

SERFF Tracking Number: SUNL-126691533 State: Arkansas
Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 46050
Company Tracking Number: SUN CARE WL
TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
Product Name: Sun Care WL - 2010
Project Name/Number: Sun Care WL - 2010/SunCare WL - 2010

Filing at a Glance

Company: Sun Life Assurance Company of Canada

Product Name: Sun Care WL - 2010 SERFF Tr Num: SUNL-126691533 State: Arkansas
TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- State Tr Num: 46050
Closed

Sub-TOI: L071.111 Single Premium - Single Life Co Tr Num: SUN CARE WL State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird

Disposition Date: 06/29/2010
Authors: Margaret Carvalho,
Thomas Miele, Christopher
McAuliffe, Pat Squillacioti, Susan
Burke
Date Submitted: 06/24/2010 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Sun Care WL - 2010
Project Number: SunCare WL - 2010
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/29/2010

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 06/29/2010
Created By: Christopher McAuliffe
Corresponding Filing Tracking Number: Sun
Care WL - 2010

Deemer Date:
Submitted By: Margaret Carvalho

Filing Description:
Sun Life Assurance Company of Canada
NAIC # 549-80802
FEIN # 38-1082080

Re: SPWL-2010 - Single Premium Whole Life Insurance Policy

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ABRLTC-2010 - Accelerated Benefit Rider for Long Term Care Services
EOBLTC-2010 - Extension of Benefits Rider for Long Term Care Services
NFBR-2010 - Nonforfeiture Benefit Rider
RBR-2010 - Residual Benefit Rider
HAE-2010 - Policy Endorsement
14-755 - Part I of Application for Life Insurance with Benefits for Long Term Care Services
14-756 - Part II of Application for Life Insurance with Benefits for Long Term Care Services

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.

SPWL-2010 - Single Premium Whole Life Insurance Policy

This is a single premium whole life insurance policy that will only be used in combination with benefit riders that cover expenses for long term care services. The issue ages for this policy are ages 30-80.

ABRLTC-2010 - Accelerated Benefit Rider for Long Term Care Services

This rider accelerates the death benefit of the enclosed single premium whole life insurance policy for qualified long-term care services. It also includes an optional return of premium benefit and optional inflation protection. This rider may only be elected at the time of application for the life insurance policy to which it will be attached. There is a single premium required in consideration for the basic coverage and each optional feature provided by the rider. This rider is noncancellable so there will be no change to the single premium paid for it.

EOBLTC-2010 - Extension of Benefits Rider for Long Term Care Services

This optional rider extends the benefits provided by the Accelerated Benefit Rider for Long Term Care Services after the benefits under it are exhausted. It also includes an optional return of premium benefit and optional inflation protection. This rider and the optional benefits may only be elected at the time of application for the policy and the Accelerated Benefit Rider for Long Term Care Services. There is a single premium required in consideration for the basic coverage and each optional feature provided by the rider. This rider is noncancellable so there will be no change to the single premium paid for it.

NFBR-2010 - Nonforfeiture Benefit Rider

This optional rider provides for limited long-term care coverage if the policy and Extension of Benefits Rider terminates. There is a single premium required in consideration for this rider.

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RBR-2010 - Residual Benefit Rider

This rider provides a residual benefit when the face amount is reduced to less than the residual benefit amount as a result benefit payments under the Accelerated Benefit Rider for Long Term Care Services. It will be automatically issued with the policy and the Accelerated Benefit Rider.

HAE-2010 - Policy Endorsement

This endorsement provides a Covered Person with healthcare advocacy and assistance services provided by a third party vendor through which we have contracted. There is no indemnity or reimbursement for any expense incurred for any health coverage the Covered Person may ultimately receive. The endorsement will automatically be issued with the enclosed policy.

14-755 - Part I of Application for Life Insurance with Benefits for Long Term Care Services

We will use this new application to offer the enclosed new whole life insurance policy with the long term care insurance benefit riders.

14-756 - Part II of Application for Life Insurance with Benefits for Long Term Care Services

We will use this new application to offer the enclosed new whole life insurance policy with the long term care insurance benefit riders. This portion of the application contains the medical questions necessary to properly underwrite the proposed insured.

The Application Process

This product will include a telephone interview during which the Part I Application and Part II Application will be completed. Prior to the telephone interview an initial meeting will take place between the client and one of our licensed sales representatives. If the client wishes to apply for this product, the sales representative will complete a product ticket and will submit the ticket to the Home Office. The ticket will include the name and telephone number of the client along with details of the coverage the client wishes to apply for. The sales representative will then ask the client when the best time is for the telephone interview to take place and then the sales representative will call and schedule the telephone interview with a company representative. If the interview is not scheduled at the time the ticket is completed then a company representative will attempt to contact the client in order to schedule the interview.

During the telephone interview the company representative will ask the proposed insured the questions contained on the Part I Application (form # 14-755) and record the answers. The Part II Application (form # 14-756) will also be completed during the telephone interview. There are certain questions on the Part II Application, which if answered "yes", will require further information from the proposed insured. On the Part II Application there is a space where additional information will be recorded if required due to a "yes" answer. If the sales representative were taking the Part II Application in person, the sales representative would be required to ask questions in order to obtain additional information for this section.

<i>SERFF Tracking Number:</i>	<i>SUNL-126691533</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Sun Life Assurance Company of Canada</i>	<i>State Tracking Number:</i>	<i>46050</i>
<i>Company Tracking Number:</i>	<i>SUN CARE WL</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.111 Single Premium - Single Life</i>
<i>Product Name:</i>	<i>Sun Care WL - 2010</i>		
<i>Project Name/Number:</i>	<i>Sun Care WL - 2010/SunCare WL - 2010</i>		

Once the questions have been asked during the interview and the responses recorded on the Part I Application, Part II Application, and any required approved supplements, all completed forms will be sent to the sales representative to obtain all required signatures. The sales representative will then meet with the proposed insured and/or owner (if different than the proposed insured) to review the completed forms, answer any unanswered questions, and obtain the needed signatures. The signed copies of the Part I Application, Part II Application, and any supplements will be returned to the company and made a part of the policy.

These forms will be used in the general individual life market. None of these forms will be mass marketed or solicited by mail. They will be marketed with an illustration on an individual basis by our licensed sales representatives. Please note that the illustration does not contain any non-guaranteed elements.

Please be advised that Milliman, Inc. is authorized to act on our behalf with regard to the actuarial components that relate to this submission. We also request that such materials be handled on a confidential basis.

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.

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	CoCode: 80802	State of Domicile: Michigan
One Sun Life Executive Park	Group Code: 549	Company Type:
SC2175, State Filings	Group Name:	State ID Number:
Wellesley Hills, MA 02481	FEIN Number: 38-1082080	
(800) 432-1102 ext. [Phone]		

Filing Fees

SERFF Tracking Number: SUNL-126691533 State: Arkansas
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Fee Required? Yes
Fee Amount: \$400.00
Retaliatory? Yes
Fee Explanation: 50.00 x 8 = 400.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada	\$400.00	06/24/2010	37524487

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/29/2010	06/29/2010

SERFF Tracking Number: SUNL-126691533 *State:* Arkansas
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Disposition

Disposition Date: 06/29/2010

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	AR Compliance Certification		Yes
Supporting Document	Statements of Variability		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Advertising Materials		Yes
Form	Single Premium Whole Life Insurance Policy		Yes
Form	Accelerated Benefit Rider for Long Term Care Services		Yes
Form	Extension of Benefits for Long Term Care Services		Yes
Form	Nonforeiture Benefit Rider		Yes
Form	Residual Benefit Rider		Yes
Form	Health Advocate Endorsement		Yes
Form	Application		Yes
Form	Application		Yes

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Post Submission Update Request Submitted On 06/25/2010

Status: Submitted
Created By: Margaret Carvalho

General Information:

Field Name	Requested Change	Prior Value
Project Number	Sun Care WL - 2010	SunCare WL - 2010
Domicile Status Comments		
Explanation for Combination/Other		

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Form Schedule

Lead Form Number: SPWL-2010

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SPWL-2010	Policy/Cont Single Premium ract/Fratern Whole Life Insurance al Policy Certificate	Initial		50.500	AR SPWL-2010 - Whole Life Policy - 6-24-10.pdf
	ABRLTC-2010	Policy/Cont Accelerated Benefit ract/Fratern Rider for Long Term al Care Services Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.500	ABRLTC-2010 - Accelerated Benefit for LTC - 6-24-10.pdf
	EOBLTC-2010	Policy/Cont Extension of Benefits ract/Fratern for Long Term Care al Services Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.500	EOBLTC-2010 - Extension of Benefits for LTC - 6-24-10.pdf
	NFBR-2010	Policy/Cont Nonforeiture Benefit ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.500	NFBR-2010 - Nonforfeiture Benefit Rider - 6-24-10.pdf

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RBR-2010	Policy/Cont Residual Benefit ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.500	RBR-2010 - Residual Benefit Rider - 6-24-10.pdf
HAE-2010	Policy/Cont Health Advocate ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.500	HAE-2010 - Health Advocate Endorsement - 6-24-10.pdf
14-755	Application/ Application Enrollment Form	Initial	50.500	14-755 Application Part I - 6-23- 10.pdf
14-756	Application/ Application Enrollment Form	Initial	50.500	14-756 Application Part II - 6-23- 10.pdf

SUN LIFE ASSURANCE COMPANY OF CANADA

U.S. Headquarters Office:
[One Sun Life Executive Park
Wellesley Hills, MA 02481
800-225-3950]
Head Office:
[Toronto, Canada]

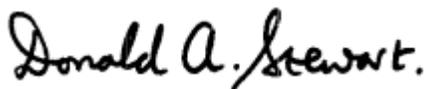
[Sun Care WL], a Single Premium Whole Life Insurance Policy

Insured [John Doe]

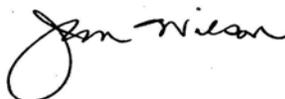
Policy Number [000000001]

We, Sun Life Assurance Company of Canada (“the Company”, “we”, “us”, “our”), a member of the Sun Life Financial group of companies, agree, subject to the conditions and provisions of this Policy, to pay the Beneficiary such amounts as are due and payable upon receipt of Due Proof of the Insured’s death. Until that time, we agree to provide you, as Owner, the other rights and benefits of this Policy. These rights and benefits are subject to the provisions on the pages of this Policy. This Policy is a legal contract between you and us.

Signed at Wellesley Hills, Massachusetts, on the Issue Date.



[Donald A. Stewart, Chief Executive Officer]



[Joan M. Wilson, Secretary]

RIGHT TO EXAMINE POLICY

Please read this Policy carefully. If you are not satisfied, you may return it within 30 days after receipt. To return it, deliver or mail it to the sales representative through whom it was purchased, or to us at One Sun Life Executive Park, Wellesley Hills, MA 02481. This Policy will then be void, as though it had never been applied for, and any Premium paid will be promptly refunded.

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

No additional premium payments will be accepted.

Policy Proceeds are payable upon receipt of Due Proof of the Insured's death.

Does not participate in dividends.



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1. POLICY SPECIFICATIONS

Insured	[John Doe]
Policy Number	[000000001]
Issue Age, Sex	[55, Male]
Class	[Preferred]
Face Amount	[\$120,000]
Issue Date	[January 1, 2010]
Policy Date	[January 1, 2010]
Currency	United States Dollars
Owner	[John Doe]
Beneficiary	As stated in the Application unless subsequently changed
Minimum Withdrawal Amount	[\$1,000]

Single Premium Payments

Policy Single Premium
[\$46,299.60]

Riders Single Premium
[\$44,163.54]

Total Premium
[\$90,463.14]

1. POLICY SPECIFICATIONS

[Supplemental Benefits and Rider(s):]

[Accelerated Benefit Rider for Long Term Care Services]

Benefit Period: [24 months]

Elimination Period: [90 Days]

Maximum Monthly Benefit Amount: [\$5,000.00]

Maximum Benefit Amount: [\$120,000.00]

ABR Single Premium: [\$3,702.00]

[Optional ABR Return of Premium Benefit]

ABR ROP Single Premium - [\$5,666.40]

[Optional Inflation Protection - [Simple Inflation]

ABR Inflation Rate - [3%]

ABR Inflation Single Premium - [\$8,560.80]

[Extension of Benefits Rider for Long Term Care Services]

EOB Benefit Period: [48 months]

EOB Maximum Monthly Benefit Amount: [\$5,000.00]

EOB Maximum Benefit Amount: [\$240,000.00]

EOB Single Premium: [\$9,472.80]

[Optional EOB Return of Premium Benefit]

EOB ROP Single Premium - [\$5,694.00]

[Optional Inflation Protection - [Simple Inflation]

EOB Inflation Rate - [3%]

EOB Inflation Single Premium - [\$6,870.00]

[Nonforfeiture Benefit Rider]

Rider Single Premium - [\$3,735.54]

[Residual Benefit Rider]

Rider Single Premium - [\$462.00]

2. TABLE OF CASH VALUES

Policy Year	Cash Value	Policy Year	Cash Value
[1	49,521.60	44	108,444.00
2	51,055.20	45	108,909.60
3	52,617.60	46	109,333.20
4	54,212.40	47	109,747.20
5	55,834.80	48	110,151.60
6	57,478.80	49	110,545.20
7	59,137.20	50	110,926.80
8	60,802.80	51	111,298.80
9	62,474.40	52	111,661.20
10	64,152.00	53	112,012.80
11	65,839.20	54	112,353.60
12	67,539.60	55	112,684.80
13	69,256.80	56	113,004.00
14	70,993.20	57	113,312.40
15	72,744.00	58	113,611.20
16	74,504.40	59	113,898.00
17	76,260.00	60	114,174.00
18	78,002.40	61	114,439.20
19	79,731.60	62	114,693.60
20	81,452.40	63	114,937.20
21	83,161.20	64	115,170.00
22	84,854.40	65	115,383.60
23	86,521.20	66	120,000.00]
24	88,149.60		
25	89,730.00		
26	91,257.60		
27	92,731.20		
28	94,155.60		
29	95,528.40		
30	96,843.60		
31	98,091.60		
32	99,266.40		
33	100,363.20		
34	101,379.60		
35	102,314.40		
36	103,182.00		
37	104,000.40		
38	104,770.80		
39	105,489.60		
40	106,153.20		
41	106,772.40		
42	107,362.80		
43	107,923.20		

Basis of Values: Commissioners' 2001 Standard Ordinary Tables, Age Last Birthday, Ultimate, Male and Female Tables, Nonsmoker and Smoker at [4%] Interest.

3. DEFINITIONS

Anniversary: The same day in each succeeding year as the day of the year corresponding to the Policy Date.

Application: Your Application for this Policy, a copy of which is attached hereto and incorporated herein.

Attained Age: The Insured's Issue Age plus the number of completed Policy Years.

Beneficiary: The person or entity entitled to receive the Policy Proceeds as they become due at the Insured's death.

Cash Surrender Value: The Cash Value less Policy Debt.

Cash Value: An amount used to determine the Death Benefit and certain Policy benefits. See Section 8.

Class: The risk and underwriting classification of the Insured. See Section 1.

Company: Sun Life Assurance Company of Canada.

Death Benefit: The amount used in determining Policy Proceeds. See Section 7.

Due Proof: Such evidence as we may reasonably require to establish that Policy Proceeds or any other benefits are due and payable.

Face Amount: The amount of life insurance coverage, with the initial requested amount shown in Section 1.

Insured: The person on whose life this Policy is issued.

Issue Age: The Insured's age as of the Insured's last birthday prior to the Policy Date. See Section 1.

Issue Date: The date from which the Suicide and Incontestability periods are measured. The Issue Date is shown in Section 1.

Our Principal Office: Sun Life Assurance Company of Canada, [One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481], or such other address as we may hereafter specify to you by written notice.

Owner: The person, persons or entity entitled to the ownership rights stated in this Policy.

Policy: This life insurance contract, including the Application and any supplemental application.

Policy Date: The date shown in Section 1.

Policy Debt: The principal amount of any outstanding loan against this Policy plus accrued but unpaid interest on such loan.

Policy Proceeds: The amount determined in accordance with the terms of this Policy which is payable upon receipt of Due Proof of the death of the Insured. This amount is the Death Benefit as described in Section 7.

Policy Single Premium: An amount paid to us by the Owner or on the Owner's behalf as consideration for the benefits provided by this Policy. The amount is shown in Section 1.

Policy Year: A one-year period commencing on the Policy Date or any Anniversary and ending on the next Anniversary.

Total Premium: The Single Premium paid for this Policy plus the premiums paid for any supplemental benefits and riders.

Withdrawal: A withdrawal of a portion of the Cash Surrender Value. See Section 9.

4. GENERAL PROVISIONS

Effective Date of Coverage

The effective date of coverage for this Policy is the Policy Date shown in Section 1.

Entire Contract

Your entire contract with us consists of this Policy, the Application and any supplemental Applications, and any Policy riders and endorsements attached hereto.

Alteration

Sales representatives do not have the authority to alter or modify this Policy or to waive any of its provisions. The only persons with this authority are our president, actuary, secretary or one of our vice presidents.

Assignments

During the lifetime of the Insured, you may assign all or some of your rights under this Policy. All assignments must be filed at Our Principal Office in written form satisfactory to us. The assignment will then be effective as of the date you signed the form, subject to any action taken before we acknowledge receipt. We are not responsible for the validity or legal effect of any assignment.

Nonparticipating

This Policy does not pay dividends.

Misstatement of Age or Sex

If the age or sex of the Insured is stated incorrectly, any amount payable by us will be recalculated to that which the Single Premium would have purchased for the correct age and sex.

Suicide

If the Insured, whether sane or insane, commits suicide within two years after the Issue Date of this Policy, we will not pay any part of the Policy Proceeds. We will refund the Single Premium paid, less any Policy Debt and less any Withdrawals.

If the Insured, whether sane or insane, commits suicide within two years after the effective date of reinstatement, we will not pay any part of the Policy Proceeds. We will refund the Premiums paid since the effective date of reinstatement, less the amount of any Policy Debt and less any Withdrawals.

Incontestability

All statements made in the Application or in a supplemental Application are representations and not warranties. We relied and will rely on these statements when approving the issuance of this Policy. No statement can be used by us in defense of a claim unless the statement was made in a written Application. In the absence of fraud, after this Policy has been in force during the lifetime of the Insured for a period of two years from its Issue Date, we cannot contest it.

5. OWNERS AND BENEFICIARIES

The Owner and Beneficiary are named in the Application. You, as Owner, have the sole and absolute power to exercise all rights and privileges under this Policy without the consent of any other person unless you provide otherwise by written notice. While the Insured is alive, you may change the Owner and Beneficiary by written notice. No change or revocation will take effect unless we acknowledge receipt of the notice. If such acknowledgment occurs, then (1) a change of Beneficiary will take effect on the date the notice is signed, and (2) a change or a revocation of Owner will take effect as of the date stated in the notice, or if no such date is stated, on the date the notice is signed. A change or revocation will take effect whether or not you or the Insured is alive on the date we acknowledge receipt. A change or revocation will be subject to the rights of any assignee of record with us and subject to any payment made or other action taken by us before we acknowledge receipt.

If there is no surviving Beneficiary upon the death of the Insured, the Insured's estate will be the Beneficiary.

6. SINGLE PREMIUM

The Single Premium as shown in Section 1 is due and payable to us at Our Principal Office as of the Policy Date shown in Section 1. No further premium payments are allowed.

7. DEATH BENEFIT

Death Benefit

The Death Benefit is the Face Amount reduced by the amount of Policy Debt.

You may not change the Face Amount of this Policy. However, the Face Amount will be reduced whenever a Withdrawal is made in accordance with Section 9.

Method of Determining Death Benefit

We will determine the Death Benefit while this Policy is in force using the Face Amount in effect on the date of the death of the Insured.

8. CASH VALUE

How Cash Value is Computed

The basis for the Cash Values is shown in Section 2. We have filed a detailed statement of our methods for computing cash values with the insurance department regulating this Policy. These values are equal to or in excess of the minimum required by law.

9. POLICY BENEFITS

Benefits at Death

The Policy Proceeds will be paid upon our receipt of Due Proof of the Insured's death. Payment will be made in a lump sum unless some other plan of payment has been elected. The Beneficiary, or the Owner by prior election, may elect in writing any plan of payment which we make available. If not paid within 30 days of our receipt of Due Proof, the Policy Proceeds will include 8% interest, measured from the date of death to the date of payment.

