkbox"/> Payment of Stipulated Amount Rider Amount: \$ _____</p> <p><input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70]</p> <p>[Accumulation UL] _____</p> <p><input type="checkbox"/> Supplemental Insurance Rider Amount: \$ _____</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Charitable Giving Benefit Rider**</p> <p><input type="checkbox"/> Payment of Stipulated Amount Rider Amount: \$ _____</p> <p><input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70]</p> <p>[Sun Survivorship Universal Life] _____</p> <p><input type="checkbox"/> Estate Preservation Rider</p> <p><input type="checkbox"/> Policy Split Option</p> <p><input type="checkbox"/> Charitable Giving Benefit Rider**]</p>	<p>[Variable Universal Life (VUL)]</p> <p>[Sun Protector VUL] _____</p> <p><input type="checkbox"/> Payment of Stipulated Amount Rider Amount: \$ _____</p> <p><input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Supplemental Insurance Rider Amount: \$ _____</p> <p><input type="checkbox"/> Charitable Giving Benefit Rider**</p> <p><input type="checkbox"/> Surrender Charge Modification Endorsement</p> <p><input type="checkbox"/> No Lapse Guarantee Rider]</p> <p>[Futurity Accumulator II] _____</p> <p><input type="checkbox"/> Accidental Death Benefit Rider Amount: \$ _____</p> <p><input type="checkbox"/> Payment of Stipulated Amount Rider Amount: \$ _____</p> <p><input type="checkbox"/> Age 65 <input type="checkbox"/> Age 70</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Supplemental Insurance Rider Amount: \$ _____</p> <p><input type="checkbox"/> Corporate Benefit Provision]</p>
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****Charitable Giving Benefit Rider – Complete if selected above:**

2a. Name of Accredited Organization	2b. 501(c) Tax ID Number
2c. Address	
2d. After you receive confirmation of the charitable organization, choose one: <input type="checkbox"/> I/We will notify the charity of my/our intent OR <input type="checkbox"/> Permit the Company to notify the charity of my/our intent upon my/our death]	

Section D: Premium and Billing Information

1a. Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly (VUL only) <input type="checkbox"/> Monthly (pre-authorized checking) <input type="checkbox"/> List Bill (If existing list bill, provide number: _____) <input type="checkbox"/> Single Pay
1b. Planned Periodic Premium Amount (leave blank if Single Pay)
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.
1d. What is the source of the premium that will be used to fund the policy applied for in this application?

Section E: Beneficiary

Name	Primary (P)/ Contingent (C)	Relationship to Proposed Insured(s)	%
1a.	1b. <input type="checkbox"/> P <input type="checkbox"/> C	1c.	1d.
2a.	2b. <input type="checkbox"/> P <input type="checkbox"/> C	2c.	2d.
3a.	3b. <input type="checkbox"/> P <input type="checkbox"/> C	3c.	3d.
4a.	4b. <input type="checkbox"/> P <input type="checkbox"/> C	4c.	4d.
5a.	5b. <input type="checkbox"/> P <input type="checkbox"/> C	5c.	5d.

For additional beneficiaries complete and submit the Beneficiary Supplement form.

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

Section F: Payor

1. If the payor is Proposed Insured 1, Proposed Insured 2, or the Primary Owner then proceed to section G.
2. If the payor is other than Proposed Insured 1, Proposed Insured 2, or the Primary Owner, indicate type Company Individual Trust and complete questions 2a – 2d.

2a. Name	2b. Social Security/Tax ID Number
2c. Mailing Address (street, city, state, zip code, country)	
2d. Name(s) of Authorized Representative(s) (only if a Company is the Payor) or Trustee(s) if a Trust is the Payor.	

Section G: Other Insurance/Replacement Information

1. Does the Applicant/Owner(s) have any existing individual life insurance policy or annuity contract including those under a binding or conditional receipt or those within an unconditional refund period? Yes No

If yes and the contract state is an NAIC replacement state then state replacement forms are required prior to issue.

2. Will any existing life insurance policy or annuity contract be lapsed, forfeited, surrendered, partially surrendered, assigned, reduced in value or used as a source of premium for the coverage for which application is being made? Yes No

If yes provide details below and complete and submit state replacement forms.

