

CANADIAN DENTISTS' INVESTMENT PROGRAM

A member benefit of the CDA and participating provincial and territorial dental associations.



For investment planning advice, call CDSPI Advisory Services Inc.:

1-877-293-9455 (toll-free) or (416) 296-9455 Ext. 5023

For assistance filling out this form, call CDSPI:

1-800-561-9401 (toll-free) or (416) 296-9401 Ext. 5020

Please return the completed form to:

CDSPI, 155 Lesmill Road, Toronto, Ontario M3B 2T8

Fax: 1-866-561-2250 (toll-free) or (416) 296-9459

E-mail queries: investment@cdspi.com

Annuity Contract Issued By: Sun Life Assurance Company of Canada

**AUTHORIZATION AND DIRECTION AND CONTINUING POWER OF ATTORNEY**

Please return completed form **via regular mail** to the above address.

Original hand-written signatures are required, therefore this form cannot be accepted by fax.

Questions? Contact CDSPI at extension 5020.

**TO: CDSPI and CDSPI Advisory Services Inc.**

**RE: The account(s) of**

\_\_\_\_\_  
*PRINT NAME OF CANADIAN DENTISTS' INVESTMENT PROGRAM ACCOUNT HOLDER*

**Canadian Dentists' Investment Program account type(s) and number(s):**

\_\_\_\_\_  
*ACCOUNT TYPE*

\_\_\_\_\_  
*ACCOUNT NUMBER*

\_\_\_\_\_  
*ACCOUNT TYPE*

\_\_\_\_\_  
*ACCOUNT NUMBER*

I authorize and direct CDSPI and CDSPI Advisory Services Inc. to permit

\_\_\_\_\_  
***PRINT*** NAME OF AUTHORIZED PERSON AND RELATIONSHIP TO ACCOUNT HOLDER

(the "Authorized Person") to view and have access to my account(s) in the Canadian Dentists' Investment Program through the private client section of the CDSPI website. I nominate, constitute and appoint the Authorized Person as my true and lawful attorney to act in my name and on my behalf to authorize all transactions in my account(s) through CDSPI's on-line facilities or by instructing CDSPI and/or CDSPI Advisory Services Inc. either orally or in writing as I could authorize on my own behalf. This continuing power of attorney does not grant authority to designate or change the designation of any beneficiary of my investment account(s).

The granting of this authorization and direction and this continuing power of attorney will not impair or limit my ability to make and implement decisions with respect to the above-described account(s) by instructing CDSPI and/or CDSPI Advisory Services Inc. through CDSPI's on-line facilities or by giving such instructions orally or in writing.

In accordance with applicable law, I declare that this power of attorney may be exercised during any subsequent mental incapacity on my part. This authorization and direction and continuing power of attorney will terminate upon the happening of any one of the following three events:

1. CDSPI and/or CDSPI Advisory Services Inc. receives written notice of my death;
2. I revoke this authorization and direction and power of attorney in favour of the Authorized Person by written notice to CDSPI and/or CDSPI Advisory Services Inc.; and
3. Upon my mental incapacity, a guardian of property, committee or equivalent is appointed on my behalf under applicable law.

This authorization and direction and continuing power of attorney will be binding on me and my personal representatives, successors and assigns.

**Note: The witnesses to the signatures on this form must not be related to the Account Holder or Authorized Person.**

\_\_\_\_\_  
SIGNATURE OF ACCOUNT HOLDER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF WITNESS\*

\_\_\_\_\_  
SIGNATURE OF WITNESS\*

\* Residents of Ontario and Quebec require two witnesses.

I accept this appointment.

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED PERSON

If the "Authorized Person" is a participant in the Canadian Dentists' Investment Program, please provide their Investment Program account number as identification:

\_\_\_\_\_

(If not a Program participant, please complete the information below.)

**About the Authorized Person**

(To be completed for the person appointed to act as the "Authorized Person" if said person is NOT a Canadian Dentists' Investment Program participant.)

\_\_\_\_\_  
HOME ADDRESS

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

\_\_\_\_\_  
DATE OF BIRTH RELATIONSHIP TO CANADIAN DENTISTS' INVESTMENT PROGRAM ACCOUNT HOLDER

**Valid Identification\*\***

(Complete the section below and include photocopies of two pieces of valid identification\*\*.)

\_\_\_\_\_  
ID TYPE ID NUMBER EXPIRY DATE WHERE ISSUED

\_\_\_\_\_  
ID TYPE ID NUMBER EXPIRY DATE WHERE ISSUED

\*\* Valid Identification Includes:

- i) A government-issued Age of Majority Card, Birth Certificate, Driver's License, Passport or National Identity Card and;
- ii) A second item from i) above or a credit card issued by a Canadian chartered bank.

**Important Note: At least one piece of valid identification must include the Authorized Person's photograph.**