Cash Surrender Value

You may surrender this Policy for its Cash Surrender Value at any time. The Cash Surrender Value will equal the Cash Value less Policy Debt.

Withdrawal

Withdrawals are not allowed during the first Policy Year. After the first Policy Year, you may make only one Withdrawal each Policy Year. The amount of a Withdrawal can not be less than the minimum Withdrawal amount shown in Section 1.

When a Withdrawal occurs, the Cash Value will be reduced by the amount of the Withdrawal. A Withdrawal will reduce the Face Amount in the same proportion as it reduces the Cash Value. Withdrawals also reduce rider benefits to the extent described in any riders attached to this Policy.

Policy Loan

You may request a Policy loan in writing. The maximum Policy loan is equal to the Cash Value less any existing Policy Debt less interest to the end of the Policy Year at the loan interest rate in effect at the time of loan.

Interest on all Policy loans will accrue from day to day at the Policy loan interest rate described below. This interest shall be due and payable on each Anniversary. Any unpaid interest will be added to the principal amount of the Policy loan and will bear interest at the same rate and in the same manner as the Policy loan.

Loan Interest Rate

Policy loans under this Policy bear interest at an adjustable interest rate. We may adjust the rate on each Policy Anniversary. The new rate will apply to both new and outstanding loans. We will provide notice of the initial rate for Policy loans when a loan is made. We will also provide reasonable advance notice prior to any change in interest rate while a Policy loan is outstanding. The interest rate charged during any Policy Year will not exceed the maximum rate for that year, which will be the greater of (a) or (b), where:

- (a) is the "Published Monthly Average" (as defined below) for the calendar month which ends two months prior to the month in which the Policy Anniversary occurs; and
- (b) is the rate used to compute the Cash Value of this policy during the applicable period plus 1 percent.

The term "Published Monthly Average" means the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. or its successors. If such average is no longer published, we will use the average established by law or regulation by the insurance supervisory official of the jurisdiction in which this Policy was delivered. We guarantee that the interest rate charged will never exceed the maximum rate imposed by law or regulation in the jurisdiction in which this Policy was delivered. We will not increase the loan interest rate until the new maximum rate exceeds the rate then currently charged under this Policy by at least .5% annually. We will reduce the rate being charged whenever such reduction results in a new annual maximum rate that is at least .5% lower than the rate then currently being charged under this Policy.

Loan Repayment

You may repay any Policy Debt at any time prior to the Insured's death. When the Policy Proceeds become due, we will deduct the Policy Debt from the amount due.

If the Policy Debt ever equals or exceeds the Cash Value, this Policy will terminate 31 days after we mail notice to you at your last known address and the last known address of any assignee of record unless we receive repayment of the Policy Debt before that date.

Age 121 Continuation

If the Insured is alive on and after the date on which the Attained Age of the Insured is 121 and if this Policy is in force on that date:

- (1) interest will continue to be charged on Policy Debt, as provided in Section 9; and
- (2) the Death Benefit after that date will continue to be based on the Method of Determining Death Benefit provision in Section 7.

If there is no Policy Debt, then this Policy will continue in force until the death of the Insured.

Important Notice concerning the Age 121 Continuation

The continuation of coverage past the Insured's Attained Age 100 may disqualify this Policy from treatment as "life insurance" as defined by the Internal Revenue Code. We recommend that you consult a professional tax advisor.

Deferral of Payment

We reserve the right to defer payment of the Cash Surrender Value, Policy loan or Withdrawal amount for a period not exceeding six months from the date we receive your request. We will not defer a payment that is to be used to pay premium on any policy with us.

Termination

This Policy terminates on the earliest of:

- (1) 31 days after the date we mail notice stating the Policy Debt equals or exceeds the Cash Value and no portion of the Policy Debt is repaid before that date such that the Policy Debt is less than the Cash Value;
- (2) the date we receive your request to surrender it for the Cash Surrender Value; and
- (3) the date of death of the Insured.

Reinstatement

If this Policy terminates, other than due to a request to surrender, you may reinstate it within five years of the date of termination. Reinstatement requires that we receive:

- (1) evidence satisfactory to us of the insurability of the Insured; and
- (2) an amount equal to any Policy Debt.

The effective date of a reinstated Policy will be the date we approve your request for reinstatement.

SUN LIFE ASSURANCE COMPANY OF CANADA

U.S. Headquarters Office:
[One Sun Life Executive Park
Wellesley Hills, MA 02481
800-225-3950]

Head Office:
[Toronto, Canada]

SINGLE PREMIUM WHOLE LIFE INSURANCE POLICY

No additional premium payments will be accepted.

Policy Proceeds are payable upon receipt of Due Proof of the Insured's death.

Does not participate in dividends.



SUN LIFE ASSURANCE COMPANY OF CANADA

ACCELERATED BENEFIT RIDER FOR LONG TERM CARE SERVICES

This rider is made a part of the Policy to which it is attached. It is subject to all of the terms and conditions of the Policy unless stated otherwise in this rider. This rider is also referred to as the "Accelerated Benefit Rider" or "ABR".

READ THIS RIDER CAREFULLY.

This rider accelerates the Policy's Face Amount to reimburse the Owner for expenses the Insured incurs for Qualified Long Term Care Services that are covered under this rider.

TAXATION

This rider is intended to be federally tax-qualified long term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191 (herein referred to as the "Code").

CONFORMITY WITH INTERNAL REVENUE CODE

If on or after its effective date, any provision of this rider does not comply with the requirements of the Code, the provision will be treated as if it had been changed to comply with those requirements. We will inform the Owner in writing of any such required change in the provisions of this rider.

RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. AS WITH ALL TAX MATTERS, THE OWNER SHOULD CONSULT A PROFESSIONAL TAX ADVISOR TO ASSESS THE EFFECT OF THIS RIDER.

RIGHT TO RETURN THIS RIDER AND THE POLICY WITHIN 30 DAYS

The Owner may return this rider and the Policy for any reason within 30 days after its delivery by taking it or mailing it to us or to the sales representative through whom this rider and the Policy was purchased. Immediately upon delivery or mailing to us, this rider and the Policy will be deemed void from the beginning. Any premium paid for this rider and the Policy will be returned.

NOTICE TO OWNER

This rider may not cover all of the costs associated with long term care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the Policy and this rider.

CAUTION

The issuance of this rider is based upon the responses to the questions on the Application for the Policy and this rider. A copy of the Application is attached to the Policy. If any answers are incorrect or untrue, the Company has the right to deny benefits or rescind this rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any answers are incorrect, contact the Company at the address shown on the front page of the Policy.

RENEWABILITY

This rider is noncancellable. This means that we may not, on our own, cancel or reduce coverage provided by this rider and we can not change the Single Premium paid for this rider. Subject to the Incontestability and Termination provisions, this rider will remain in force for as long as the Policy remains in force.

CONSIDERATION

This rider is issued in consideration of the Application for this rider and payment of the Single Premium for the rider coverage.

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SECTION 1: DEFINITIONS

The following are key words used in this rider. When they are used, they are capitalized. Also, some terms are capitalized and defined within the Policy or the provisions in which they appear in this rider.

Activities of Daily Living (ADLs) means the following functions:

- a. **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- b. **Contenance:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- c. **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- d. **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.
- e. **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- f. **Transferring:** Moving into or out of a bed, chair or wheelchair.

Adult Day Care Services means a program for six (6) or more individuals of social and health related services provided during the day in a community setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the Home.

Assisted Living Facility means a facility that is not excluded below and is engaged primarily in providing Maintenance or Personal Care Services to its residents. It must provide those services 24 hours a day, every day:

- a. under a license, certificate, or substantially similar permit and oversight from the federal government or the State in which it is located; OR
- b. operates, in accordance with all applicable laws, and continuously meets all of the following requirements:
 1. it has accommodations for at least ten (10) residents;
 2. it maintains records for all care and services provided to each resident;
 3. it has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from an inability to perform Activities of Daily Living or Severe Cognitive Impairment;
 4. it has an awake employee who is aware of the whereabouts of the resident inpatients;
 5. it provides, at a minimum, assistance with Bathing and Dressing;
 6. it provides three (3) meals a day and accommodates special dietary needs;
 7. it has written formal procedures, including an agreement with a physician or Nurse, for the furnishing of medical care and services in case of an emergency; and
 8. it has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Living Facility is NOT any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;
- d. a Nursing Facility;
- e. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- f. an adult residence establishment or environment which is substantially similar to the above.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the above definition.

Chore Services means assistance with the following light work activities:

- a. minor household repairs related to the Insured's safety at Home (such as to handrails and safety rails, stairs, or floors);
- b. taking out the garbage; and
- c. simple cleaning tasks to remove unsafe debris or dirt in the Insured's Home.

Chore Services do not include any type of:

- a. residential upkeep;
- b. construction;
- c. renovation or routine home preservation (such as painting);
- d. lawn or yard care;
- e. snow removal;
- f. vehicle or equipment maintenance; or
- g. similar tasks.

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- a. being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- b. requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

Covered Care means only those Qualified Long Term Care Services for which this rider pays benefits or would pay benefits in the absence of an Elimination Period. These are described in Section 5.

Current Eligibility Certification is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that the Insured meets the above requirements for being a Chronically Ill Individual.

Elimination Period means the total number of days that the Insured remains a Chronically Ill Individual and receives Covered Care before benefits are payable under those Benefits subject to the Elimination Period. The Elimination Period is shown in Section 1 of the Policy. Each Benefit states how the Elimination Period affects its payment if it applies.

The Elimination Period can be satisfied by days for which payment would otherwise be made under those Benefits to which the Elimination Period applies. It can also be satisfied by days for which the Company makes payment under the Home Care Benefit. Days used to satisfy the Elimination Period do not need to be consecutive and can be accumulated over time. The Elimination Period only needs to be satisfied once during the Insured's lifetime.

Family Member means: (a) the Insured's spouse and (b) the following relatives of the Insured or the Insured's spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Home means the Insured's primary place of residence in the area the Insured uses principally for independent residential living. This could be: (a) a house; (b) a condominium; (c) an apartment; (d) a unit in a congregate care community; or (e) similar residential environment. The Insured's Home does not include: (a) a hospital; (b) Nursing Facility; or (c) Assisted Living Facility.

Home Health Aide and Personal Care Services means assistance or supervision the Insured receives for: (a) simple health care tasks; (b) personal hygiene; (c) managing medications; (d) Activities of Daily Living performance; and (e) Severe Cognitive Impairment.

Homemaker Services means assistance with one or more of the following tasks: (a) meal planning and preparation; (b) doing laundry; and (c) light house cleaning, such as: (1) vacuuming; (2) mopping; (3) dishwashing; (4) cleaning the kitchen or bath; and (5) changing soiled bedding.

Hospice Care means services that are designed to:

- a. provide palliative care to the Insured; or
- b. alleviate the Insured's physical, emotional and spiritual discomforts because the Insured is experiencing the last phases of life due to a terminal disease (diagnosed with six (6) months or less to live).

Hospice Care can be provided in:

- a. the Insured's Home; or
- b. a separate facility that is licensed or certified to provide Hospice Care by the state in which it is located. Room and board expenses provided in such a facility will be a Covered Care expense under this rider.

Hospice Care does not include coverage for prescription drugs.

Insured means the person named as the Insured in Section 1 of the Policy.

Licensed Health Care Practitioner means any of the following who is not a Family Member:

- a. a physician as defined in Section 1861(r)(1) of the Social Security Act;
- b. a registered professional Nurse;
- c. a licensed social worker; or
- d. any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Maintenance or Personal Care Services as used above and elsewhere in this rider means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN), and is operating within the scope of that license.

Nurse and Therapist Services means services provided in the Insured's Home by:

- a. a Nurse; or
- b. a licensed physical, occupational, respiratory, or speech therapist.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse. The facility must employ at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Facility does NOT include any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;

- d. an Assisted Living Facility;
- e. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- f. an adult residence establishment or environment which is similar to the above.

Out-of-Country Nursing Facility is an institution, not excluded below, that:

- a. is located outside the United States, its territories and possessions; and
- b. is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- c. satisfies all of the following Conditions.

Conditions: To satisfy this Out-of-Country Nursing Facility definition, such facility, or a separate portion, ward, wing or unit thereof, must at all times:

- a. provide such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to the Company that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Nursing Facility Benefit of this rider;
- b. employ at least one full-time (employed at least 30 hours per week) Graduate Nurse;
- c. have a Graduate Nurse on duty or on call in the facility at all times;
- d. have an awake employee on duty in the facility who is:
 - 1. trained and ready to provide its residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
 - 2. aware of the whereabouts of the residents;
- e. provide three meals a day and accommodate special dietary needs;
- f. have arrangements with a duly licensed physician or Graduate Nurse to furnish medical care and services in case of an emergency;
- g. have the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications; and
- h. have accommodations for at least ten resident inpatients in that location.

For the purposes of this definition, a Graduate Nurse is a person who has:

- a. completed an extensive post-secondary nursing care training program; and
- b. a current license to provide skilled nursing care to sick or infirm individuals under the direction of a licensed physician.

Excluded Places: The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;
- d. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- e. an adult residence establishment or environment which is substantially similar to the above.

Plan of Care means a written, individualized plan for care and support services for the Insured that:

- a. has been developed as a result of an assessment and incorporates any information provided by the Insured's personal physician;
- b. has been prescribed by a Licensed Health Care Practitioner;
- c. fairly, accurately and appropriately addresses the Insured's long term care and support service needs; and
- d. specifies the following:
 - 1. the type, frequency and duration of all services required to meet those needs;
 - 2. the providers appropriate to furnish those services; and

3. an estimate of the appropriate cost of such services.

We retain the right to discuss the Plan of Care with the Licensed Health Care Practitioner. We may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual. The Plan of Care must be updated as the Insured's needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make a copy of the current Plan of Care available to the Insured's personal physician, when requested. No more than one Plan of Care may be in effect at a time.

Qualified Long Term Care Services means the necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which are:

- a. required if the Insured becomes a Chronically Ill Individual; and
- b. provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Important Note: To be eligible for payment under this rider, it is not sufficient for services to be only Qualified Long Term Care Services. Such services must also:

- a. be care or support services for which this rider pays benefits; and
- b. satisfy all requirements for Benefit eligibility and payment.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that is:

- a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- b. measured by clinical evidence and standardized tests that reliably measure impairment in the person's:
 1. short-term or long-term memory;
 2. orientation as to people, places, or time;
 3. deductive or abstract reasoning; and
 4. judgment as it relates to safety awareness.

Substantial Assistance is either:

- a. **Hands-on Assistance**, which is the physical assistance (minimal, moderate or maximal) of another person without which the Insured would be unable to perform an Activity of Daily Living; or
- b. **Standby Assistance**, which is the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include verbal cueing, prompting, gestures, or other demonstrations) by another nearby person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

SECTION 2: WHEN THE RIDER TAKES EFFECT AND CONTINUES IN FORCE

EFFECTIVE DATE

This rider is issued with the Policy. Its effective date is the Policy Date shown in Section 1 of the Policy.

RIDER TERMINATION

This rider will terminate on the earliest of:

- a. the date the Maximum Benefit Amount is exhausted; or
- b. the date the Policy terminates as described in the Policy.

Upon termination of this rider, no further benefits will be paid under this rider except as provided under the Continuation of Benefits under the Accelerated Benefit Rider provision of this rider.

CONTINUATION OF BENEFITS UNDER THE ACCELERATED BENEFIT RIDER

If the Policy would otherwise terminate because the Policy Debt equals or exceeds the Cash Value and benefits are being paid under this rider, the Insured will continue to be eligible for benefits under this rider until the earliest of the following:

- a. the date the Insured's continuous confinement in a facility that provides Covered Care ceases;
- b. the date that continuous coverage under the Home Care Benefit ceases;
- c. the date the Maximum Benefit Amount is exhausted; or
- d. the date the Insured ceases to meet the requirements of the Eligibility for the Payment of Benefits provision in this rider.

For the purposes of this provision, continuous confinement will include:

- a. receiving another level of care in the same facility;
- b. being transferred to another facility that provides Covered Care; and
- c. transferring back to a facility that provides Covered Care from a temporary or acute hospitalization for which Bed Reservation Benefits are payable.

SECTION 3: BENEFITS PAYABLE UNDER THIS RIDER

This rider accelerates the Policy Face Amount to reimburse the Owner for expenses the Insured incurs for Qualified Long Term Care Services that are covered under this rider. The term "acceleration" means that any benefits paid for Covered Care expenses will reduce the Policy Face Amount on a dollar for dollar basis and reduce the Policy's Cash Value as described in Section 4. The benefit is based on the **Maximum Benefit Amount** and the **Maximum Monthly Benefit Amount** shown in Section 1 of the Policy.

The Maximum Benefit Amount is the total amount of expenses for Qualified Long Term Care Services that can be paid out in the form of accelerating the Policy's Death Benefit. On the Policy Date, it is equal to the Policy Face Amount. The Maximum Benefit Amount will decrease due to Withdrawals and due to benefit payments made under this rider.

The Maximum Monthly Benefit Amount on the Policy Date is the Maximum Benefit Amount divided by the number of months in the Benefit Period as shown in Section 1 of the Policy. It is the maximum monthly amount the Company will pay for Covered Care expenses under this rider.

The amount that can be reimbursed for each month of Covered Care is the lesser of:

- a. the Maximum Monthly Benefit Amount; or
- b. the Covered Care expenses actually incurred for that month.

To the extent that the benefit that is paid for any month is less than the Maximum Monthly Benefit Amount, the number of months of accelerated benefit payments will be extended until the Maximum Benefit Amount has been reduced to zero.

Optional ABR Return of Premium (ROP) Benefit. If you have elected this optional benefit, the ABR ROP Single Premium is shown in Section 1 of the Policy. If you surrender and terminate the Policy before benefit payments begin under this rider and no Withdrawals have been made from the Policy, then you will receive the following:

- a. the Single Premium for the Policy; plus
- b. the Single Premium for this rider; plus
- c. the Single Premium for any optional coverages selected for this rider; plus
- d. the Single Premium for the Residual Benefit Rider; less
- e. the Cash Value for the Policy.

If you surrender and terminate the Policy before benefit payments begin under this rider and Withdrawals were made from the Policy, then the amount you receive will be determined in the same manner as described above except that 'a', 'b', 'c' and 'd' will be multiplied by the ratio of the adjusted Face Amount after withdrawals divided by the initial Face Amount.

In no instance will the Optional ABR Return of Premium Benefit exceed the Single Premium for this rider. Additionally, as the Cash Value for the Policy increases, the portion of the amount you receive representing the Optional ABR Return of Premium Benefit decreases.

Once benefit payments begin under this rider, no ABR ROP Benefit will be paid.

Optional Simple Inflation Protection. If you have elected optional Simple Inflation Protection, it is shown in Section 1 of the Policy. With optional Simple Inflation Protection coverage, the Maximum Monthly Benefit Amount will increase on each Policy Anniversary and will equal 'a' plus 'b' where:

- a. is the Maximum Monthly Benefit Amount prior to the Policy Anniversary; and
- b. is the ABR Inflation Rate shown in Section 1 of the Policy times the initial Maximum Monthly Benefit Amount adjusted for all Withdrawals made since the Policy Date.

The Maximum Monthly Benefit Amount will increase up to an amount not to exceed two times the Maximum Monthly Benefit Amount shown in Section 1 of the Policy adjusted for any Withdrawals.

The Maximum Benefit Amount will not be adjusted on each Policy Anniversary due to the impact of optional Simple Inflation Protection coverage,

Inflation Protection Premium. If you elected optional Inflation Protection, the ABR Inflation Single Premium due and payable to us is shown in Section 1 of the Policy.

SECTION 4: EFFECT OF ABR BENEFIT PAYMENTS

EFFECT OF ABR BENEFIT PAYMENTS

Any benefit payment made for a specific month up to the amount of the Maximum Monthly Benefit Amount in effect on the Policy Date will have the following impact:

1. It will reduce the Face Amount by the amount of such benefit payment.
2. It will reduce the Policy Cash Value by a divided by b, where:
 - a. is the Face Amount after the benefit payment; and
 - b. is the Face Amount in effect prior to such benefit payment.
3. It will reduce the remaining Maximum Benefit Amount by the amount of such benefit payment.

If the Insured is on claim at the time the Policy terminates, the claim will continue to be paid based on the Continuation of Benefits under the Accelerated Benefit Rider provision.