Insurance Company	Policy Number

3. If a replacement is involved, is it intended as an IRC Section 1035 exchange? . Yes No

If yes submit the 1035 Exchange Absolute Assignment Form.

4. Does either Proposed Insured have any insurance inforce or pending on a formal basis with the Company or any other companies? Y N

If yes then provide details in the table below. Include all policies owned personally or by a third party including but not restricted to individuals, businesses, charities, life settlement, or viatical companies.

Proposed Insured	Company	Business (B)/ Personal (P)/ Settlement (S)	Issue Year/Pending	Total Face Amount
a. <input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> B <input type="checkbox"/> P <input type="checkbox"/> S		
b. <input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> B <input type="checkbox"/> P <input type="checkbox"/> S		
c. <input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> B <input type="checkbox"/> P <input type="checkbox"/> S		
d. <input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> B <input type="checkbox"/> P <input type="checkbox"/> S		
e. <input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> B <input type="checkbox"/> P <input type="checkbox"/> S		

5. For each Proposed 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.

Proposed Insured 1 \$ _____ Proposed Insured 2 \$ _____

6. 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 and submit the Life Insurance Source of Premium Eligibility Questionnaire.

7. If a policy applied for through this application is issued by the Company, will the policy within the next three years be used for any purpose other than the purpose indicated in Section B (Owner), Section E (Beneficiary) and Section H (Finances/Plan Use) of this application? Yes No If yes, provide details. _____

8. Has an Application for insurance on the life/lives of the Proposed Insured(s) been declined or offered on a basis other than applied? . . . Yes No

If yes, provide details:

Section H: Proposed Insured Finances/Plan Use

1. Gross Annual Earned Income\$	2. Gross Annual Unearned Income \$	3. Total Household Net Worth \$
---------------------------------	------------------------------------	---------------------------------

4. Within the past 5 years has the Proposed Insured(s) or any business of which they are an owner, executive, or partner experienced any major financial issues such as bankruptcy? Y N

If yes, provide details.

5. The coverage will be used primarily for:

- Income Replacement Split Dollar Business Continuity Supplemental Retirement Income
- Deferred Compensation Plan Estate Plan Key Person Charitable Gift Bonus Plan
- Premium Financing Other _____

Section I: VUL Suitability [& Delivery of Prospectuses]

If applying for a VUL product then complete questions [1-2] otherwise leave blank and proceed to Section J.

1. Has it been explained to you that the values and benefits provided by the coverage are based on the investment experience of a separate account and may increase or decrease depending upon the investment experience? Yes No

2. Is the coverage, as applied for, in accordance with the insurance and financial objectives you have expressed? Yes No

[3.Product and fund prospectuses for the VUL product elected in Section C can be delivered to the policy owners electronically via email or CD or paper copies can be sent via regular mail. Please elect how you wish to receive product and fund prospectuses: E-Mail (email address _____)

Section J: Proposed Insured(s) Lifestyle Information

- | | | |
|--|---------------------------|---------------------------|
| | Proposed Insured 1 | Proposed 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
 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 K: Proposed Insured(s) Medical Contact Information

Proposed Insured 1		Proposed Insured 2	
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)

If the application is being submitted on a non-medical basis, complete a separate Part II of Application for Life insurance.

Section L: Medical Certification

Complete this section only if a medical exam from another company is being submitted instead of a Sun Life exam.

1.

Proposed Insured	Insurance Company	Date of Exam
a. _1 _2		
b. _1 _2		

2. To the best of my knowledge and belief all information in the exam is true and complete as of the date this application is signed and that I have not been attended to by a physician or other medical practitioner for any reason since the date of the exam. Proposed Insured 1 Yes No Proposed Insured 2 Yes No

A Sun Life non-medical Part II of Application for Life Insurance is required for any Proposed Insured that answers "No" to question 2.

Section M: Additional Information/Special Requests

Section N: 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. Except as provided in a Temporary Life Insurance Agreement having the same date as the Application, no insurance requested in this Application will be effective (a) until coverage is issued during the lifetime of the Proposed Insured(s); and (b) until the Company has received the first full premium due on any coverage that is not Variable Universal Life or the initial premium due on any Variable Universal Life coverage requested; and (c) **the statements made in this Application are still complete and true as of the date the coverage is delivered.**
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.
6. 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.
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 various 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 the variable universal life insurance.