Any payments made under this rider in excess of the Maximum Monthly Benefit Amount due to the presence of the optional Inflation Protection coverage will have no impact on either the Face Amount or the Cash Value.

Once benefit payments begin under this rider, no Withdrawals may be made except to fully surrender the Policy which will terminate this rider.

EFFECT OF WITHDRAWALS

When a Withdrawal is made under the Policy, it will reduce the Maximum Monthly Benefit Amount by (a) divided by (b), where:

- (a) is the Face Amount after the Withdrawal; and
- (b) is the Face Amount prior to the Withdrawal.

The Maximum Benefit Amount will be reduced in the same proportion as the Maximum Monthly Benefit Amount. Any reduction in the Maximum Benefit Amount and the Maximum Monthly Benefit Amount will apply only to expenses incurred on or following the date of the Withdrawal.

EFFECT OF POLICY LOANS

When a Policy Loan is outstanding at the time of a benefit payment under this rider, a portion of the benefit payment will be allocated to reduce the Policy Debt and will not be paid to the Owner. The amount so allocated will equal (a) times (b), where:

- (a) is the reduction to the Cash Value when a payment is made as described in the Effect of ABR Benefit Payments provision;
- (b) is the ratio of the Policy Loan to the Cash Value prior to the payment being made.

EFFECT OF DEATH BENEFIT PAYMENTS

When the Death Benefit is paid, the Maximum Benefit Amount will be reduced to zero and no further benefits will be paid under this rider. Payment of a Death Benefit will not affect payment of eligible claims for Covered Care expenses incurred prior to the date of death of the Insured. We reserve the right to withhold any portion of the Death Benefit that would otherwise be payable until we verify that we have received all remaining claims for incurred Covered Care expenses.

SECTION 5: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For benefits to be payable under this rider:

- a. the Insured must be a Chronically Ill Individual;
- b. we must receive a Current Eligibility Certification for the Insured; and
- c. we must receive ongoing proof which demonstrates that the Covered Care the Insured receives is needed due to his or her continually being a Chronically Ill Individual. The proof can be based on information from care providers, personal physicians, or other Licensed Health Care Practitioners.

CONDITIONS FOR PAYMENT

Benefits will be paid as reimbursement for incurred Covered Care expenses that meet all of the following conditions:

- a. the Owner must submit a claim for benefits under this rider;
- b. the Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- c. the Insured has not reached any limits applicable to the specific benefits claimed;
- d. the Insured meets all additional requirements for the specific benefits claimed;
- e. the Insured satisfies the Elimination Period if it applies; and
- f. except as stated in the Continuation of Benefits under the Accelerated Benefit Rider provision in this rider, the Policy and this rider must be in force on the date the expense, fee, or charge for an item of Covered Care is incurred. An expense, fee or charge will be considered to be incurred on the day on which the Covered Care is received.

Once we determine that the Insured is eligible for benefits, the Insured's eligibility for benefits will continue for as long as the Insured continues to be eligible for benefits and has not reached the Maximum Benefit Amount. We reserve the right to perform periodic reassessments of the Insured's eligibility. Regardless of the Policy Date, the monthly payment is based on a calendar month time period.

SECTION 5-1: HOME CARE BENEFIT

We will pay for expenses the Insured incurs for the following Covered Care:

- a. Adult Day Care Services;
- b. Nurse and Therapist Services;
- c. Home Health Aide and Personal Care Services;
- d. Homemaker Services;
- e. Chore Services; and
- f. Hospice Care.

These services must be:

- a. received in the Insured's Home, unless they are Adult Day Care Services or Hospice Care provided in a facility providing Hospice Care;
- b. necessary to enable the Insured to continue to stay safely at Home, unless the services are in a facility providing Hospice Care;
- c. necessary because the Insured alone is not able to perform them due to the Insured being a Chronically Ill Individual; and
- d. consistent with the needs addressed in the Insured's Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

Payment Limitations: The Elimination Period does not apply to this Benefit, but any days for which Home Care Benefits are payable will be used to satisfy the Elimination Period. This Benefit will not be payable at the same time as any benefits for confinement in a Nursing Facility, Assisted Living Facility, or Out-of-Country Nursing Facility.

SECTION 5-2: NURSING FACILITY BENEFIT

We will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by a Nursing Facility while the Insured is confined there as a resident inpatient. This includes expenses for:

- a. private duty nursing care; and
- b. all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility.

The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Elimination Period.

SECTION 5-3: ASSISTED LIVING FACILITY BENEFIT

We will pay the expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Assisted Living Facility while the Insured is confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility. No payment will be made for any service which does not facilitate the performance of an Activity of Daily Living.

Payment Limitations: Payment of this Benefit is subject to the Elimination Period.

SECTION 5-4: BED RESERVATION BENEFIT

We will continue to pay benefits, or give Elimination Period credit for expenses the Insured incurs for Covered Care under the Nursing Facility Benefit while the Insured:

- a. is temporarily absent during a stay in a Nursing Facility or Assisted Living Facility; and
- b. is charged to reserve the Insured's accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay or when the Insured spends holidays or other time with his or her family.

Payment Limitations: This benefit is limited to no more than 30 days (continuous or not) each calendar year. The amount payable for this benefit can not exceed 1/30th of the Maximum Monthly Benefit for each day the bed is reserved.

SECTION 5-5: RESPITE CARE BENEFIT

We will pay Covered Care expenses the Insured incurs for Respite Care. Respite Care means short-term care that is provided to the Insured in order to relieve the person who normally provides the Insured with unpaid informal care in the Insured's Home. The Insured's Plan of Care must state:

- a. the name of the unpaid caregiver for whom respite is being provided;
- b. the period of respite; and
- c. the Covered Care the Insured will require to replace that care normally provided by the unpaid caregiver.

Respite Care can be received in the Insured's Home, or during a temporary stay in a Nursing Facility or Assisted Living Facility.

Payment Limitations: This Benefit will not be payable at the same time as any other Benefit except when the Company pays for caregiver training. This benefit is limited to no more than 30 days (continuous or not) each calendar year. The amount payable for this benefit can not exceed 1/30th of the Maximum Monthly Benefit Amount for each day of Respite Care.

SECTION 5-6: CAREGIVER TRAINING BENEFIT

We will pay Covered Care expenses the Insured incurs for training an unpaid informal caregiver to care for the Insured in the Insured's Home. All the following conditions apply to this Benefit:

- a. We will not pay to train someone who will be paid to care for the Insured.
- b. The training can be received while the Insured is confined in a hospital, Nursing Facility, or Assisted Living Facility only if it is reasonably expected that the training will make it possible for the Insured to go Home where the Insured can be cared for by the person receiving the training.

SECTION 5-7: SUPPORTIVE EQUIPMENT BENEFIT

We will pay Covered Care expenses the Insured incurs for Supportive Equipment if it is specified and provided in accordance with the Insured's Plan of Care. We will pay for expenses, including installation fees, labor and related costs, the Insured incurs for the purchase or rental of Supportive Equipment, if such equipment is:

- a. intended to assist the Insured in living at Home by relieving the Insured's need for direct physical assistance; and
- b. specified and provided in accordance with the Insured's Plan of Care stating that the equipment is expected to enable the Insured to remain at Home for at least 90 days after the date of purchase or first rental.

Supportive Equipment includes items such as the following:

- a. pumps and other devices for intravenous injection;

- b. ramps to permit movement from one level of a residence to another;
- c. grab bars to assist in toileting, bathing or showering; and
- d. stair lifts for going between levels of the Insured's Home.

Supportive Equipment does not include either:

- a. equipment that will, other than incidentally, increase the value of the residence in which it is installed; or
- b. artificial limbs, teeth, medical supplies, or equipment placed in the Insured's body, temporarily or permanently.

SECTION 5-8: INTERNATIONAL COVERAGE BENEFIT

We will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Out-of-Country Nursing Facility while the Insured is confined there as a resident inpatient. This includes expenses for all levels of care (whether skilled, intermediate or custodial) provided by the Out-of-Country Nursing Facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in the Out-of-Country Nursing Facility.

Payment of this Benefit is subject to the following conditions:

- a. Payment will be in lieu of all other Benefits and reimbursement otherwise provided by this rider for expenses incurred during the period for which payment is made under this Benefit.
- b. Payment will only be made in the lawful money of the United States of America. Any foreign exchange rate will be determined by the Company.
- c. This Benefit will not be payable if it is prohibited by United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Asset Control (or its successor organization).
- d. We must receive proof, satisfactory to us, that the Insured has met all of the requirements stated in the Limitations or Conditions on Eligibility for Benefits section. We must be furnished, at no expense to us, with complete documentation in English. Such documentation shall include, but is not limited to:
 - 1. a Current Eligibility Certification;
 - 2. a satisfactory Plan of Care prescribing the need for care due to the Insured's being a Chronically Ill Individual;
 - 3. properly completed claims forms, billing statements, and supporting medical and care documentation;
 - 4. a copy of the Insured's passport, airline ticket or other proof acceptable to us that the Insured is outside the United States of America, its territories and possessions; and
 - 5. we may require that all of the above information be provided at reasonable intervals. We will not require this more frequently than monthly.

Payment Limitations: Payment of this benefit is subject to the Elimination Period.

SECTION 6: GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- a. provided by a Family Member, unless:
 - 1. the Family Member is a regular employee of the organization that is providing the services; and
 - 2. such organization receives payment for the services; and
 - 3. the Family Member receives no compensation other than the normal compensation for employees in her or his job category;
- b. for which no charge is normally made in the absence of insurance;

- c. provided outside of the United States of America, its territories and possessions; except as provided in the International Coverage Benefit;
- d. provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured or the Insured's estate;
- e. arising out of the Insured's attempted suicide or an intentionally self-inflicted injury; or
- f. for the Insured's alcoholism or addiction to drugs or narcotics; but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

NON-DUPLICATION

Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid). However, this Non-Duplication provision will not disqualify an expense for Covered Care from being used to satisfy the Elimination Period if it applies.

SECTION 7: CLAIMS PROVISIONS

STARTING THE CLAIMS PROCESS

Contacting us as soon as it appears the Insured may be a Chronically Ill Individual will facilitate a timely claim review. This can help us greatly in the claims process and at the same time lead to early planning of the Insured's Covered Care.

TELLING THE COMPANY ABOUT A CLAIM

Notice of Claim

We must be notified when there is a claim. The notice should be given to us at Our Principal Office. It must be received within 30 days of the date the covered loss starts, or as soon as reasonably possible. The notice should include at least:

- a. the Owner's name;
- b. the Insured's name;
- c. the Policy Number (as shown in Section 1 of the Policy); and
- d. an address to which the claim forms should be sent.

Claim Forms

When we receive a notice of claim, we will send out the necessary forms to be used to file proof of loss. The forms to be completed will explain how to complete the forms and where to send them and should be signed by the Owner, and by the Insured where required.

All required information must be provided. Proof of loss must be in the form of written documentation acceptable to the Company that:

- a. describes and confirms that the Insured is a Chronically Ill Individual;
- b. includes a Current Eligibility Certification from a Licensed Health Care Practitioner;
- c. describes and confirms the Insured's confinement in a covered facility (if applicable);
- d. describes and confirms any other Covered Care the Insured is receiving;
- e. includes copies of itemized bills, paid invoices or cancelled checks for charges the Insured incurred for Covered Care.

We must be provided with the authorization necessary for us to request copies of the Insured's medical records or a care provider's daily notes of care. We may choose to consult by telephone with the Licensed Health Care Practitioner who prescribed the Insured's Plan of Care, or with any care provider the Insured used. This information will assist us in the evaluation of the claim so that we can determine the benefits for which the Insured is eligible.

If we do not provide the necessary claim forms within 15 days, proof of loss can be filed without them by sending us a letter, signed by the Owner, which describes the occurrence and the character and the

extent of the loss for which claim is made. That letter must be sent to us at Our Principal Office within the time period stated in the next paragraph.

Proof of Loss

When this rider provides for payment for continuing loss, written proof of the loss must be given us within 90 days after the end of each monthly period for which benefits may be payable. For any other Covered Care expense loss covered by this rider, written proof must be given to us within 90 days after such loss. If it was not reasonably possible to give us written proof in the time required, we shall not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the Owner is not legally capable, the required proof must always be given to the Company no later than one (1) year from the time specified.

OUR EVALUATION CRITERIA AND THE CLAIMS PAYMENT PROCESS

How the Company Evaluates Claims

We will obtain information about the Insured by working with the Insured, the Owner, and the Insured's personal physician, as appropriate. We will also consult with any Licensed Health Care Practitioners, agencies and other care providers the Insured used. We will then review that information to determine eligibility for benefits. We reserve the right, as part of the review and at our expense, to do an assessment or a physical examination of the Insured. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. We may use outside services to assist in evaluating the Insured's condition.

On an ongoing basis, we must receive updates to the Insured's Plan of Care and Current Eligibility Certifications. We will also need a copy of the Insured's Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Physical Examinations

At our expense, we have the right to require a medical examination of the Insured when a claim is made and at reasonable intervals while continued benefits are being claimed.

Time of Payment of Claim

After we receive the proper written proof of loss, we will pay any benefits then due immediately. When the loss is expected to result in on-going benefits, we will pay any benefits at the end of each monthly period after the first payment date.

Payment of Claims

Benefits will be paid to the Owner. Any benefits unpaid at the Owner's death may be paid to the Owner's estate. If benefits are paid to the Owner's estate, we may pay a portion of those benefits, up to \$1,000, directly to someone related to the Owner who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

We may pay all or a portion of any benefits for care or services the Insured receives to the provider of the care or services, unless the Owner directs us to do otherwise in writing by the time proofs of loss are filed. We do not require that a particular provider provide the care or services.

APPEALING A CLAIM DECISION

We will inform the Owner in writing if a claim, or any part of a claim, is denied.

Appeal Process

If it is believed that our decision on a claim is in error, the Owner may appeal, and we will reconsider the claim. To make an appeal, the Owner must send us a brief note (no special form needed) that tells us why it is felt that we should change our decision. The Owner may authorize someone else to act for him or her in this appeal process.

The written appeal should include the names, addresses and phone numbers of any providers the Company should contact to learn more about the health and the care received by the Insured. This would

include those physicians, health care professionals and other care providers who treated the Insured, and the facilities from which the Insured received care, treatment, services, equipment or other items.

We will provide the Owner with a written explanation of the reasons for any claim denial and make available all information directly related to that denial within 60 days of the date of any written claims appeal. We will immediately pay any benefits due as a result of our reconsideration.

Legal Actions

We cannot be sued on any claim before 60 days after proof of claim has been given to us as required by this rider. We cannot be sued after 3 years from the time the written proof of loss is required to be given.

Right To Recover

If we pay benefits under the Policy and this rider, and the total of such benefits is greater than the amount payable under the Policy and this rider, we will have the right to recover such excess from:

- a. any person to whom, or for whom, such payments were made;
- b. any organization which should have made such payments; and
- c. future benefit payments, if any.

We will have a right to:

- a. reimbursement for benefits paid under this rider, if it is found that such payments were paid in error; and
- b. recover any benefits paid under this rider as a result of fraudulent claims submitted for Covered Care not rendered or purchased.

SECTION 8: GENERAL PROVISIONS

ASSIGNMENT

During the lifetime of the Insured, you may assign the benefits payable under this rider. All assignments must be filed at Our Principal Office in written form satisfactory to us. The assignment will then be effective as of the date you signed the form, subject to any action taken before we acknowledge receipt. We are not responsible for the validity or legal effect of any assignment.

SURRENDERS

If you surrender the Policy as part of an exchange under Internal Revenue Code §1035, the intended tax-qualified status of this rider may be affected and may result in adverse tax consequences. Consult a professional tax advisor before making a surrender of the Policy for this purpose.

REINSTATEMENT

If the Policy to which this rider is attached is reinstated, this rider will also be reinstated, subject to the same terms and conditions of the Reinstatement provision in the Policy, unless the Maximum Benefit Amount has been exhausted. The reinstatement shall be subject to satisfactory evidence of insurability from the Insured. Upon reinstatement, this rider will:

- a. only provide benefits for Covered Care received after the date of reinstatement; and
- b. be subject to all terms and conditions of the Policy and this rider.

If, however, the Insured was a Chronically Ill Individual when the Policy and this rider lapsed and, if the reinstatement is requested within five (5) months after the date of the lapse, then in lieu of submitting evidence of insurability, the Policy and this rider may be reinstated by submitting to the Company satisfactory proof that the Insured is a Chronically Ill Individual. Upon reinstatement, this rider will:

- a. provide benefits for Covered Care received after the date of the lapse as if coverage had remained in force; and
- b. be subject to all terms and conditions of the Policy and this rider.

REPRESENTATIONS

In the absence of fraud, any statement made by the Owner or the Insured will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed Application.

INCONTESTABILITY PERIOD

A misstatement by the Owner or the Insured in any Application for the Policy or this rider may be used to rescind (void) or cancel this rider or deny an otherwise valid claim. During the first six (6) months following the Issue Date of this rider, the Company may take such action only if the misstatement was material to the issuance of this rider. After the first six (6) months, but before the end of the first twenty-four (24) months, the Company may take such action only if the misstatement was material to both the issuance of this rider and the claim for which benefits are being sought. After this rider has been in force for twenty-four (24) months from the Issue Date of this rider, the Company can take such action only if the Company can show that the Owner or the Insured knowingly and intentionally misrepresented relevant facts relating to the Insured's health. No benefits will be paid under this rider if it is rescinded or canceled.

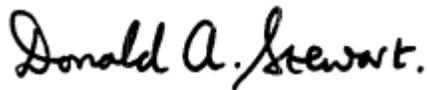
In the event of death of the Insured, this provision will not apply to the remaining Death Benefit payable under the Policy which will be governed by the Incontestability provision in the Policy.

PRE-EXISTING CONDITIONS NOT EXCLUDED

Except as permitted above, the Company will not reduce or deny any claim under this rider because of a sickness or a physical or medical condition that existed before the Policy Date.

CONFORMITY WITH STATE STATUTES

If any provision of this rider is in conflict with the statutes of the state in which the Policy is delivered, the provisions of this rider will be automatically amended to meet the minimum requirements of such statutes.

A handwritten signature in black ink that reads "Donald A. Stewart." The signature is written in a cursive, flowing style.

[Donald A. Stewart, Chief Executive Officer]

SUN LIFE ASSURANCE COMPANY OF CANADA

EXTENSION OF BENEFITS RIDER FOR LONG TERM CARE SERVICES

This rider is made a part of the Policy to which it is attached. It is subject to all of the terms and conditions of the Policy and of the Accelerated Benefit Rider for Long Term Care Services unless stated otherwise in this rider. This rider is also referred to as "Extension of Benefits" or "EOB".

READ THIS RIDER CAREFULLY.

This rider provides benefits to reimburse the Owner for expenses the Insured incurs for Qualified Long Term Care Services after the benefits under the Accelerated Benefit Rider for Long Term Care Services have been exhausted.

TAXATION

This rider is intended to be federally tax-qualified long term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191 (herein referred to as the "Code").

CONFORMITY WITH INTERNAL REVENUE CODE

If on or after its effective date, any provision of this rider does not comply with the requirements of the Code, the provision will be treated as if it had been changed to comply with those requirements. We will inform the Owner in writing of any such required change in the provisions of this rider.

RECEIPT OF BENEFITS MAY BE TAXABLE. AS WITH ALL TAX MATTERS, THE OWNER SHOULD CONSULT A PROFESSIONAL TAX ADVISOR TO ASSESS THE EFFECT OF THIS RIDER.

RIGHT TO RETURN THIS RIDER WITHIN 30 DAYS

The Owner may return this rider for any reason within 30 days after its delivery by taking it or mailing it to us or to the sales representative through whom this rider was purchased. Immediately upon delivery or mailing to us, this rider will be deemed void from the beginning. Any premium paid for this rider will be returned.

NOTICE TO OWNER

This rider may not cover all of the costs associated with long term care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the Policy, the Accelerated Benefit Rider for Long Term Care Services and this rider.

CAUTION

The issuance of this rider is based upon the responses to the questions on the Application for the Policy and this rider. A copy of the Application is attached to the Policy. If any answers are incorrect or untrue, the Company has the right to deny benefits or rescind this rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any answers are incorrect, contact the Company at the address shown on the front page of the Policy.

RENEWABILITY

This rider is noncancellable. This means that we may not, on our own, cancel or reduce coverage provided by this rider and we can not change the Single Premium paid for this rider. Subject to the Incontestability and Termination provisions, this rider will remain in force for as long as the Policy remains in force.

CONSIDERATION

This rider is issued in consideration of the Application for this rider and payment of the Single Premium for the rider coverage.

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SECTION 1: DEFINITIONS

The following are key words used in this rider. When they are used, they are capitalized. Also, some terms are capitalized and defined within the Policy or the provisions in which they appear in this rider.

Activities of Daily Living (ADLs) means the following functions:

- a. **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- b. **Continence:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- c. **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- d. **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.
- e. **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- f. **Transferring:** Moving into or out of a bed, chair or wheelchair.

Adult Day Care Services means a program for six (6) or more individuals of social and health related services provided during the day in a community setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the Home.

Assisted Living Facility means a facility that is not excluded below and is engaged primarily in providing Maintenance or Personal Care Services to its residents. It must provide those services 24 hours a day, every day:

- a. under a license, certificate, or substantially similar permit and oversight from the federal government or the State in which it is located; OR
- b. operates, in accordance with all applicable laws, and continuously meets all of the following requirements:
 1. it has accommodations for at least ten (10) residents;
 2. it maintains records for all care and services provided to each resident;
 3. it has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from an inability to perform Activities of Daily Living or Severe Cognitive Impairment;
 4. it has an awake employee who is aware of the whereabouts of the resident inpatients;
 5. it provides, at a minimum, assistance with Bathing and Dressing;
 6. it provides three (3) meals a day and accommodates special dietary needs;
 7. it has written formal procedures, including an agreement with a physician or Nurse, for the furnishing of medical care and services in case of an emergency; and
 8. it has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Living Facility is NOT any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;
- d. a Nursing Facility;
- e. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- f. an adult residence establishment or environment which is substantially similar to the above.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the above definition.

Chore Services means assistance with the following light work activities:

- a. minor household repairs related to the Insured's safety at Home (such as to handrails and safety rails, stairs, or floors);
- b. taking out the garbage; and
- c. simple cleaning tasks to remove unsafe debris or dirt in the Insured's Home.

Chore Services do not include any type of:

- a. residential upkeep;
- b. construction;
- c. renovation or routine home preservation (such as painting);
- d. lawn or yard care;
- e. snow removal;
- f. vehicle or equipment maintenance; or
- g. similar tasks.

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- a. being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- b. requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

Covered Care means only those Qualified Long Term Care Services for which this rider pays benefits or would pay benefits in the absence of an Elimination Period. These are described in Section 5.

Current Eligibility Certification is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that the Insured meets the above requirements for being a Chronically Ill Individual.

Elimination Period means the total number of days that the Insured remains a Chronically Ill Individual and receives Covered Care before benefits are payable under those Benefits subject to the Elimination Period. The Elimination Period is shown in Section 1 of the Policy. Each Benefit states how the Elimination Period affects its payment if it applies.

The Elimination Period can be satisfied by days for which payment would otherwise be made under those Benefits to which the Elimination Period applies. It can also be satisfied by days for which the Company makes payment under the Home Care Benefit. Days used to satisfy the Elimination Period do not need to be consecutive and can be accumulated over time. The Elimination Period only needs to be satisfied once during the Insured's lifetime.

Family Member means: (a) the Insured's spouse and (b) the following relatives of the Insured or the Insured's spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Home means the Insured's primary place of residence in the area the Insured uses principally for independent residential living. This could be: (a) a house; (b) a condominium; (c) an apartment; (d) a unit in a congregate care community; or (e) similar residential environment. The Insured's Home does not include: (a) a hospital; (b) Nursing Facility; or (c) Assisted Living Facility.

Home Health Aide and Personal Care Services means assistance or supervision the Insured receives for: (a) simple health care tasks; (b) personal hygiene; (c) managing medications; (d) Activities of Daily Living performance; and (e) Severe Cognitive Impairment.

Homemaker Services means assistance with one or more of the following tasks: (a) meal planning and preparation; (b) doing laundry; and (c) light house cleaning, such as: (1) vacuuming; (2) mopping; (3) dishwashing; (4) cleaning the kitchen or bath; and (5) changing soiled bedding.

Hospice Care means services that are designed to:

- a. provide palliative care to the Insured; or
- b. alleviate the Insured's physical, emotional and spiritual discomforts because the Insured is experiencing the last phases of life due to a terminal disease (diagnosed with six (6) months or less to live).

Hospice Care can be provided in:

- a. the Insured's Home; or
- b. a separate facility that is licensed or certified to provide Hospice Care by the state in which it is located. Room and board expenses provided in such a facility will be a Covered Care expense under this rider.

Hospice Care does not include coverage for prescription drugs.

Insured means the person named as the Insured in Section 1 of the Policy.

Licensed Health Care Practitioner means any of the following who is not a Family Member:

- a. a physician as defined in Section 1861(r)(1) of the Social Security Act;
- b. a registered professional Nurse;
- c. a licensed social worker; or
- d. any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Maintenance or Personal Care Services as used above and elsewhere in this rider means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN), and is operating within the scope of that license.

Nurse and Therapist Services means services provided in the Insured's Home by:

- a. a Nurse; or
- b. a licensed physical, occupational, respiratory, or speech therapist.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse. The facility must employ at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Facility does NOT include any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;

- d. an Assisted Living Facility;
- e. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- f. an adult residence establishment or environment which is similar to the above.

Out-of-Country Nursing Facility is an institution, not excluded below, that:

- a. is located outside the United States, its territories and possessions; and
- b. is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- c. satisfies all of the following Conditions.

Conditions: To satisfy this Out-of-Country Nursing Facility definition, such facility, or a separate portion, ward, wing or unit thereof, must at all times:

- a. provide such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to the Company that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Nursing Facility Benefit of this rider;
- b. employ at least one full-time (employed at least 30 hours per week) Graduate Nurse;
- c. have a Graduate Nurse on duty or on call in the facility at all times;
- d. have an awake employee on duty in the facility who is:
 - (1) trained and ready to provide its residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
 - (2) aware of the whereabouts of the residents;
- e. provide three meals a day and accommodate special dietary needs;
- f. have arrangements with a duly licensed physician or Graduate Nurse to furnish medical care and services in case of an emergency;
- g. have the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications; and
- h. have accommodations for at least ten resident inpatients in that location.

For the purposes of this definition, a Graduate Nurse is a person who has:

- a. completed an extensive post-secondary nursing care training program; and
- b. a current license to provide skilled nursing care to sick or infirm individuals under the direction of a licensed physician.

Excluded Places: The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- a. a clinic or hospital;
- b. a subacute care or rehabilitation hospital or unit;
- c. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;
- d. the Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); and
- e. an adult residence establishment or environment which is substantially similar to the above.

Plan of Care means a written, individualized plan for care and support services for the Insured that:

- a. has been developed as a result of an assessment and incorporates any information provided by the Insured's personal physician;
- b. has been prescribed by a Licensed Health Care Practitioner;
- c. fairly, accurately and appropriately addresses the Insured's long term care and support service needs; and
- d. specifies the following:
 - 1. the type, frequency and duration of all services required to meet those needs;
 - 2. the providers appropriate to furnish those services; and

3. an estimate of the appropriate cost of such services.

We retain the right to discuss the Plan of Care with the Licensed Health Care Practitioner. We may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual. The Plan of Care must be updated as the Insured's needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make a copy of the current Plan of Care available to the Insured's personal physician, when requested. No more than one Plan of Care may be in effect at a time.

Qualified Long Term Care Services means the necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which are:

- a. required if the Insured becomes a Chronically Ill Individual; and
- b. provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Important Note: To be eligible for payment under this rider, it is not sufficient for services to be only Qualified Long Term Care Services. Such services must also:

- a. be care or support services for which this rider pays benefits; and
- b. satisfy all requirements for Benefit eligibility and payment.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that is:

- a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- b. measured by clinical evidence and standardized tests that reliably measure impairment in the person's:
 1. short-term or long-term memory;
 2. orientation as to people, places, or time;
 3. deductive or abstract reasoning; and
 4. judgment as it relates to safety awareness.

Substantial Assistance is either:

- a. **Hands-on Assistance**, which is the physical assistance (minimal, moderate or maximal) of another person without which the Insured would be unable to perform an Activity of Daily Living; or
- b. **Standby Assistance**, which is the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include verbal cueing, prompting, gestures, or other demonstrations) by another nearby person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

SECTION 2: WHEN THE RIDER TAKES EFFECT AND CONTINUES IN FORCE

EFFECTIVE DATE

The effective date for this rider is the Policy Date shown in Section 1 of the Policy.

RIDER TERMINATION

This rider will terminate on the earliest of:

- a. the date the EOB Maximum Benefit Amount is exhausted; or
- b. the date the Policy terminates as described in the Policy.

SECTION 3: BENEFITS PAYABLE UNDER THIS RIDER

This rider reimburses the Owner for expenses the Insured incurs for Qualified Long Term Care Services after the benefits under the Accelerated Benefit Rider for Long Term Care Services have been exhausted. The benefit payments are based on the **EOB Maximum Monthly Benefit Amount**, the **EOB Maximum Benefit Amount**, and the **EOB Benefit Period**, as shown in Section 1 of the Policy.

The EOB Maximum Monthly Benefit Amount on the Policy Date is the same as the Maximum Monthly Benefit Amount for the Accelerated Benefit Rider for Long Term Care Services on the Policy Date. It is the maximum monthly amount the Company will pay for Covered Care expenses under this rider.

The EOB Maximum Benefit Amount on the Policy Date is equal to the EOB Maximum Monthly Benefit Amount on the Policy Date multiplied by the number of months of the EOB Benefit Period. It is the total amount of Covered Care expenses that can be paid under this rider.

The amount that can be reimbursed for each month of Covered Care is the lesser of:

- a. the EOB Maximum Monthly Benefit Amount; or
- b. the Covered Care expenses actually incurred for that month.

Each payment will reduce the remaining EOB Maximum Benefit Amount by the amount of the payment. To the extent that the benefit that is paid for any month is less than the EOB Maximum Monthly Benefit Amount, the number of months of benefit payments will be extended until the EOB Maximum Benefit Amount has been reduced to zero.

Optional EOB Return of Premium (ROP) Benefit. If you have elected this optional benefit, the EOB ROP Single Premium is shown in Section 1 of the Policy. If you surrender and terminate the Policy before benefit payments begin under the Accelerated Benefit Rider for Long Term Care Services and no Withdrawals have been made from the Policy, then you will receive the following:

- a. the Total Premium for the Policy; less
- b. the Cash Value for the Policy; less
- c. the amount of the ABR Return of Premium Benefit paid, if any.

If you surrender and terminate the Policy before benefit payments begin under the Accelerated Benefit Rider for Long Term Care Services and Withdrawals were made from the Policy, then the amount you receive will be determined in the same manner as described above except that 'a' will be multiplied by the ratio of the adjusted Face Amount after withdrawals divided by the initial Face Amount.

In no instance will the Optional EOB Return of Premium Benefit exceed the Single Premium for this rider. Additionally, as the Cash Value for the Policy increases, the portion of the amount you receive representing the Optional EOB Return of Premium Benefit decreases.

Once benefit payments begin under the Accelerated Benefit Rider, no EOB ROP Benefit will be paid.

Optional Inflation Protection: If you have elected optional Inflation Protection, the option selected is shown in Section 1 of the Policy. The options for this rider are:

Simple Inflation

With optional Simple Inflation Protection, the Maximum Monthly Benefit Amount will increase on each Policy Anniversary and will equal 'a' plus 'b' where:

- a. is the Maximum Monthly Benefit Amount prior to the Policy Anniversary; and
- b. is the EOB Inflation Rate shown in Section 1 of the Policy times the initial Maximum Monthly Benefit Amount adjusted for all Withdrawals made since the Policy Date.

The Maximum Monthly Benefit Amount will increase up to an amount not to exceed two times the Maximum Monthly Benefit Amount shown in Section 1 of the Policy adjusted for any Withdrawals.

The Maximum Benefit Amount on each Policy Anniversary will equal 'a' times 'b' less 'c' where:

- a. is the Maximum Monthly Benefit Amount on the Policy Anniversary;
- b. is the number of months for the EOB Benefit Period elected as shown in Section 1 of the Policy; and
- c. is the cumulative amount of EOB claims that have been paid prior to the Policy Anniversary.

Compound Inflation

The Maximum Monthly Benefit Amount on each Policy Anniversary will equal the Maximum Monthly Benefit Amount prior to the Policy Anniversary multiplied by 1 plus the EOB Inflation Rate shown in Section 1 of the Policy.

The Maximum Benefit Amount on each Policy Anniversary will equal the Maximum Benefit Amount prior to the Policy Anniversary multiplied by 1 plus the EOB Inflation Rate shown in Section 1 of the Policy.

Inflation Protection Premium. If you elected optional Inflation Protection, the EOB Inflation Single Premium due and payable to us is shown in Section 1 of the Policy.

SECTION 4: EFFECT OF BENEFIT PAYMENTS

EFFECT OF EOB RIDER BENEFIT PAYMENTS

When a benefit payment is made under this rider, it will reduce the remaining EOB Maximum Benefit Amount by the amount of the benefit payment.

Once benefit payments begin under this rider, no Withdrawals may be made except to fully surrender the Policy which will terminate this rider.

EFFECT OF WITHDRAWALS

When a Withdrawal is made under the Policy, it will reduce the EOB Maximum Monthly Benefit Amount by (a) divided by (b), where:

- (a) is the Face Amount after the Withdrawal;
- (b) is the Face Amount prior to the Withdrawal.

The EOB Maximum Benefit Amount will be reduced in the same proportion as the EOB Maximum Monthly Benefit Amount. Any reduction in the EOB Maximum Benefit Amount and the EOB Maximum Monthly Benefit Amount will apply only to expenses incurred on or following the date of the Withdrawal.

EFFECT OF A DEATH BENEFIT PAYMENT

When the Death Benefit is paid, the EOB Maximum Benefit Amount will be reduced to zero and no further benefits will be paid under this rider. Payment of a Death Benefit will not affect payment of eligible claims for Covered Care expenses incurred prior to the date of death of the Insured. We reserve the right to withhold any portion of the Death Benefit that would otherwise be payable until we verify that we have received all remaining claims for incurred Covered Care expenses.

SECTION 5: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For benefits to be payable under this rider:

- a. the Insured must be a Chronically Ill Individual;
- b. we must receive a Current Eligibility Certification for the Insured; and

- c. we must receive ongoing proof which demonstrates that the Covered Care the Insured receives is needed due to his or her continually being a Chronically Ill Individual. The proof can be based on information from care providers, personal physicians or other Licensed Health Care Practitioners.

CONDITIONS FOR PAYMENT

Benefits will be paid as reimbursement for incurred Covered Care expenses that meet all of the following conditions:

- a. Benefits under the Accelerated Benefit Rider for Long Term Care Services must be exhausted;
- b. the Owner must submit a claim for benefits under this rider;
- c. The Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- d. The Insured has not reached any limits applicable to the specific benefits claimed;
- e. The Insured meets all additional requirements for the specific benefits claimed;
- f. The Policy and this rider must be in force on the date the expense, fee, or charge for an item of Covered Care is incurred. An expense, fee or charge will be considered to be incurred on the day on which the Covered Care is received.

Once we determine that the Insured is eligible for benefits, the Insured's eligibility for benefits will continue for as long as the Insured continues to be eligible for benefits and has not reached the EOB Maximum Benefit Amount. We reserve the right to perform periodic reassessments of the Insured's eligibility. Regardless of the Policy Date, the monthly payment is based on a calendar month time period.

SECTION 5-1: HOME CARE BENEFIT

We will pay for expenses the Insured incurs for the following Covered Care:

- a. Adult Day Care Services;
- b. Nurse and Therapist Services;
- c. Home Health Aide and Personal Care Services;
- d. Homemaker Services;
- e. Chore Services; and
- f. Hospice Care.

These services must be:

- a. received in the Insured's Home, unless they are Adult Day Care Services or Hospice Care provided in a facility providing Hospice Care;
- b. necessary to enable the Insured to continue to stay safely at Home, unless the services are in a facility providing Hospice Care;
- c. necessary because the Insured alone is not able to perform them due to the Insured being a Chronically Ill Individual; and
- d. consistent with the needs addressed in the Insured's Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

Payment Limitations: The Elimination Period does not apply to this Benefit, but any days for which Home Care Benefits are payable will be used to satisfy the Elimination Period. This Benefit will not be payable at the same time as any benefits for confinement in a Nursing Facility, Assisted Living Facility, or Out-of-Country Nursing Facility.

SECTION 5-2: NURSING FACILITY BENEFIT

We will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by a Nursing Facility while the Insured is confined there as a resident inpatient. This includes expenses for:

- a. private duty nursing care; and
- b. all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility.

The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Elimination Period.

SECTION 5-3: ASSISTED LIVING FACILITY BENEFIT

We will pay the expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Assisted Living Facility while the Insured is confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility. No payment will be made for any service which does not facilitate the performance of an Activity of Daily Living.

Payment Limitations: Payment of this Benefit is subject to the Elimination Period.

SECTION 5-4: BED RESERVATION BENEFIT

We will continue to pay benefits, or give Elimination Period credit for expenses the Insured incurs for Covered Care under the Nursing Facility Benefit while the Insured:

- a. is temporarily absent during a stay in a Nursing Facility or Assisted Living Facility; and
- b. is charged to reserve the Insured's accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay or when the Insured spends holidays or other time with his or her family.

Payment Limitations: This benefit is limited to no more than 30 days (continuous or not) each calendar year. The amount payable for this benefit can not exceed 1/30th of the EOB Maximum Monthly Benefit for each day the bed is reserved.

SECTION 5-5: RESPITE CARE BENEFIT

We will pay Covered Care expenses the Insured incurs for Respite Care. Respite Care means short-term care that is provided to the Insured in order to relieve the person who normally provides the Insured with unpaid informal care in the Insured's Home. The Insured's Plan of Care must state:

- a. the name of the unpaid caregiver for whom respite is being provided;
- b. the period of respite; and
- c. the Covered Care the Insured will require to replace that care normally provided by the unpaid caregiver.

Respite Care can be received in the Insured's Home, or during a temporary stay in a Nursing Facility or Assisted Living Facility.

Payment Limitations: This Benefit will not be payable at the same time as any other Benefit except when the Company pays for caregiver training. This benefit is limited to no more than 30 days (continuous or not) each calendar year. The amount payable for this benefit can not exceed 1/30th of the EOB Maximum Monthly Benefit Amount for each day of Respite Care.

SECTION 5-6: CAREGIVER TRAINING BENEFIT

We will pay Covered Care expenses the Insured incurs for training an unpaid informal caregiver to care for the Insured in the Insured's Home. All the following conditions apply to this Benefit:

- a. We will not pay to train someone who will be paid to care for the Insured.
- b. The training can be received while the Insured is confined in a hospital, Nursing Facility, or Assisted Living Facility only if it is reasonably expected that the training will make it possible for the Insured to go Home where the Insured can be cared for by the person receiving the training.

SECTION 5-7: SUPPORTIVE EQUIPMENT BENEFIT

We will pay Covered Care expenses the Insured incurs for Supportive Equipment if it is specified and provided in accordance with the Insured's Plan of Care. We will pay for expenses, including installation fees, labor and related costs, the Insured incurs for the purchase or rental of Supportive Equipment, if such equipment is:

- a. intended to assist the Insured in living at Home by relieving the Insured's need for direct physical assistance; and
- b. specified and provided in accordance with the Insured's Plan of Care stating that the equipment is expected to enable the Insured to remain at Home for at least 90 days after the date of purchase or first rental.

Supportive Equipment includes items such as the following:

- a. pumps and other devices for intravenous injection;
- b. ramps to permit movement from one level of a residence to another;
- c. grab bars to assist in toileting, bathing or showering; and
- d. stair lifts for going between levels of the Insured's Home.

Supportive Equipment does not include either:

- a. equipment that will, other than incidentally, increase the value of the residence in which it is installed; or
- b. artificial limbs, teeth, medical supplies, or equipment placed in the Insured's body, temporarily or permanently.

SECTION 5-8: INTERNATIONAL COVERAGE BENEFIT

We will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Out-of-Country Nursing Facility while the Insured is confined there as a resident inpatient. This includes expenses for all levels of care (whether skilled, intermediate or custodial) provided by the Out-of-Country Nursing Facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in the Out-of-Country Nursing Facility.