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.

[General Warning: 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.

For Colorado the following fraud warning applies: 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.

For the District of Columbia and Rhode Island the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Kansas the following fraud warning applies: 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 be guilty of insurance fraud as determined by a court of law.

For Kentucky the following fraud warning applies: 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 may be a crime and subjects that person to criminal and civil penalties.

For Puerto Rico the following fraud warning applies: 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.

For Tennessee and Washington the following fraud warning applies: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

Customer Identification Notice: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who makes an application. This means we will ask you for your name, address, date of birth and other information that will allow us to identify you. We may ask to see your driver's license or other identifying documents.

I acknowledge receipt of the Customer Identification Notice. I understand that the identity information being provided by me is required by Federal law to be collected in order to verify my identity and I authorize its use for this purpose.

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 30 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 Insureds

Signature of Proposed Insured 1 (not required if under age 15)

Signature of Proposed Insured 2 (not required if under age 15)

Signed by Proposed Insured 1 at (city/state)	Signed by Proposed Insured 2 at (city/state)
--	--

Signature of Owners (if other than the Proposed Insureds)

Signature of Primary Owner	Signature of Co-Owner
Signed by Primary Owner at (city/state)	Signed by Co-Owner at (city/state)
Signature of Co-Owner	Signature of Co-Owner
Signed by Co-Owner at (city/state)	Signed by Co-Owner at (city/state)

Signature of Brokers/Registered Representatives

Signature of Broker/Registered Representative	Signature of Broker/Registered Representative
Signed by Broker/Registered Representative at (city/state)	Signed by Broker/Registered Representative at (city/state)
Signature of Broker/Registered Representative	Signature of Broker/Registered Representative
Signed by Broker/Registered Representative at (city/state)	Signed by Broker/Registered Representative at (city/state)

Date of Signing

The Application was signed on (m/d/y)

STOP!

- **Have all owners signed in capacity? If trust owned did all trustees include “Trustee” in their signature? If corporate owned do signatures of authorized officers include their title? A new Part 1 of Application for Life Insurance will be required if owners have not signed in capacity.**
- **Have all Proposed Insureds, Owners, and Brokers/Registered Representatives recorded the city and state in which they signed?**

Section O: Broker’s/Registered Representative’s Report Page

1. If the Application was taken on a non-medical basis, were answers from the

Proposed Insured 1 Proposed Insured 2

Proposed Insured(s) obtained personally and in your presence? Yes No Yes No
 2. Does the Proposed Insured(s) appear to be in good health? Yes No Yes No
 3. Are you aware of anything about the lifestyle, habits or driving record of the Proposed Insured(s) that would have an adverse effect on insurability? Yes No Yes No
 If yes, provide details:
 4. Do you have any knowledge as to whether a formal or informal application for life insurance on the Proposed Insured has been submitted to another insurer or reviewed by one or more reinsurance companies on a facultative basis? Yes No Yes No

If yes, provide details. _____
 5. Previous address of Proposed Insured(s) if moved within the last two years: _____
 6. Does the Applicant/Owner(s) have any existing individual life insurance policy or annuity contract, including those under a binding or conditional receipt or those within an unconditional refund period? Yes No
 If "yes", provide the applicable state form(s).
 7. Will any existing life insurance policy or annuity contract be lapsed, forfeited, surrendered, partially surrendered, assigned, reduced in value or used as a source of premium for the coverage for which application is being made? Yes No
 If "yes", provide details and applicable state form(s).
 8. Based on your reasonable inquiry about the Owner's financial situation, insurance objectives and needs, do you believe that the coverage as applied for is suitable for the insurance needs and anticipated financial objectives of the Owner? . . . Yes No
 9. Proposed Insured's Marital Status: Life One _____ Life Two _____
 10. Proposed Insured's Annual Household Income: Life One _____ Life Two _____

CERTIFICATION:

I, _____ certify:
 Print Broker's/Registered Representative's Name
 1. (a) that the questions contained in this Application were asked of the Proposed Insured(s) and Owner and correctly recorded; (b) that this Application, report and any accompanying information are complete and true to the best of my knowledge and belief; (c) that I have given the Proposed Insured(s) the Privacy Information Notices including Medical Information Bureau, Inc. (MIB, Inc.), Fair Credit Reporting Act, and Consumer Report Notices; and (d) that the provisions of the Temporary Life Insurance Agreement, including limitations and exclusions, have been explained to the Owner.
 2. For Variable Universal Life applications: (a) that I have reviewed with the Owner all the policy features and have given a current prospectus for the plan of insurance indicated in Section C of this Application, and (b) that information regarding the policy applied for and the Owner's financial situation, insurance objectives and needs has been submitted to my Broker/Dealer for suitability review.
 3. That evidence as to the identities of the Owner(s) has been obtained and recorded.
 4. That the source of funds for purchase of the insurance has been obtained and recorded.

[Commission Payout Election

A commission payout election is required only if the [Sun AccumULATOR] product is applied for. Only one commission payout election is allowed per application meaning that all brokers/registered representatives will be paid in the manner elected here. Failure to make an election for eligible products may delay policy issue and the payment of commissions.

[Heaped Deferred]

[Anti-Money Laundering Customer Identity Information

I have reviewed the Owner's identity document presented and recorded the following information from it:
 Applicant's Name _____
 Address _____
 City _____ State _____ Date of Birth _____/_____/_____
 ID Document (Individual) _____
 (e.g., Driver's License)
 ID Document (Corporation or other non-natural person) _____
 (e.g., a government issued document showing the existence of the entity, e.g., a certificate of good standing or equivalent)
 ID Number _____ Expiration Date _____/_____/_____]

Anti-Money Laundering Training

I have received relevant anti-money laundering training within the last 12 months, given by the Company, another

insurance company or other financial institution, or offered through a national association (e.g., NAIFA, NAILBA) or competent third party (e.g., LIMRA). I also hereby acknowledge my obligations, including compliance with the Company's Anti-Money Laundering Program, as described in the Company's Market Conduct Guide for Individual Life and Annuity Producers. ____Yes ____No

Date (m/d/y)	State Insurance License Number	Signature(s) of Broker(s)/Registered Representative(s)
		X
		X
		X

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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 Assurance Company of Canada is domiciled in Michigan

Sun Life Assurance Company of Canada (U.S.) is domiciled in Delaware

Application Supplement – Medical Certification

Complete this form only if a medical exam from another company is being submitted instead of a Sun Life exam and the Medical Certification section of the Part 1 of Application for Life Insurance was not completed. This form attaches to and becomes part of any policy issued.

1. Case ID or Policy Number
2. Proposed Insured 1 Name
3. Proposed Insured 2 Name

4.

Proposed Insured	Insurance Company	Date of Exam
a. __1 __2		
b. __1 __2		

5. To the best of my knowledge and belief all information in the exam is true and complete as of the date this application supplement is signed and that I have not been attended to by a physician or other medical practitioner for any reason since the date of the exam. Proposed Insured 1 __Yes __No Proposed Insured 2 __Yes __No

A Sun Life non-medical Part II of Application for Life Insurance is required for any Proposed Insured that answers “No” to question 5.

[General Warning: 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.

For Colorado the following fraud warning applies: 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.

For District of Columbia the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Florida the following fraud warning applies: 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.

For Kansas the following fraud warning applies: 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 be guilty of insurance fraud as determined by a court of law.

For Kentucky the following fraud warning applies: 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 may be a crime and subjects that person to criminal and civil penalties.

For Maryland the following fraud warning applies: 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.

For Oregon the following fraud warning applies: 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 commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

For Pennsylvania the following fraud warning applies: 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.

For Tennessee, Virginia and Washington the following fraud warning applies: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Vermont the following fraud warning applies: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.]

I/we declare that the answers recorded above are complete and true to the best of my/our knowledge.

Signature of Proposed Insureds

Signature of Proposed Insured 1 (not required if under age 15)
Signature of Proposed Insured 2 (not required if under age 15)

Signature of Brokers/Registered Representatives

Signature of Broker/Registered Representative
Signature of Broker/Registered Representative
Signature of Broker/Registered Representative

Location and Date of Signing

City/State
Date

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SERFF Tracking Number: SUNL-126536988 State: Arkansas
 Filing Company: Sun Life Assurance Company of Canada (U.S.) State Tracking Number: 45158
 Company Tracking Number: 14-750 PART I APPLICATION AND 14-272 APPLICATION SUPPLEMENT
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
 Product Name: 14-750 Part I Application and 14-272 Application Supplement
 Project Name/Number: 14-750 Part I Application and 14-272 Application Supplement/14-750 Part I Application and 14-272 Application Supplement