Payment of this Benefit is subject to the following conditions:

- a. Payment will be in lieu of all other Benefits and reimbursement otherwise provided by this rider for expenses incurred during the period for which payment is made under this Benefit.
- b. Payment will only be made in the lawful money of the United States of America. Any foreign exchange rate will be determined by the Company.
- c. This Benefit will not be payable if it is prohibited by United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Asset Control (or its successor organization).
- d. We must receive proof, satisfactory to us, that the Insured has met all of the requirements stated in the Limitations or Conditions on Eligibility for Benefits section. We must be furnished, at no expense to us, with complete documentation in English. Such documentation shall include, but is not limited to:
 1. a Current Eligibility Certification;

2. a satisfactory Plan of Care prescribing the need for care due to the Insured's being a Chronically Ill Individual;
3. properly completed claims forms, billing statements, and supporting medical and care documentation;
4. a copy of the Insured's passport, airline ticket or other proof acceptable to us that the Insured is outside the United States of America, its territories and possessions; and
5. we may require that all of the above information be provided at reasonable intervals. We will not require this more frequently than monthly.

Payment Limitations: Payment of this Benefit is subject to the Elimination Period.

SECTION 6: GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- a. provided by a Family Member, unless:
 1. the Family Member is a regular employee of the organization that is providing the services; and
 2. such organization receives payment for the services; and
 3. the Family Member receives no compensation other than the normal compensation for employees in her or his job category;
- b. for which no charge is normally made in the absence of insurance;
- c. provided outside of the United States of America, its territories and possessions; except as provided in the International Coverage Benefit;
- d. provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured or the Insured's estate;
- e. arising out of the Insured's attempted suicide or an intentionally self-inflicted injury; or
- f. for the Insured's alcoholism or addiction to drugs or narcotics; but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

NON-DUPLICATION

Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid). However, this Non-Duplication provision will not disqualify an expense for Covered Care from being used to satisfy the Elimination Period if it applies.

SECTION 7: CLAIMS PROVISIONS

STARTING THE CLAIMS PROCESS

Contacting us as soon as it appears the Insured may be a Chronically Ill Individual will facilitate a timely claim review. This can help us greatly in the claims process and at the same time lead to early planning of the Insured's Covered Care.

TELLING THE COMPANY ABOUT A CLAIM

Notice of Claim

We must be notified when there is a claim. The notice should be given to us at Our Principal Office. It must be received within 30 days of the date the covered loss starts, or as soon as reasonably possible. The notice should include at least:

- a. the Owner's name;
- b. the Insured's name;
- c. the Policy Number (as shown in Section 1 of the Policy); and
- d. an address to which the claim forms should be sent.

Claim Forms

When we receive a notice of claim, we will send out the necessary forms to be used to file proof of loss. The forms to be completed will explain how to complete the forms and where to send them and should be signed by the Owner, and by the Insured where required.

All required information must be provided. Proof of loss must be in the form of written documentation acceptable to the Company that:

- a. describes and confirms that the Insured is a Chronically Ill Individual;
- b. includes a Current Eligibility Certification from a Licensed Health Care Practitioner;
- c. describes and confirms the Insured's confinement in a covered facility (if applicable);
- d. describes and confirms any other Covered Care the Insured is receiving;
- e. includes copies of itemized bills, paid invoices or cancelled checks for charges the Insured incurred for Covered Care.

We must be provided with the authorization necessary for us to request copies of the Insured's medical records or a care provider's daily notes of care. We may choose to consult by telephone with the Licensed Health Care Practitioner who prescribed the Insured's Plan of Care, or with any care provider the Insured used. This information will assist us in the evaluation of the claim so that we can determine the benefits for which the Insured is eligible.

If we do not provide the necessary claim forms within 15 days, proof of loss can be filed without them by sending us a letter, signed by the Owner, which describes the occurrence and the character and the extent of the loss for which claim is made. That letter must be sent to us at Our Principal Office within the time period stated in the next paragraph.

Proof of Loss

When this rider provides for payment for continuing loss, written proof of the loss must be given us within 90 days after the end of each monthly period for which benefits may be payable. For any other Covered Care expense loss covered by this rider, written proof must be given to us within 90 days after such loss. If it was not reasonably possible to give us written proof in the time required, we shall not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the Owner is not legally capable, the required proof must always be given to the Company no later than one (1) year from the time specified.

OUR EVALUATION CRITERIA AND THE CLAIMS PAYMENT PROCESS

How the Company Evaluates Claims

We will obtain information about the Insured by working with the Insured, the Owner, and the Insured's personal physician, as appropriate. We will also consult with any Licensed Health Care Practitioners, agencies and other care providers the Insured used. We will then review that information to determine eligibility for benefits. We reserve the right, as part of the review and at our expense, to do an assessment or a physical examination of the Insured. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. We may use outside services to assist in evaluating the Insured's condition.

On an ongoing basis, we must receive updates to the Insured's Plan of Care and Current Eligibility Certifications. We will also need a copy of the Insured's Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Physical Examinations

At our expense, we have the right to require a medical examination of the Insured when a claim is made and at reasonable intervals while continued benefits are being claimed.

Time of Payment of Claim

After we receive the proper written proof of loss, we will pay any benefits then due immediately. When the loss is expected to result in on-going benefits, we will pay any benefits at the end of each monthly period after the first payment date.

Payment of Claims

Benefits will be paid to the Owner. Any benefits unpaid at the Owner's death may be paid to the Owner's estate. If benefits are paid to the Owner's estate, we may pay a portion of those benefits, up to \$1,000, directly to someone related to the Owner who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

We may pay all or a portion of any benefits for care or services the Insured receives to the provider of the care or services, unless the Owner directs us to do otherwise in writing by the time proofs of loss are filed. We do not require that a particular provider provide the care or services.

APPEALING A CLAIM DECISION

We will inform the Owner in writing if a claim, or any part of a claim, is denied.

Appeal Process

If it is believed that our decision on a claim is in error, the Owner may appeal, and we will reconsider the claim. To make an appeal, the Owner must send us a brief note (no special form needed) that tells us why it is felt that we should change our decision. The Owner may authorize someone else to act for him or her in this appeal process.

The written appeal should include the names, addresses and phone numbers of any providers the Company should contact to learn more about the health and the care received by the Insured. This would include those physicians, health care professionals and other care providers who treated the Insured, and the facilities from which the Insured received care, treatment, services, equipment or other items.

We will provide the Owner with a written explanation of the reasons for any claim denial and make available all information directly related to that denial within 60 days of the date of any written claims appeal. We will immediately pay any benefits due as a result of our reconsideration.

Legal Actions

We cannot be sued on any claim before 60 days after proof of claim has been given to us as required by this rider. We cannot be sued after 3 years from the time the written proof of loss is required to be given.

Right to Recover

If we pay benefits under the Policy and this rider, and the total of such benefits is greater than the amount payable under the Policy and this rider, we will have the right to recover such excess from:

- a. any person to whom, or for whom, such payments were made;
- b. any organization which should have made such payments; and
- c. future benefit payments, if any.

We will have a right to:

- a. reimbursement for benefits paid under this rider, if it is found that such payments were paid in error; and
- b. recover any benefits paid under this rider as a result of fraudulent claims submitted for Covered Care not rendered or purchased.

SECTION 8: GENERAL PROVISIONS**ASSIGNMENT**

During the lifetime of the Insured, you may assign the benefits payable under this rider. All assignments must be filed at Our Principal Office in written form satisfactory to us. The assignment will then be

effective as of the date you signed the form, subject to any action taken before we acknowledge receipt. We are not responsible for the validity or legal effect of any assignment.

SURRENDERS

If you surrender the Policy as part of an exchange under Internal Revenue Code §1035, the intended tax-qualified status of this rider may be affected and may result in adverse tax consequences. Consult a professional tax advisor before making a surrender of the Policy for this purpose.

REINSTATEMENT

If the Policy to which this rider is attached is reinstated, this rider will also be reinstated, subject to the same terms and conditions of the Reinstatement provision in the Policy, unless the EOB Maximum Benefit Amount has been exhausted. The reinstatement shall be subject to satisfactory evidence of insurability from the Insured. Upon reinstatement, this rider will:

- a. only provide benefits for Covered Care received after the date of reinstatement;
- b. be subject to all terms and conditions of the Policy, the Accelerated Benefit Rider for Long Term Care Services, and this rider.

If, however, the Insured was a Chronically Ill Individual when the Policy and this rider lapsed and, if the reinstatement is requested within five (5) months after the date of the lapse, then in lieu of submitting evidence of insurability, the Policy and this rider may be reinstated by submitting to the Company satisfactory proof that the Insured is a Chronically Ill Individual. Upon reinstatement, this rider will:

- a. provide benefits for Covered Care received after the date of the lapse as if coverage had remained in force; and
- b. be subject to all terms and conditions of the Policy, the Accelerated Benefit Rider for Long Term Care Services, and this rider.

REPRESENTATIONS

In the absence of fraud, any statement made by the Owner or the Insured will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed Application.

INCONTESTABILITY PERIOD

A misstatement by the Owner or the Insured in any Application for the Policy or this rider may be used to rescind (void) or cancel this rider or deny an otherwise valid claim. During the first six (6) months following the Issue Date of this rider, the Company may take such action only if the misstatement was material to the issuance of this rider. After the first six (6) months, but before the end of the first twenty-four (24) months, the Company may take such action only if the misstatement was material to both the issuance of this rider and the claim for which benefits are being sought. After this rider has been in force for twenty-four (24) months from the Issue Date of this rider, the Company can take such action only if the Company can show that the Owner or the Insured knowingly and intentionally misrepresented relevant facts relating to the Insured's health. No benefits will be paid under this rider if it is rescinded or canceled.

In the event of death of the Insured, this provision will not apply to the remaining Death Benefit payable under the Policy which will be governed by the Incontestability provision in the Policy.

PRE-EXISTING CONDITIONS NOT EXCLUDED

Except as permitted elsewhere, we will not reduce or deny any claim under this rider because of a sickness or a physical or medical condition that existed before the Policy Date.

CONFORMITY WITH STATE STATUTES

If any provision of this rider is in conflict with the statutes of the state in which the Policy is delivered, the provisions of this rider will be automatically amended to meet the minimum requirements of such statutes.

Donald A. Stewart.

[Donald A. Stewart, Chief Executive Officer]

SUN LIFE ASSURANCE COMPANY OF CANADA

NONFORFEITURE BENEFIT RIDER

This rider is part of the Policy to which it attaches and is effective as of the Policy Date. It is part of, and subject to, the other terms and conditions of the Policy. If the terms of this rider and the Policy conflict, this rider's provisions will control.

Nonforfeiture Benefit

If the Policy terminates, this rider will cover eligible claims for Covered Care.

This Nonforfeiture Benefit will continue as paid-up long-term care coverage until the earlier of:

- a. the death of the Insured; or
- b. the date the Nonforfeiture Benefit Limit described below has been reached.

Nonforfeiture Benefit Limit

The Nonforfeiture Benefit Limit under this rider will be an amount equal to the greater of:

- a. one month's EOB Maximum Monthly Benefit Amount as of the date the Extension of Benefits Rider terminates; or
- b. an amount equal to the premiums paid for the Extension of Benefits Rider, plus the ABR Inflation Single Premium, if any, plus the Single Premium for this rider,

less any benefit payments made under the Extension of Benefits Rider, and less the amount of any benefit payments under the ABR Simple Inflation Protection option.

Consideration

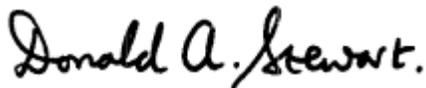
This rider is issued in consideration of the Application for this rider and payment of the Single Premium for the rider coverage as shown in Section 1 of the Policy.

Termination of Rider

This rider terminates upon the earliest of:

- a. the death of the Insured; or
- b. the date the Nonforfeiture Benefit Limit is reached.

If the policy and the Extension of Benefits Rider are reinstated after they terminate, this rider will also be reinstated if it was in force at the time the policy and the Extension of Benefits Rider terminated.



[Donald A. Stewart, Chief Executive Officer]

SUN LIFE ASSURANCE COMPANY OF CANADA

RESIDUAL BENEFIT RIDER

This rider is part of the Policy to which it attaches and is effective as of the Policy Date. It is part of, and subject to, the other terms and conditions of the Policy. If the terms of this rider and the Policy conflict, this rider's provisions will control.

Benefit

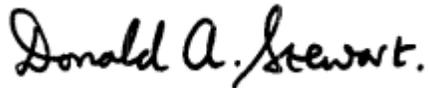
If as the result of benefit payments under the Accelerated Benefit Rider, the Face Amount has been reduced to less than the Residual Death Benefit Amount, the death benefit payable under the policy shall equal the Residual Death Benefit Amount less Policy Debt. The Residual Death Benefit Amount is the lesser of 5% of the initial Face Amount and \$5,000.

Fee

The fee for the benefit provided by this rider is the Single Premium shown in Section 1 of the Policy.

Termination

This rider will terminate upon termination of the Policy.



[Donald A. Stewart, Chief Executive Officer]

SUN LIFE ASSURANCE COMPANY OF CANADA

POLICY ENDORSEMENT

This endorsement is part of the Policy to which it attaches and is effective as of the Policy Date. It is part of, and subject to, the other terms and conditions of the Policy. If the terms of this endorsement and the Policy conflict, this endorsement's provisions will control.

Benefit

While this endorsement is in force and subject to the conditions below, we may arrange for third party service providers to provide Covered Persons with some or all of the support and information services described in the Covered Services section of this endorsement.

Definitions

Covered Persons:

- For a Policy which is not trust-owned, the person insured under the Policy and their spouse, dependent children, parents and parents-in-law.
- For a Policy which is trust-owned, the person insured under the Policy and their spouse, dependent children, parents and parents-in-law, only if the trustee, in his/her sole and exclusive discretion, elects to make the Covered Services available.

Covered Services

A Covered Person has access to: [

1. coordinated care among physicians and medical institutions;
2. assistance with prescription drug issues including formulary and benefit questions;
3. assistance with sorting out and resolving claims and related paperwork issues;
4. comparative cost estimates for common medical services and procedures based on zip-code;
5. assistance with negotiating fees with healthcare providers to attempt to lower out-of-pocket costs;
6. advice or assistance when filing a complaint or grievance with a healthcare provider;
7. information and coaching to help them become active participants in the management of their health;
and
8. assistance with making arrangements for special services needs.]

General

How to elect Covered Services

A Covered Person may elect any of the available Covered Services by contacting the third party provider that we arranged at the following:

Phone - [1-866-695-8622]

Internet - [www.HealthAdvocate.com]

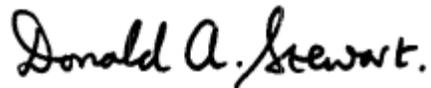
Email - [answers@HealthAdvocate.com]

Fees

There are no fees or charges to Covered Persons for the Covered Services provided by this endorsement.

Termination

This endorsement will terminate upon termination of the Policy.

A handwritten signature in black ink that reads "Donald A. Stewart." The signature is written in a cursive, slightly slanted style.

[Donald A. Stewart, Chief Executive Officer]

Sun Life Assurance Company of Canada

(Hereinafter referred to as "the Company")

[One Sun Life Executive Park, Wellesley Hills, MA 02481]

[Sun Care WL] - Part I of Application for Life Insurance with Benefits for Long Term Care Services



Section A: Insured

1a. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs.		1b. Name (first, middle initial, last)			
1c. <input type="checkbox"/> Male <input type="checkbox"/> Female	1d. Birth Date (m/d/y)	1e. Birthplace (country/state)	1f. Social Security Number	1g. Married* <input type="checkbox"/> Yes <input type="checkbox"/> No	
1h. Address (street, city, state, zip code, country) (If mailing address differs, provide in Section H.)					
1i. Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No		1j. Years in U.S.	1k. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	1l. If No: Valid Green Card or Visa Number	
1m. Occupation, Employer Name, and Address					
1n. Total Annual Income \$			1o. Total Net Worth \$		

*The term "married" means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and responsibilities as a married couple; and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.

Section B: Owner

1. Is the Owner the Insured? Yes No (if yes, proceed to Section C, otherwise complete questions 2 – 2i)
2. The Owner is a: Individual Company Trust

2a. Full Legal Name		
2b. Social Security/Tax ID Number	2c. Birth/Trust Date (m/d/y)	2d. Relationship to Insured
2e. Address (street, city, state, zip code, country) (If mailing address differs, provide in Section H.)		
2f. Permanent U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	2g. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	2h. State Trust Established
2i. Authorized Representative(s)/Trustee(s)		

For additional owners, complete and submit the Multiple Owner Supplement.

Section C: Payor

1. Is the Payor the Insured or the Owner? (If so, proceed to Section D, otherwise complete questions 2 – 2c)
2. The Payor is a: Individual Company Trust

2a. Name	2b. Social Security/Tax ID Number
2c. Relationship to Insured	

Section D: Beneficiary

Name	Primary (P)/ Contingent (C)	Relationship to Insured	%
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.

For additional beneficiaries, complete and submit the Beneficiary Supplement form.

Note: Unless otherwise specified, surviving beneficiaries within a class will share the proceeds equally. If there are no surviving beneficiaries, the proceeds will be paid to the estate of the last survivor of the insured and beneficiaries.

Section E: Coverage & Premium Information

1a. Single Premium Amount \$	1b. Face Amount \$	1c. Inflation Protection (select one) [<input type="checkbox"/> Simple <input type="checkbox"/> Compound <input type="checkbox"/> Rejected]
1d. LTC ABR Benefit (select one) [<input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years]	1e. Extension of Benefits (EOB – select one) [<input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 6 Years <input type="checkbox"/> None]	
1f. Return of Premium (ROP) <input type="checkbox"/> Yes <input type="checkbox"/> No	1g. Nonforeiture Benefit Rider (only available if ROP is <u>not</u> elected and EOB is elected) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section F: Other Insurance/Replacement Information

1. Does the Insured have any life insurance, long term care (LTC), annuity, health care or medical care policies or certificates including health maintenance contracts inforce or pending with the Company or any other companies?
 Yes No *If yes, provide details in the table below.*

Insurance Company	Policy Type	Issue Year/ Pending	Total Face/ Benefit Amount
a.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health		
b.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health		
c.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health		

2. Will any existing life insurance or annuity contract be lapsed, forfeited, surrendered, partially surrendered, assigned, reduced in value or used as a source of premium for the coverage applied for in this Application? Yes No

3. Will any existing long term care, health care or medical care policies or certificates including health maintenance contracts be replaced by the coverage applied for in this Application? Yes No

4. If a “yes” answer was provided to questions 2 and/or 3 then please complete the information requested in the table below for any policies that will be replaced.

Insurance Company & Policy Number	Policy Type
a.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health
b.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health
c.	<input type="checkbox"/> Life <input type="checkbox"/> Life w/LTC <input type="checkbox"/> LTC <input type="checkbox"/> Annuity <input type="checkbox"/> Annuity w/LTC <input type="checkbox"/> Health

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

6. State the ultimate amount of life insurance coverage that will be in place on the life of the Insured (excluding group life or corporate owned life insurance) with the issue of this policy and any other pending application with another company.
 \$ _____

7. Has an Application for life insurance, long term care, health care or medical care coverage including health maintenance contracts on the life of the Insured been declined, postponed, or offered on a basis other than applied?
 Yes No *If yes, provide details:*

8. Have you had any long term care, health care or medical care policies or certificates including health maintenance contracts with this or any other company which have lapsed, been surrendered, or otherwise terminated within the past 12 months? Yes No *If yes, please provide details below.*

Insurance Company	LTC Benefit Amount	Issue Date	Date of Lapse, Surrender, or Termination
a.			
b.			

9. Are you currently covered by Medicaid? Yes No

Section G: Secondary Addressee

You have the right to designate someone in addition to yourself to receive copies of lapse notices. If you would like to designate a secondary addressee then please provide the following information.

Name
Address

Section H: Additional Information/Special Requests

Section I: Signature Section

Declarations

I 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 producer 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 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 written consent.
4. No insurance requested in this Application will be effective (a) until coverage is issued during the lifetime of the Insured; and (b) until the Company has received the full single premium amount due; and (c) **the statements made in this Application are still complete and true as of the date the coverage is delivered.**
5. I 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.
7. I have received copies of the Long Term Care Personal Worksheet, Things You Should Know Before You Buy Long Term Care Insurance, Outline of Coverage, Long Term Care Shopper's Guide, and Privacy Information Notices including Medical Information Bureau, Inc. (MIB, Inc.).

I 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 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 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 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 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 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 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 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 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.

For the 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.]

[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 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 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 have or have applied for with the Company.

I 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 do business. I 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 may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I 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 am entitled to receive a copy of the Authorization upon request. A copy of this Authorization shall be as valid as the original.

Inflation Protection

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the Long Term Care Accelerated Benefit Rider and the Extension of Benefits Rider with and without the optional Inflation Protection feature. I understand and agree that I will be issued a rider or riders with optional Inflation Protection on either a simple or compound basis depending upon the election I have made in Section E of this Application **unless** I elected to reject Inflation Protection in Section E of this Application.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Signature of Insured

Signature of Insured (not required if under age 15)

Signed by Insured at (city/state)

Signature of Owners (if other than the Insured)

Signature of Owner

Signature of Co-Owner

Signed by Owner at (city/state)

Signed by Co-Owner at (city/state)

Signature of Producers

Signature of Producer

Signature of Producer

Signed by Producer at (city/state)

Signed by Producer at (city/state)

Date of Signing

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

Section J: Producer Report

1. Does the Insured have any life insurance, long term care (LTC), annuity, health care or medical care policies or certificates including health maintenance contracts inforce or pending with the Company or any other companies?
 Yes No

2. Will any existing insurance be lapsed, forfeited, surrendered, partially surrendered, assigned, reduced in value or used as a source of premium for the coverage applied for in this Application? Yes No

3. Please list all health insurance or long term care policies that you have sold to the Insured in the last 5 years and indicate whether they are in force or not in force.

Company	Policy Number	Issue Year	Status
			<input type="checkbox"/> In force <input type="checkbox"/> Not In force
			<input type="checkbox"/> In force <input type="checkbox"/> Not In force
			<input type="checkbox"/> In force <input type="checkbox"/> Not In force

Certification:

I, _____ certify:
 Print Producer's Name

1. That the Application submitted for the Insured named above and any accompanying information are complete and true to the best of my knowledge and belief.

2. I have verified the identity of the Insured and the Owner(s) by reviewing valid forms of identification.

3. That the source of funds for the purchase of the insurance coverage applied for in this Application has been identified and I have received permission to move the funds upon approval.

4. If a replacement of existing long term care (LTC), life insurance with LTC rider, annuity with LTC rider, health care or medical care policies or certificates including health maintenance contracts is intended I have provided the Insured/Owner with a copy of the required notice regarding replacement of individual accident and sickness or long term care insurance.

[5. I have received relevant anti-money laundering training within the last 24 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.]

[Anti-Money Laundering Customer Identity Information

I have reviewed the Owner's identity document presented and recorded the following information from it:

Owner'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 ____/____/____]

Signature of Producer	License Number	Date
Signature of Producer	License Number	Date

Sun Life Assurance Company of Canada

(Hereinafter referred to as "the Company")

[One Sun Life Executive Park, Wellesley Hills, MA 02481]

[Sun Care WL] - Part II of Application for Life Insurance with Benefits for Long Term Care Services



1a. Insured Name (first, middle initial, last)		1b. Birth Date (m/d/y)	
1c. Application number			
2a. Name and address of your Primary Care Physician			
2b. Date last consulted		2c. Reason for visit	
3a. Height		3b. Weight	
3c. Have you had any change in weight within the past 12 months? Gain _____ lbs Loss _____ lbs		3d. Reason for weight change	
4. Have you used tobacco (cigarettes, cigars, chewing tobacco, etc.) or products containing nicotine (nicorette gum, nicotine patch, etc.) within the past 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Within the past five years, while operating a motor vehicle, boat or aircraft, have you:			
a. Been convicted or plead guilty to any moving violations?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Had your operator's license restricted, suspended or revoked?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Been convicted or plead guilty to operating while under the influence of alcohol or drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Within the past five years, have you participated in big game hunting, boxing, kick-boxing, cave exploration, cliff diving, extreme sports, hang gliding, heli-skiing, mountain climbing, organized auto, motorcycle or powerboat racing, parachuting, rodeo events, underwater diving, white water rafting?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Are you actively at work on a full-time basis, at least 30 hours per week, performing the regular duties of your job in a normal capacity, and not been absent for more than five consecutive days due to illness or medical treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Are you currently living in an Assisted Living Facility or Independent Community?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Within the past 24 months have you:			
a. Been or are you currently confined, or has a licensed medical professional recommended admission, to a nursing home, nursing facility or hospital?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Received or are you currently receiving home health care?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Attended or are you currently attending adult day care?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Are you currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability or any other form of disability insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Do you use mechanical devices, such as a cane, walker, crutches, wheelchair, motorized scooter, hospital bed, stairlift, catheter, dialysis machine, oxygen or other mechanical device?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Within the past 24 months have you:			
a. Had any falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Had any injury or fracture as a result of a fall?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Do you have any hobbies or participate in any of the following activities: physical or recreational activities, volunteer, travel, social clubs, other?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Do you need or receive assistance with any of the following: laundry, cleaning, shopping, use of transportation, telephone use, meal preparation, managing your finances or managing your medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Do you need or receive assistance in doing any of the following activities of daily living: bathing, dressing, toileting, maintaining continence, transferring, eating/feeding?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

16. Have you ever had, been told you have, been treated by a physician, been hospitalized or have taken/currently take medication for:	
a. High blood pressure, heart murmur, chest discomfort, angina, coronary artery disease, congestive heart failure, atrial fibrillation, peripheral vascular disease or other disease of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes, sugar in the urine, thyroid, or other glandular (endocrine) disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Kidney disease, bladder, urinary or prostate disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Protein (albumin), blood or pus in the urine, sexually transmitted disease or venereal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Cancer, tumor, leukemia, lymphoma, polyp, cysts or disorder of the skin, lymph nodes or immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, pneumonia, allergies, sleep apnea or other respiratory or lung disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease), muscular dystrophy, Huntington's disease or systemic lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Alzheimer's disease, dementia, cognitive impairment, organic brain syndrome or memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Stroke, transient ischemic attack (TIA), seizure, convulsion, epilepsy, fainting, loss of consciousness, syncope, dizziness, vertigo, tremor, falls, paralysis, or other disorder of the nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Nervous, mental, psychological or emotional condition or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Colitis, hepatitis, ulcers, or other disorders of the stomach, liver, intestines, pancreas or digestive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Arthritis, rheumatoid arthritis, osteopenia/osteoporosis, gout, or any impairment of the back, spine, muscles, nerves, bones, or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Chronic pain condition or chronic fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Impairment of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Disease or disorder of the reproductive organs, testicles, breast, ovaries, uterus or cervix?	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Anemia, bleeding, or blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
q. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
r. A positive blood test for antibodies to the AIDS (HIV) virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you:	
a. Regularly used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Used alcoholic beverages within the past 12 months? If yes, please provide: Type _____ Frequency _____ Amount _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Been advised to reduce your consumption of alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Been treated or counseled for alcoholism or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you have any health symptoms for which a physician has not been consulted or treatment received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Other than previously stated, have you within the past five years:	
a. Consulted a physician or any other practitioner, had a checkup, illness, surgery or been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had an electrocardiogram, stress or exercise test, x-ray, blood test or other diagnostic test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. List all medication and dosage you are currently taking, including prescription drugs, over the counter drugs, aspirin and supplements.	

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 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 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 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.

For the 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.]

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Signature of Insured	
Signed by Insured at (city/state)	Date (m/d/y)

SERFF Tracking Number: SUNL-126691533 State: Arkansas
 Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 46050
 Company Tracking Number: SUN CARE WL
 TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
 Product Name: Sun Care WL - 2010
 Project Name/Number: Sun Care WL - 2010/SunCare WL - 2010

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: SPWL-2010 Readability Certification 6-24-10.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application Forms being filed in this filing. Please refer to the Form Schedule tab.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: AR Compliance Certification		
Comments:		
Attachment: AR Reg 19+49+23-79-138 Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statements of Variability		
Comments:		
Attachments: SPWL-2010 SOV - 6-24-10 .pdf ABRLTC-2010 SOV.pdf EOBLTC-2010 SOV.pdf NFBR-2010 SOV.pdf RBR-2010 SOV.pdf HAE-2010 SOV.pdf 14-755 Application Part I SOV 6-23-10.pdf 14-756 Application Part II SOV 6-23-10.pdf		

SERFF Tracking Number: SUNL-126691533 State: Arkansas
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TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
Product Name: Sun Care WL - 2010
Project Name/Number: Sun Care WL - 2010/SunCare WL - 2010

Item Status: **Status**
Date:

Satisfied - Item: Outline of Coverage
Comments:
Attachment:
LTC-OOC-2010 - Outline of Coverage - 6-24-10.pdf

Item Status: **Status**
Date:

Satisfied - Item: Advertising Materials
Comments:
Attached are the advertising materials for informational purpose.
Attachments:
GX04-10330n_LinkedBenSunCareBro_10.5pt.pdf
GX09-10416L SunCareWLProductHighlights.pdf

READABILITY CERTIFICATION

Company Name: Sun Life Assurance Company of Canada

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
SPWL-2010	50.5
ABRLTC-2010	See above
EOBLTC-2010	See above
NFBR-2010	See above
RBR-2010	See above
HAE-2010	See above
14-755	See above
14-756	See above

When calculated with Policy, the riders, endorsements and applications score 50+.



Thomas Miele
Assistant Vice President

June 24, 2010
Date

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: Sun Life Assurance Company of Canada

Form Title(s): Single Premium Whole Life Insurance Policy
Accelerated Benefit Rider for Long Term Care Services
Extension of Benefits Rider for Long Term Care Services
Nonforfeiture Benefit Rider
Residual Benefit Rider
Part I of Application for Life Insurance with Benefits for Long Term Care Services
Part II of Application for Life Insurance with Benefits for Long Term Care Services

Form Number(s): SPWL-2010, ABRLTC-2010, EOBLTC-2010, NFBR-2010, RBR-2010, HAE-2010, 14-755, 14-756

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Regulations 19 and 49, ACA 23-79-138 as well as the other laws and regulations of the State of Arkansas.



Thomas Miele
Assistant Vice President

June 24, 2010
Date

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: SPWL-2010

Revision Date: June 24, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	Headquarters Address	Address and phone number are bracketed to accommodate future changes.
1	Head Office	Address is bracketed to accommodate future changes.
1	Sun Care WL	This is the marketing name of this whole life product. No other marketing names are contemplated at this time.
1	Insured	Hypothetical - John Doe specimen information.
1	Policy Number	Hypothetical - John Doe specimen information.
1	Officers	These will vary if officers change
3	Insured	Hypothetical - John Doe specimen information.
3	Policy Number	Hypothetical - John Doe specimen information.
3	Issue Age, Sex	Issue Age Range = 30 - 80. Sex Range = Male and Female. Variability for insured specific information and the issue ages allowed.
3	Class	Variability Range = Preferred, Standard. Variability based on insured-specific underwriting evaluation.
3	Face Amount	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
3	Issue Date	Hypothetical - John Doe specimen information.
3	Policy Date	Hypothetical - John Doe specimen information.
3	Owner	Hypothetical - John Doe specimen information.
3	Minimum Withdrawal Amount	Variable Amount Range = \$1000 - \$10,000 Variability only intended for a future change by the Company after an actuarial pricing evaluation. Any such change would apply to new issues on a going forward basis only.

Page No.	Field	Scope of Variation
3	Policy Single Premium	Hypothetical - John Doe specimen information.
3	Riders Single Premium	Hypothetical - John Doe specimen information.
3	Total Premium	Hypothetical - John Doe specimen information.
4	Supplemental Benefits and Rider(s):	Any approved and available rider elected by the policy owner will appear.
4	Accelerated Benefit Rider for Long Term Care Services	This rider and corresponding information will print if elected by the Owner.
4	Benefit Period:	Variable Range = 24 Months - 36 Months Variability based on the election of the owner. No other ABR benefit periods are contemplated at this time.
4	Elimination Period:	Variable Range = 0 Days – 120 Days The current elimination period is 90 Days. Variability only intended for a future change by the Company after an actuarial pricing evaluation. Any such change would apply to new issues on a going forward basis only.
4	Maximum Monthly Benefit Amount:	Hypothetical - John Doe specimen information. Variability based on the policy face amount and the benefit period elected.
4	Maximum Benefit Amount:	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class. Initially, the maximum benefit amount is the policy face amount.
4	ABR Single Premium:	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Optional ABR Return of Premium Benefit	This rider option and corresponding information will print if elected by the Owner.
4	ABR ROP Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Optional Inflation Protection	This rider option and corresponding information will print if elected by the Owner.
4	Simple Inflation	Variable Range = Simple Inflation Variability based on the election of the owner. No other type of ABR optional inflation protection is contemplated at this time.

Page No.	Field	Scope of Variation
4	ABR Inflation Rate	Variable Range = 1% - 5% Hypothetical - John Doe specimen information. Variability based on the election of the owner.
4	ABR Inflation Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Extension of Benefits Rider for Long Term Care Services	This rider and corresponding information will print if elected by the Owner.
4	EOB Benefit Period:	Variable Range = 12 Months - 72 Months Variability based on the election of the owner. No other EOB benefit periods are contemplated at this time.
4	EOB Maximum Monthly Benefit Amount:	Hypothetical - John Doe specimen information. Variability based on the ABR maximum monthly benefit amount elected by the policy owner.
4	EOB Maximum Benefit Amount:	Hypothetical - John Doe specimen information. Variability determined by the benefit period elected by the policy owner and the EOB maximum monthly benefit amount.
4	EOB Single Premium:	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Optional EOB Return of Premium Benefit	This rider option and corresponding information will print if elected by the Owner.
4	EOB ROP Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Optional Inflation Protection	This rider option and corresponding information will print if elected by the Owner.
4	Simple Inflation	Variable Range = Simple Inflation - Compound Inflation Variability based on the election of the owner. No other type of EOB optional inflation protection is contemplated at this time.
4	EOB Inflation Rate	Variable Range = 1% - 5% Hypothetical - John Doe specimen information. Variability based on the election of the owner.

Page No.	Field	Scope of Variation
4	EOB Inflation Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Nonforfeiture Benefit Rider	This rider option and corresponding information will print if elected by the Owner.
4	Rider Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
4	Residual Benefit Rider	This rider option and corresponding information will print if elected by the Owner.
4	Rider Single Premium	Hypothetical - John Doe specimen information. Variability determined by the policy owner's request and insured's risk class.
5	Table of Cash Values	Hypothetical - John Doe specimen information. Variability determined by the policy face amount and the insured's risk class.
5	4%	Variable Range = 3% - 5% Hypothetical - John Doe specimen information. Variability based on the optional return of premium election of the owner.
6	Our Principal Office:	Address is bracketed to accommodate future changes.

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: ABRLTC-2010

Revision Date: May 25, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
17	Officer	This will vary if the officer changes.

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: EOBLTC-2010

Revision Date: May 25, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
17	Officer	This will vary if the officer changes.

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: NFBR-2010

Revision Date: May 25, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	Officer	This will vary if the officer changes.

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: RBR-2010

Revision Date: June 21, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	Officer	This will vary if the officer changes.

**Sun Life Assurance Company of Canada
Statement of Variability**

Form #: HAE-2010

Revision Date: May 25, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	Covered Services	These services may change upon agreement with our service provider. Any such change would apply to new issues on a going forward basis only.
2	Phone	This number may change should our current service provider change their phone number or if our service provider changes.
2	Internet	This internet address may change should our current service provider change their internet address or if our service provider changes.
2	E-Mail	This e-mail address may change should our current service provider change their e-mail address or if our service provider changes.
2	Officer	This will vary if the officer changes.

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

For Form Number: 14-755

Revision Date: June 23, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	One Sun Life Executive Park, Wellesley Hills, MA 02481	Address is bracketed to accommodate future changes.
1	Sun Care WL	This is the marketing name of an available whole life/long-term care product. The marketing name is bracketed to accommodate potential future product changes.
2	Section E1c: <input type="checkbox"/> Simple <input type="checkbox"/> Compound <input type="checkbox"/> Rejected	This is the current range of inflation protection options available at this time. The inflation protection options are bracketed to accommodate potential future product changes.
2	Section E1d: <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years	This is the current range of ABR benefit period options available at this time. The ABR benefit period options are bracketed to accommodate potential future product changes.
2	Section E1e: <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 6 Years <input type="checkbox"/> None	This is the current range of EOB benefit period options available at this time. The EOB benefit period options are bracketed to accommodate potential future product changes.
3-4	General Warning: ... and confinement in prison.	These are the general and state specific fraud warnings. Variability to accommodate changes to comply with future state requirements.
4	Customer Identification Notice: ... use for this purpose.	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.
6	5. I have received ... Life and Annuity Producers.	This language will appear as written on the application or not at all.
6	Anti-Money Laundering Customer Identity Information ... Expiration Date_____/_____/_____	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.

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

For Form Number: 14-756

Revision Date: June 23, 2010

Variability denoted by bracketing

Page No.	Field	Scope of Variation
1	One Sun Life Executive Park, Wellesley Hills, MA 02481	Address is bracketed to accommodate future changes.
1	Sun Care WL	This is the marketing name of an available whole life/long-term care product. The marketing name is bracketed to accommodate potential future product changes.
3-4	General Warning: ... and confinement in prison.	These are the general and state specific fraud warnings. Variability to accommodate changes to comply with future state requirements.

LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE

ACCELERATED BENEFIT RIDER FOR LONG TERM CARE SERVICES – ABRLTC-2010

EXTENSION OF BENEFITS RIDER FOR LONG TERM CARE SERVICES – EOBLTC-2010

Caution: The issuance of the Accelerated Benefit Rider for Long Term Care Services and Extension of Benefits Rider for Long Term Care Services, if applicable, described in this outline is based on your answers to the questions on your application for such rider. If your answers are incorrect or untrue, Sun Life Assurance Company of Canada may deny benefits or rescind these riders and the policy to which they are attached. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the U.S. Headquarters Office Mailing Address shown above.

NOTICE TO OWNER: The rider described in this outline may not cover all of the costs associated with long term care incurred by the Insured during the period of coverage. You are advised to carefully review all policy and rider limitations.

Notice: The long term care benefits described here are provided as part of a life insurance policy. Your premiums pay for life insurance and the rider(s) that provide coverage for long term care expenses. Whenever long term care benefits are paid through this rider, the payments will reduce the available cash value and insurance benefit under the life insurance policy. Receipt of the long term care benefits may be taxable and assistance should be sought from a personal tax advisor.

1. INDIVIDUAL COVERAGE.

The Accelerated Benefit Rider for Long Term Care Services and Extension of Benefits Rider for Long Term Care Services, if applicable, described in this outline is attached to, and made a part of, an individual life insurance policy.

2. PURPOSE OF OUTLINE OF COVERAGE.

This Outline of Coverage provides a very brief description of the important features of the Accelerated Benefit Rider for Long Term Care Services and Extension of Benefits Rider for Long Term Care Services, if applicable. You should compare this Outline of Coverage to outlines of coverage for other policies and riders available to you.

This is not an insurance contract, but only a summary of coverage. Only the riders and the individual life insurance policy to which they are attached contain the governing contractual provisions. This means that the riders and the policy set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES.

The riders described in this outline are intended to be federally tax-qualified long-term care insurance contracts under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THESE RIDERS MAY BE CONTINUED IN FORCE OR DISCONTINUED.

RENEWABILITY: THIS POLICY IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums. The Company cannot change any of the terms of your policy on its own and cannot change the premium.

WAIVER OF PREMIUM: The policy and rider do not contain a waiver of premium provision.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**

We do not have the right to increase the premium for the riders.

6. **TERMS UNDER WHICH THE RIDERS MAY BE RETURNED AND PREMIUM REFUNDED.**

The riders may be returned for any reason within 30 days after its delivery by taking it or mailing it to the Company or to the sales representative through whom the Policy and rider were purchased. Immediately upon delivery or mailing to the Company, the riders will be deemed void from the beginning and any premium paid will be returned.

These riders do not contain provisions providing for a refund or partial refund of rider premiums upon the death of the Insured or upon the surrender of the riders or policy, unless the Optional ABR Return of Premium (ROP) Benefit has been selected.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If the Insured is eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. Neither Sun Life Assurance Company of Canada nor its sales representatives represent Medicare, the federal government or any state government.