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Certificate of Compliance Rule & Reg 19 _U.S. Co_.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Please refer to Form Schedule Tab.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: 14-750 SOV Part I of Application		
Comments:		
Attachment: 14-750 SOV Part I of Application.pdf		

	Item Status:	Status Date:
Satisfied - Item: 14-272 SOV Application Supplement-Medical Certification		
Comments:		
Attachment: 14-272 SOV Application Supplement-Medical Certification.pdf		

**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATE OF COMPLIANCE WITH RULE AND REGULATION 19

RE: Form Numbers: 14-750 & 14-272

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.)

A handwritten signature in black ink that reads "Thomas Miele". The signature is written in a cursive style with a long horizontal stroke at the beginning.

Thomas Miele, Assistant Vice President

March 5, 2010

Date

**Sun Life Assurance Company of Canada
Memorandum of Variable Material**

Form Number: 14-750

Revision Date: February 24, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	Address	Will vary if the address changes.
2	Universal Life (UL)	This is the list of approved Universal Life (UL) products currently available for sale. If we offer new approved UL products or discontinue existing products in the future, then this list of products will be updated accordingly.
2	Sun Universal Protector ____ ... Sun Survivorship Universal Life____	These are the marketing names of the current UL products. If the names change in the future, then this list will be updated accordingly. No other names are contemplated at this time.
2	___ Accidental Death Benefit Rider Amount: \$ ____ ... ___ Charitable Giving Benefit Rider**	These are the approved riders currently available for each of the UL products. If we offer new approved riders or discontinue existing riders in the future, then this list of riders will be updated accordingly.
2	Variable Universal Life (VUL)	This is the list of approved Variable Universal Life (VUL) products currently available for sale. If we offer new approved VUL products or discontinue existing products in the future, then this list of products will be updated accordingly.
2	Sun Protector VUL____ ... Futurity Accumulator II____	These are the marketing names of the current VUL products. If in the future the names change then this list will be updated accordingly. No other names are contemplated at this time.
2	___ Payment of Stipulated Amount Rider ... ___ Corporate Benefit Provision	These are the approved riders currently available for each of the VUL products. If we offer new approved riders or discontinue existing riders in the future, then this list of riders will be updated accordingly.
2	2a – 2d ** Charitable Giving Benefit Rider – Complete if selected above: ... upon my/our death	This is the additional information required in the event that the Charitable Giving Benefit Rider is elected. If we discontinue this rider in the future, then the text 2a – 2d will not be printed.
4	& Delivery of Prospectuses	Variability intended to include reference if we decide to provide other methods of delivery in the future.
4	1-2	Variable range: 1-3 Variability intended to include cross-reference to question 3 if we decide to provide other methods of delivery in the future.
4-5	3. Product and fund prospectus ... Regular Mail	Variability intended to include question 3 if we decide to provide other methods of delivery in the future.
6-7	General Warning ... warning applies:	These are the general and state specific fraud warnings. Variability to accommodate changes to comply with future state requirements.
9	Commission Payout Election	Variability intended for future use if we decide to no longer offer products that permit an agent to elect a commission option.

Page No.	Field	Scope of Variation
9	Sun AccumULator	<p>Variable range: Products to which agent commission options apply.</p> <p>Variability intended for future changes to products that include commission options.</p>
9	__ Heaped __Deferred	<p>Variable range: Heaped, Deferred, Semi-Deferred</p> <p>Variability intended for future changes to the agent commission options.</p>
9	Anti-Money Laundering Customer Identity Information	<p>This is the current language required by the Federal Government, but the Anti-Money Laundering Customer Identity Information language is not yet final. Once final, this section will be updated to comply with the Federal Patriot Act requirements and we will file a revised statement of variability.</p>

**Sun Life Assurance Company of Canada
Statement of Variable Material**

Form # 14-272

Revision Date: February 24, 2010

Variable Information is denoted by bracketing

Page No.	Field	Scope of Variation
1	Address	This will vary if the address changes.
1-2	General Warning	These are the general and state specific fraud warnings. Variability to accommodate changes to comply with future state requirements.