8. **LONG-TERM CARE COVERAGE.**

Policies and riders of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. These services are referred to as Covered Care and are more fully defined in the Accelerated Benefit Rider for Long Term Care Services and Extension of Benefits Rider for Long Term Care Services, if applicable.

These riders provide accelerated benefits by reimbursing actual charges incurred by the Insured during the period of coverage for Covered Care, subject to rider limitations and requirements.

9. **BENEFITS PROVIDED.**

Covered Care

Subject to the terms of the riders, we will reimburse expenses incurred by the Insured for the following Covered Care to the extent that such services are qualified long-term care services:

Adult Day Care Services

A program for six (6) or more individuals of social and health related services provided during the day in a community setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the Home. The 90 day elimination period does not apply to this service.

Assisted Living Facility

Services provided by a facility (including one for people with Alzheimer's) that is engaged primarily in providing Maintenance or Personal Care Services to its residents. It must provide those services 24 hours a day, every day. The 90 day elimination period applies to this service.

Bed Reservation

The expense incurred by the Insured to reserve the Insured's bed in a Nursing Home while he or she is temporarily absent during a stay in a Nursing Home or Assisted Living Facility and is charged to reserve the Insured's accommodations in that facility. The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay or when the Insured spends holidays or other time with his or her family. This benefit is limited to no more than 30 calendar days each policy year. The amount payable for this benefit cannot exceed 1/30th of the maximum

monthly benefit of the rider then in effect for each day that the bed is reserved. The 90 day elimination period does not apply to this service.

Caregiver Training

Training given to the primary caregiver by a properly accredited medical or instructional institution or by a qualified individual such as a licensed nurse to provide the primary caregiver with the knowledge and skills necessary to care for the Chronically Ill Insured. The 90 day elimination period does not apply to this service.

Chore Services

Assistance with light work activities including minor household repairs related to the Insured's safety at Home (such as to handrails and safety rails, stairs, or floors), taking out the garbage, and simple cleaning tasks to remove unsafe debris or dirt in the Insured's Home. The 90 day elimination period does not apply to this service.

Home Health Aide and Personal Care Services

Assistance or supervision the Insured receives for (a) simple health care tasks; (b) personal hygiene; (c) managing medications; (d) Activities of Daily Living performance; and (e) Severe Cognitive Impairment. The 90 day elimination period does not apply to these services.

Homemaker Services

Assistance with one or more of the following tasks: (a) meal planning and preparation; (b) doing laundry; and (c) light house cleaning, such as: (1) vacuuming; (2) mopping; (3) dishwashing; (4) cleaning the kitchen or bath; and (5) changing soiled bedding. The 90 day elimination period does not apply to this service.

Hospice Care

Services that are designed to provide palliative care to the Insured or alleviate the Insured's physical, emotional and spiritual discomforts because the Insured is experiencing the last phases of life due to a terminal disease (diagnosed with six (6) months or less to live). The 90 day elimination period does not apply to this service.

Nurse and Therapist Services

Services provided in the Insured's Home by a Nurse or a licensed physical, occupational, respiratory, or speech therapist. The 90 day elimination period does not apply to this service.

Nursing Facility

Services provided by a facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse. A Nurse is someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN), and is operating within the scope of that license. The facility must employ at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times. The 90 day elimination period does apply to this service.

Out-of-Country Nursing Facility

Services provided by an institution that is located outside the United States, its territories and possessions, and is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients. The 90 day elimination period does apply to this service.

Respite Care Services

Short-term care services provided to the Insured in order to relieve the person who normally provides the Insured with unpaid informal care in the Insured's Home. This benefit is limited to no more than 30 calendar days each policy year. The amount payable for this benefit cannot exceed

1/30th of the maximum monthly benefit of the rider then in effect for each day of Respite Care Services. The 90 day elimination period does not apply to this service.

Supportive Equipment Benefit

Expenses incurred by the Insured for Supportive Equipment specified and provided in accordance with the Insured's Plan of Care, including installation fees, labor, and related costs, for the purchase or rental of equipment intended to assist the Insured in living at home by relieving the Insured's need for direct physical assistance.

Eligibility And Conditions For The Payment Of Benefits

Benefits are provided under the Accelerated Benefit Rider for Long Term Care Services until that rider's Maximum Benefit Amount has been reached. The benefits paid for any one month of Covered Care will not exceed the Maximum Monthly Benefit Amount for the rider then in effect. The Maximum Benefit Amount and Maximum Monthly Benefit Amount for the Accelerated Benefit Rider for Long Term Care are shown in the Policy Specifications page for this rider. The Extension of Benefits Rider for Long Term Care Services extends the benefits provided by the Accelerated Benefit Rider for Long Term Care Services when the benefits for that rider have been exhausted.

Some benefits paid under the riders are subject to a 90 day elimination period during which time the riders do not provide certain benefits which would otherwise be payable, as described in the riders.

For benefits to be payable under this rider:

- a. the Insured must be a Chronically Ill Individual;
- b. the Company must receive a Current Eligibility Certification for the Insured; and
- c. the Company must receive ongoing proof which demonstrates that the Covered Care the Insured receives is needed due to his or her continually being a Chronically Ill Individual. The proof can be based on information from:
 - (1) care providers;
 - (2) personal physicians; and
 - (3) other Licensed Health Care Practitioners.

Benefits will be paid as reimbursement for incurred Covered Care expenses that meet all of the following conditions:

- a. the Owner must submit a claim for benefits under this rider;
- b. the Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- c. the Insured has not exhausted any limits applicable to the specific benefits claimed;
- d. the Insured meets all additional requirements for the specific benefits claimed;
- e. the Insured satisfies the Elimination Period if it applies; and
- f. except as stated in the *Continuation of Benefits under the Accelerated Benefits Rider* provision in the rider, the Policy and the rider must be in force on the date the expense, fee, or charge for an item of Covered Care is incurred.

10. LIMITATIONS AND EXCLUSIONS.

Pre-Existing Conditions

These riders do not exclude pre-existing conditions.

Ineligible Facilities or Providers

These riders do not cover services supplied or performed by a facility or a provider that does not meet the rider definitions for such facility or provider. These riders do not cover services provided by an Insured's family member or for which no charge is normally made in the absence of insurance. These riders do not cover services provided in facilities operated primarily for the treatment of alcoholism, drug addiction, or mental illness.

Ineligible Levels of Care

This rider does not cover services that do not constitute qualified long-term care services as defined in the Accelerated Benefit Rider for Long Term Care Services and Extension of Benefits Rider for Long Term Care Services, if applicable.

Exclusions, Exceptions and Limitations

These riders will not pay benefits for:

- a. care provided in facilities operated primarily for the treatment of mental or nervous disorders, which include neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. **This exclusion does NOT apply to qualifying stays or care resulting from a clinical diagnosis of Alzheimer’s Disease or similar forms of irreversible dementia;**
- b. treatment for alcoholism, drug addiction or chemical dependency (unless the drug addiction or chemical dependency is a result of medication taken in doses as prescribed by a physician);
- c. treatment arising out of an attempt (while sane) at suicide or an intentionally self-inflicted injury;
- d. treatment provided in a Veteran’s Administration or government facility, unless the Insured or the Insured’s estate is charged for the confinement or services or unless otherwise required by law;
- e. loss to the extent that benefits are payable under any of the following: Medicare (including that which would have been payable but for the application of a deductible or a coinsurance amount), other governmental programs (except Medicaid), workers compensation laws, employer’s liability laws, occupational disease laws, and motor vehicle no-fault laws;
- f. services provided by a facility or an agency that does not meet the rider definition for such facility or agency, except as provided in the Alternative Care Services provision in the Convalescent Care Benefits Rider; and
- g. services provided by a member of the Insured’s immediate family or for which no charge is normally made in the absence of insurance.

THESE RIDERS MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Changes to the Insurance Benefit of the policy resulting from the exercise of the rights there under, including the right to make policy loans and partial withdrawals, could cause a change in the Maximum Monthly Benefit Amount, the portion of the Maximum Monthly Benefit available for reimbursement or the amount payable upon the Life Insured’s death. Once benefit payments begin under these riders, no Withdrawals may be made except to fully surrender the Policy which will terminate these riders. You may elect either optional Simple Inflation Protection coverage or optional Compound Inflation Protection coverage. With optional Simple Inflation Protection coverage, the Maximum Monthly Benefit Amount on the Accelerated Benefits Rider for Long Term Care Services and the Extension of Benefits Rider for Long Term Care Services will increase on each Policy Anniversary. With optional Compound Inflation Protection coverage, the Maximum Monthly Benefit Amount on the Extension of Benefits Rider for Long Term Care Services will increase on each Policy Anniversary.

For Example:

Maximum Monthly Benefit Amount of \$5,000						
Policy Year	ABR Period			EOB Period		
	Without Inflation	With Simple Inflation	With Compound Inflation	Without Inflation	With Simple Inflation	With Compound Inflation
1	5,000	5,000	5,000	5,000	5,000	5,000
2	5,000	5,150	5,000	5,000	5,150	5,250
3	5,000	5,300	5,000	5,000	5,300	5,513
4	5,000	5,450	5,000	5,000	5,450	5,788

5	5,000	5,600	5,000	5,000	5,600	6,078
6	5,000	5,750	5,000	5,000	5,750	6,381
7	5,000	5,900	5,000	5,000	5,900	6,700
8	5,000	6,050	5,000	5,000	6,050	7,036
9	5,000	6,200	5,000	5,000	6,200	7,387
10	5,000	6,350	5,000	5,000	6,350	7,757
11	5,000	6,500	5,000	5,000	6,500	8,144
12	5,000	6,650	5,000	5,000	6,650	8,552
13	5,000	6,800	5,000	5,000	6,800	8,979
14	5,000	6,950	5,000	5,000	6,950	9,428
15	5,000	7,100	5,000	5,000	7,100	9,900
16	5,000	7,250	5,000	5,000	7,250	10,395
17	5,000	7,400	5,000	5,000	7,400	10,914
18	5,000	7,550	5,000	5,000	7,550	11,460
19	5,000	7,700	5,000	5,000	7,700	12,033
20	5,000	7,850	5,000	5,000	7,850	12,635

Simple Inflation at 3% during both the ABR Period and the EOB Period.

Compound inflation at 0% during the ABR Period, and 5% during the EOB Period.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

These riders will cover qualified long-term care services resulting from a clinical diagnosis of Alzheimer's Disease or related degenerative and dementing illnesses.

13. PREMIUM.

The premium for these riders is shown in the Policy Specifications page for each rider.

14. ADDITIONAL FEATURES.

The issuance of these riders is subject to medical underwriting.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT SUN LIFE ASSURANCE COMPANY OF CANADA IF YOU HAVE SPECIFIC QUESTIONS REGARDING THE ACCELERATED BENEFIT RIDER FOR LONG TERM CARE SERVICES DESCRIBED IN THIS OUTLINE.



Take control of your
assets and your future

Sun Care WL
Client Overview

Sun 
Life Financial®



How can I make sure
I don't lose what I worked
so hard to save?

NOT FDIC/NCUA INSURED • MAY LOSE VALUE • NO BANK/CREDIT UNION GUARANTEE •
NOT A DEPOSIT • NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY

What to consider

As you plan for retirement, there's a natural concern about accumulating enough money to provide sufficient income for a lifetime. Some of the considerations you need to plan for are:

- ▶ **Longevity:** Will my income last as long as I do?
- ▶ **Inflation:** Can I keep up with inflation?
- ▶ **Market volatility:** Am I protected against market loss?

You may think that your retirement plans are protected if they address all of these considerations. However, one which is often overlooked is the impact that long-term care costs could have on those retirement funds.

► Long-term care:

Will I have enough income to live as I want to live, and cover long-term care costs?

Understand the facts

- At least 70% of people over age 65 will require long-term care services at some time in their lives.¹
- The average annual cost can range from \$18,000 for home health care to \$80,000 for a private room in a nursing home.²
- At age 65, a typical married couple free of chronic disease can expect to spend \$260,000 on remaining lifetime health care costs, including nursing home care, with a 5% probability of costs exceeding \$570,000.³
- At the stock market peak in 2007, less than 15% of households approaching retirement had accumulated \$570,000 in total financial assets, with much fewer assets available for health care costs.^{3,4}

1. U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information, www.longtermcare.gov, September 2008.

2. www.longtermcare.gov. Based on 2008 national averages. Cost of home health care assumes periodic personal care help from a home health aide (the average visit frequency is about three times a week).

3. "What Is the Distribution of Lifetime Health Care Costs at Age 65?" Center for Retirement Research at Boston College, March 2010.

4. Financial assets include defined contribution plans, IRAs, and other net nonretirement financial assets.



What is long-term care?

Long-term care is a variety of services designed to help people who have developed a chronic illness, cognitive impairment, or disability. Care is administered to individuals who need assistance with some of the Activities of Daily Living (ADLs), such as eating, bathing, or getting dressed. Long-term care can be provided in a variety of settings: in your home, in your community, in a residential care facility, or in a nursing home.

Today's reality

Those unexpected costs related to long-term care can jeopardize your financial security and force you to tap into assets or savings that were meant for other purposes.

Let's look at an example:

Joan and Bob Hart are married, both aged 68, and have been fully retired for 5 years. They achieved their retirement goal of accumulating enough investment assets to generate an annual income of \$80,000. The plan was to allocate their assets so they could minimize their investment risk, keep up with inflation, and have that income last over both their lifetimes.

Unexpectedly, Bob experienced a major decline in his health and now requires continual medical assistance. The Harts' retirement plans have changed dramatically and life for them may also change in the following ways:

- Joan and other family members may have to take on the role of care givers.
- If professional nursing care is required, a major portion of that \$80,000 income will be used to pay care costs.
- Additional withdrawals from their retirement assets may deplete the principal, threatening future income.

There's a widespread misconception that the government will provide coverage through Medicare or Medicaid programs. The truth is that you would need to spend down your assets to minimum levels before the government will pay for care. And you would have little control regarding the selection or quality of that care.

Because of the high probability that you or your spouse could require some type of long-term care and because of the potentially high costs associated with it, this risk is best addressed in the retirement planning process.

Funding long-term care

There are several typical ways to pay for long-term care expenses. Here are a few and the advantages and considerations of each.

Funding method	Advantages	Considerations
Self-insuring through personal savings (requires setting aside funds targeting maximum long-term care costs over and above normal living expenses)	<ul style="list-style-type: none"> • Control • Fund pays for long-term care expenses without reducing other assets • If care is not needed, money can be used for other needs or passed to heirs 	<ul style="list-style-type: none"> • Have to earmark a significant sum of money specifically for long-term care costs • Money would be tied up and couldn't be used for other purposes • Assume risk yourself • Potential for income tax on the assets used to cover long-term care
Paying with retirement income (involves allocating retirement income dollars to pay for cost of care)	<ul style="list-style-type: none"> • Control • Pays for long-term care expenses • Care estimates are built into the retirement income budget planning • If care is not required, assets can be used for other needs or passed to heirs 	<ul style="list-style-type: none"> • May require additional contribution to your retirement investments to cover potential long-term care costs • Risk that you can lose money • Funds would be tied up and couldn't be used for other purposes • Assume risk yourself • Inadequate funding • Potential for income tax on the assets used to cover long-term care
Traditional long-term care insurance (requires qualifying for coverage and paying premiums to offset the risk)	<ul style="list-style-type: none"> • Covers long-term care expenses • Some of the risk is shared by the insurance company • Leverages premium dollars 	<ul style="list-style-type: none"> • Benefits may never be used if care is not required • Annual premium cost can be expensive • Money would be expended that could be used for other purposes • Need to qualify

Traditional long-term care insurance can be expensive, and premiums that are paid into it would be lost if care is never needed. Self-insuring methods require you to set aside funds that sit idle “just in case” but that could become depleted very quickly if the need arose for long-term care.

Introducing Sun Care WL

Sun Care WL offers a way to buy long-term care coverage and know that your premium dollars will not be wasted if the coverage is never needed.

Funding method	Advantages	Considerations
Sun Care WL Requires a single premium that provides a life insurance benefit and long-term care coverage	<ul style="list-style-type: none"> • Covers long-term care expenses • Provides a death benefit to heirs • Return of Premium provision • Benefits are guaranteed • Risk is shared by the insurance company • Simplified qualification process • Reposition assets to fund the product 	<ul style="list-style-type: none"> • Requires a single premium • Need to qualify for coverage • Limited access to money

Benefit in any situation

Sun Care is a single-premium whole life insurance policy. This is important because whole life policies are required to guarantee the benefits. Contrary to traditional forms of long-term care insurance, with Sun Care, once the single premium is paid, the policy is designed to provide you with a benefit—regardless of the situation you may find yourself in:

If you require long-term care or	The policy will provide coverage for such needs as home health care, assisted living, or nursing home care on a reimbursement basis.
If you want to leave a legacy or	A death benefit will be paid income-tax-free to your beneficiaries.
If you have liquidity needs	The policy provides a Return of Premium option that allows you to receive your original single premium back if you change your mind. A portion of the amount returned may have tax implications. ¹

Built-in features

Health Advocate benefit—A leading care management advisory service provides you with resources you need to find the right support facilities. An independently assigned care manager will help you maximize your benefit dollars.²

Marital discount—If you are married when coverage is purchased, you will receive an automatic premium discount.³

Accelerated Benefit rider—Allows the death benefit to be accelerated for long-term care expenses.

Optional features

Extension of Benefits rider—Offers the ability to extend the long-term care benefit beyond the acceleration benefit period of the base policy.

Inflation Protection feature—Allows a scheduled annual increase to the benefits.

Return of Premium provision—If you decide to surrender the policy, you will receive back at least your original single premium.¹

1. Assumes no loans or withdrawals.

2. Health Advocate benefit is managed through an independent service provider currently known as Health Advocate, Inc.TM Sun Life Financial may not be able to provide this benefit in the future if we determine that Health Advocate, Inc.TM or any other independent service provider is no longer able to provide it. Certain restrictions and other conditions may apply.

3. The term spouse in this benefit includes any individual who under applicable state law is either recognized as a spouse, partner to a civil union, or otherwise accorded the same rights as a spouse.

Costs, restrictions, and other conditions may apply. Not all riders and features are available in all states. Please consult your Sun Life Financial representative for product details and for current state availability, or visit www.sunlife.com. Guarantees are based on the claims-paying ability of the issuing company.

Sun Care WL would provide a benefit in any situation

Would an unexpected long-term care event completely alter my plans for retirement?



Anne is a freelance photographer who's looking forward to a relaxing retirement. She's done some basic financial planning and would like to leave something to her niece. She's concerned that an unexpected health event could jeopardize her savings.

Profile

- 65 years old, single
- Non-smoker
- \$75,000 to invest

Considerations for Anne

- Needs coverage for an unexpected long-term care event without jeopardizing retirement security
- Wants to make sure she can stay in her own home, no matter what the situation

Anne could stay in her own home with home health care.

Benefit in any situation

If Anne requires long-term care

Anne has available up to \$4,953 in monthly benefits for 6 years for qualified long-term care costs, and she can stay in her own home through home health care.

Or, if she wants to leave a legacy

Her \$75,000 investment can provide her niece \$118,866, income-tax-free.

Or, if she has liquidity needs

If she ever changes her mind, Anne's \$75,000 can be returned to her at her request.¹

1. Request should be in writing. The amount received will be adjusted for any benefits paid and for any loans and withdrawals, and may have tax implications.

The above hypothetical illustration shows: Accelerated Benefit rider—2 years; Extension of Benefits rider—4 years; and the Return of Premium provision.

Benefits may vary by age, gender, marital status and risk class.

How would we pay for long-term care without depleting our savings?



George is a practicing physician, and Laura is a retired nurse practitioner. They have a sizable retirement nest egg but are well aware of how much money a long-term care event can cost. They want to protect their assets and at the same time be able to afford an assisted living facility if they need the care.

Profile

- George and Laura; both 60 years old, married
- Both non-smokers
- \$50,000 each to invest

Considerations for the Smiths

- Need coverage for an unexpected long-term care event without eroding retirement savings
- Want to be able to afford an assisted living facility

The Smiths could be covered in an assisted living facility if they need to.

Benefit in any situation

If either or both of the Smiths require long-term care

George has available up to \$2,675 in monthly benefits for 6 years for qualified long-term care costs, and Laura has \$2,919. These benefits will increase with inflation because each elected the Simple 3% Inflation Protection feature.

Or, if they want to leave a legacy to their children

Each \$50,000 investment has growth potential and can be left to their children, income-tax-free. The guaranteed death benefit for George would be \$64,202 and Laura for \$70,046.

Or, if they have liquidity needs

If either of them changes their mind, the \$50,000 can be returned at their request.¹

1. Request should be in writing. The amount received will be adjusted for any benefits paid and for any loans and withdrawals, and may have tax implications.

The above hypothetical illustration shows: Accelerated Benefit rider—2 years; Extension of Benefits rider—4 years; and the Return of Premium provision.

Benefits may vary by age, gender, marital status and risk class.

Sun Care WL would provide a benefit in any situation

After seeing my mother's sister with Alzheimer's, we're concerned about how we would care for mom.



The Bergens have experienced a trying time with their mother's sister, who has been suffering with Alzheimer's. They want to protect their mother, Elizabeth, who was recently widowed, without burdening their own young family. They're looking for a way to provide the help she may need without jeopardizing their finances or having to provide day-to-day care. Elizabeth had given them money for the downpayment on their first house. They'd like to use that money for the \$60,000 premium.

Profile

- Elizabeth, 70 years old, single
- Non-smoker
- \$60,000 to invest

Considerations for the Bergens

- Need coverage for a long-term care event without taking time or money away from their family
- Want to make sure they can afford a nursing home for Elizabeth (if need be)
- Want to help fulfill Elizabeth's wish to leave a legacy to her grandchildren

The Bergens would know their mother could be cared for without jeopardizing their own financial security.

Benefit in any situation

If Elizabeth requires long-term care

Elizabeth will have available to her up to \$3,271 in monthly benefits for 6 years for qualified long-term care costs in a long-term care facility.

Or, if she wants to leave a legacy

The \$60,000 investment provides a guaranteed death benefit of \$78,498 income-tax-free to their grandchildren.

Or, if they have liquidity needs

If they ever change their mind, the Bergens' \$60,000 can be returned to them at their request.¹

1. Request should be in writing. The amount received will be adjusted for any benefits paid and for any loans and withdrawals, and may have tax implications.

The above hypothetical illustration shows: Accelerated Benefit rider—2 years; Extension of Benefits rider—4 years; and the Return of Premium provision.

Benefits may vary by age, gender, marital status and risk class.

We want to leave the full legacy we've planned for our children and grandchildren.



Richard and Sharon Wilson have done very well financially and have been enjoying a wonderful retirement. They have a net worth of \$15 million with \$3 million available in cash. Their concern is not about having enough money, but about making sure a long-term care event doesn't compromise what they can leave to their children and grandchildren. They also don't want to be a burden to them.

Profile

- Richard, 70 years old; Sharon, 65 years old; married
- Both non-smokers
- \$250,000 each to invest

Considerations for the Wilsons

- Need coverage for an unexpected long-term care event without dipping into the savings they had earmarked to leave as a legacy.
- Want to purchase enough long-term care coverage to adequately fund what they might need in a care situation.
- Want to make sure any long-term care event could be completely funded by them without relying at all on their family.

The Wilsons wouldn't burden their family and could leave them a generous legacy.

Benefit in any situation

If either or both of the Wilsons requires long-term care

Richard would have up to \$12,667 in monthly benefits, and Sharon up to \$17,042 in monthly benefits, for 6 years should a long-term care event occur.

Or, if they want to leave a legacy

The \$250,000 that each invested has growth potential and could be left to their children and grandchildren income-tax-free. The guaranteed death benefit for Richard would be \$303,999 and for Sharon \$408,988.

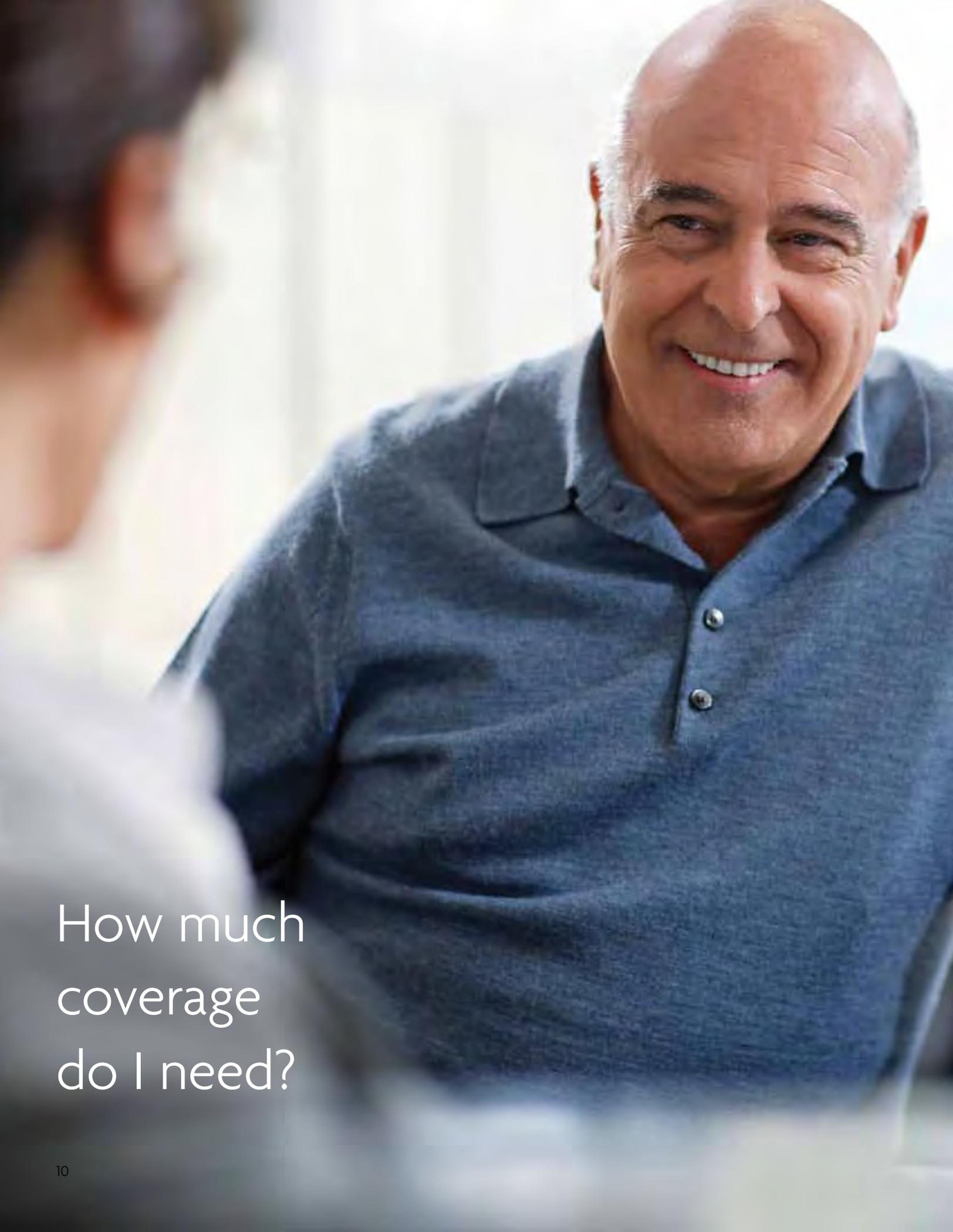
Or, if they have liquidity needs

If either of them changes their mind, the \$250,000 can be returned to each at their request.¹

1. Request should be in writing. The amount received will be adjusted for any benefits paid and for any loans and withdrawals, and may have tax implications.

The above hypothetical illustration shows: Accelerated Benefit rider—2 years; Extension of Benefits rider—4 years; and the Return of Premium provision.

Benefits may vary by age, gender, marital status and risk class.



How much
coverage
do I need?

Determining coverage

Here are two approaches to determine what amount of coverage is right for you.

Needs-analysis approach

An estimate of how much coverage you would need daily

Care at a skilled nursing facility today:

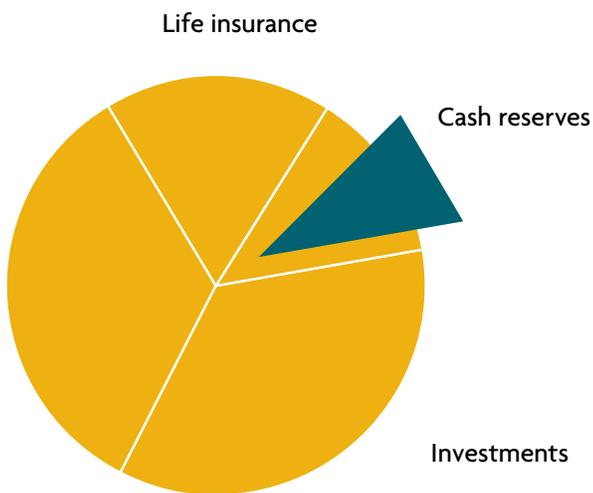
$$\begin{array}{r} \$219 \text{ per day} \\ \times 5 \text{ years} \\ \hline \$400,000 \text{ not including inflation} \end{array}$$

If that is your target coverage amount, you can request a Sun Care WL single premium quote from your financial professional for that level of coverage. *To help your policy stay in step with rising health care costs in years to come, consider starting with a larger premium or electing the Inflation Protection feature.¹*

Money purchase approach

Involves allocating a portion of your investments to cover some or all of your need

\$1 million investment portfolio



Reallocate a portion of assets—10% (\$100,000) cash, other investments, as the single premium amount, and then ask your financial professional what level of Sun Care WL coverage that amount will buy.

If this amount will be enough to fund long-term care, you have just repositioned 10% of your portfolio to protect the other 90%.

At \$80,000 a year, a long-term care event that lasts approximately 5-6 years could deplete half of this portfolio.

Retirement plans

Remember that Sun Care also offers a Return of Premium provision, so the value of the single premium is liquid as well.

1. Inflation Protection rider is available at issue only for an additional charge. State variations may apply.

How to get started

Sun Life Financial makes it easy to apply for Sun Care coverage. There are no medical exams or lab requirements.

Just a few simple steps:

1. Meet with your financial advisor to estimate your coverage needs and get a quote.
2. Review the pre-qualification questions to determine whether you are eligible to apply for coverage.
3. If you believe you'll be eligible to apply, have your financial advisor complete a Request for Coverage form and identify which funds you'll use to pay for Sun Care.
4. You'll be contacted promptly for a telephone interview to complete your application.
5. Soon after, you'll receive our underwriting decision, and if approved, you'll arrange payment of the single premium policy with your advisor.
6. Sun Life will forward your Sun Care policy to you or to your financial advisor.

The riders providing long-term care benefits may not cover all the costs associated with long-term care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the Policy and this rider. The receipt of accelerated benefits may be taxable, please consult with your tax advisor.

- ▶ Contact your financial professional today to learn more about how Sun Care WL can help you take control of your assets and your future.

Rely on Sun Life, your partner in care

A Sun Care WL policy is backed by the strength and security of Sun Life Financial. Over our 145-year history, our sustained momentum has consistently earned us top ratings from independent rating analysts and the trust of over 20 million customers worldwide.

Sun Care gives you peace of mind if there's ever a need for any type of long-term care because it will provide dollars to pay for care. It also allows you to free your children and relatives from the burden of care, and gives you the comfort of knowing that you or your family will benefit from Sun Care WL.

Sun Care WL, the Accelerated Benefit rider, and the Extension of Benefits rider may not all be available in some states. The Accelerated Benefit rider is automatically included with every Sun Care policy, and the Extension of Benefits rider is optional. The additional costs associated with these riders are included in the single premium. Restrictions and other coverage conditions may apply. Not all riders and features are available in all states. Please consult your Sun Life Financial representative for product details or for current state availability, or visit www.sunlife.com.

Sun Care WL with the Accelerated Benefit rider and/or Extension of Benefits rider is not considered long-term care insurance in some states. When the death benefit is accelerated for long-term care expenses, the death benefit is reduced dollar-for-dollar and the policy cash value is reduced proportionally off the death benefit reduction above.

For prospective policyholders in New York, this product is a life insurance policy that accelerates the death benefit for qualified long-term care services and is not a health insurance policy providing long-term care insurance subject to the minimum requirements of New York law, does not qualify for the New York State Long-Term Care Partnership program, and is not a Medicare supplement policy.

The Accelerated Benefit rider has exclusions and limitations, reductions of benefits, and terms under which it may be continued in force or discontinued.

You and your financial representative should consult state-specific coverage for additional details. Sun Care WL cannot be exchanged for any other Sun Life Financial insurance product, and replacement of Sun Care WL for a different Sun Life Financial insurance product will require full underwriting.

The Sun Care WL policy could terminate when any outstanding loan debt equals or exceeds cash value and is not repaid within the specified grace period as defined in your policy. This is the only way in which a Sun Care WL product can lapse. Withdrawals will not cause a policy to lapse, but they will reduce the available benefits.

Guaranteed product features are dependent on minimum premium requirements and the claims-paying ability of the issuer. Whole life insurance products are issued by Sun Life Assurance Company of Canada (Wellesley Hills, MA) and, in New York, by Sun Life Insurance and Annuity Company of New York (New York, NY). Both companies are members of the Sun Life Financial group of companies. All guarantees are based on the claims-paying ability of the issuing company.

SPWL-2010 – WL Policy

ABRLTC-2010 - Accelerated Benefit for LTC

EOBLTC-2010 - Extension of Benefits

NFBR-2010 –Non-forfeiture Option

HAE-2010 – Health Advocate Endorsement





Sun Care WL
Product Features
and Benefits



Sun Care WL Product Design

Product Design	Sun Care WL, a whole life insurance policy funded with a single premium payment, designed to offer fully guaranteed death benefit, cash values and an acceleration of benefits for covered long term care expenses. ¹
Issue Ages	30–80 (based on age last birthday)
Risk Classes²	Preferred and Standard; Male, Female (unisex rates in the state of Montana; male rates are used) Rated classes not allowed
Minimum Face Amount	\$25,000
Maximum Face Amount	\$750,000 (If 2-year Accelerated Benefit rider period is selected.) \$1,000,000 (If 3-year Accelerated Benefit rider period is selected.)
Maturity Age	Age 121
Face Amount Increases	Increases are not allowed.
Face Amount Decreases	Decreases are allowed in conjunction with partial withdrawals
Access to Money³	<p>Partial Withdrawals Are allowed prior to the commencement of benefits. Partial withdrawals will, in effect cancel a pro rata portion of the Face Amount and rider coverages. There is no partial withdrawal fee.</p> <p>Policy Loans Loans based upon a variable loan rate.⁴</p>

Highlights

Qualified benefits offered through Sun Care WL	The Accelerated Benefit and the Extension of Benefits riders provide coverage for a variety of services designed to assist persons covered by the policy who have developed a chronic illness. Home healthcare, adult daycare, assisted living, nursing home, and hospice benefits may be included under covered care. Benefits may vary by state.
Benefit Period Options	If both Accelerated Benefit rider and the Extension of Benefits rider are selected, then the benefit period options are 4–8 years. Benefit period options for 2 and 3 years are available with the Accelerated Benefit Rider only.
Elimination period	90 days in nursing home facilities (domestic and international) and assisted living facilities; 0 days for home healthcare services.
Reimbursement for long term care Payments	Sun Care WL provides for the reimbursement of expenses on a monthly basis for covered long term care needs up to the specified Maximum Monthly Benefit Amount (MMBA). That is, the amount covered each month is the lesser of: a. the actual expenses incurred for the month, or b. the purchased amount of MMBA

Options, Features & Riders⁵

What it is	What it does
Accelerated Benefit Rider	The acceleration period is the initial phase of benefit payments for covered expenses. This rider works as an accelerated death benefit, meaning that the payment of covered Long Term Care expenses will result in a dollar for dollar reduction in the policy's death benefit. The policy is not offered without the Accelerated Benefit rider. If the only coverage is the Accelerated Benefit rider, you may select coverage periods of 2 or 3 years.
Extension of Benefits Rider	If you select this optional rider, it extends the long term care benefit coverage period (Accelerated Benefits rider and Extension of Benefits rider) to a total of 4-8 years.
Return of Premium Benefit	The Return of Premium Benefit is available as optional coverage for an extra premium. If you decide to surrender the policy, you will receive back your original single premium, assuming no loans or withdrawals. A portion of the amount returned may have tax implications. Please consult your tax advisor for your particular situation. This benefit must be selected at the time the policy is issued.
Nonforfeiture Benefit Rider	The Nonforfeiture option is available, if the Extension of Benefits rider is selected and Return of Premium Benefit is <u>not</u> selected. If selected, the Nonforfeiture rider provides a deferred (paid up benefit) if the policy is terminated. ⁶
Optional Inflation Protection Feature	When you choose this optional feature, your policy benefits increase yearly based on a specific increase percentage. There are two types of increasing coverage from which to choose: based on a simple interest formula with a 3% increase that applies to both the Accelerated Benefit Rider and the Extension of Benefits rider; or based on a compound interest formula of 5% that applies only to the Extension of Benefits rider.
Health Advocate Benefit	This endorsement benefit provides the covered person(s) with the services and resources needed to find the right support facilities for the level of care. An independently assigned care manager will work to offer personalized services. For a complete list of covered services, please talk with your Sun Life Financial Representative. ⁷
Marital discount	If you are married when coverage is purchased you will receive an automatic premium discount. ^{2, 8}
Residual death benefit	This benefit provides for a guaranteed death benefit that is the lesser of \$5,000 or 5% of the initial specified death benefit amount less all outstanding loans should the accelerated benefit rider long term care services reduce the death benefit below the residual death benefit amount. The residual death benefit amount will be reduced by any loans.



► For product and benefit details, please contact your Sun Life Financial representative.

1. The acceleration of benefits for covered long term care expenses will reduce the death benefit and cash values.
2. The risk classes applies only to the WL policy; marital status of single/married as defined for long term care acceleration benefits rider and extension of benefits rider apply only to those premiums.
3. Loans and partial withdrawals will affect the policy proceeds and account value and may be subject to ordinary income tax. If a policy is classified as a Modified Endowment Contract (MEC), distributions are generally subject to ordinary income tax and federal tax penalty if made before age 59½.
4. Loans will not reduce Maximum Monthly Benefit Amount calculations. As benefits are paid, there will be reduction in the dollar amount of claims paid representing a repayment of the loan balance. Loan amounts can cause the policy to lapse when they are in excess of cash value.
5. Your Sun Life Financial representative can describe the benefits, limitations and costs associated with each rider, as well as provide you with an illustration that demonstrates how adding a particular rider to your policy may affect policy values. Riders that are chosen must be selected at issue. There is no option to add a rider post-issue. The Long Term Care rider options cannot be surrendered separately from the base policy. (Extension of Benefits and Non forfeiture benefit rider options do have a right to return or “freelook” period.)

This flyer provides highlights of the product, features and riders. Please consult your Sun Life Financial representative for product details. Costs, restrictions and other conditions may apply. Not all riders and features are available in all states. Please consult your Sun Life Financial representative for current state availability, or visit www.sunlife.com.

These riders may not cover all the costs associated with long term care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the policy and the riders. Receipt of Accelerated Benefits may be taxable. As with all tax matters, the owner should consult a professional tax advisor to assess the effect of this rider.

6. The maximum benefit payable is equal to the greater of the Maximum Monthly Benefit Amount at the time of the policy termination or the single premium for the Extension of Benefits rider, less any payments made during the Extension of Benefits coverage period. Certain restrictions and other conditions apply. Please consult your Sun Life Financial representative for details on this rider option.
7. Health Advocate Benefit is managed through an independent service provider currently known as Health Advocate, Inc.™ Sun Life Financial may not be able to provide this benefit in the future if we determine that Health Advocate, Inc.™ or another independent service provider is no longer able to provide it. Certain restrictions and other conditions may apply. Please consult your SLF representative for current state availability.
- 8 The term spouse in this benefit includes any individual who under applicable state law is either recognized as a spouse, partner to a civil union, or otherwise accorded the same rights as a spouse.

Whole Life products are issued by Sun Life Assurance Company of Canada (Wellesley Hills, MA) and in New York, by Sun Life Insurance and Annuity company of New York (New York, NY). Both companies are members of the Sun Life Financial group of companies. All guarantees are based on the claims-paying ability of the issuing company.

SPWL-2010 – WL Policy

ABRLTC-2010 - Accelerated Benefit for LTC

EOBLTC-2010 - Extension of Benefits

NFBR-2010 –Non-forfeiture Option

HAE-2010 – Health Advocate Endorsement

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