



REGISTERED EDUCATION SAVINGS PLAN (RESP) APPLICATION

RESP New Account Application

For investment planning advice or assistance filling out this form, call:
1.800.561.9401 or 416.296.9401

Annuity Contract Issued By: Sun Life Assurance Company of Canada

Please return the completed form to:
CDSPI, 155 Lesmill Road, Toronto, ON M3B 2T8
E-mail: investment@cdspi.com

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SHADED AREAS FOR OFFICE USE ONLY.

OFFICE USE — PLAN INFORMATION:

Name of Plan Promoter: CDSPi
Name of Trustee: Sun Life Financial Trust Inc.
Group Annuity Policy No: 62941-G

(OFFICE USE ONLY) PLAN #:

ESP Plan No.:

SECTION 1 ELIGIBILITY INFORMATION

Complete one of A, B or C.

- A. Dentist
 Member of Provincial/Territorial Dental Association*
* Excluding the ACDQ in Quebec.

OR
 Member of CDA _____
Unique Number _____

- Eligible Family Member[†] of Eligible Dentist
Name of Dentist _____
Specify Relationship to Dentist _____

- OR
B. Hygienist
 Certified Dental Assistant
 Other Employee
 Eligible Family Member[†] of Hygienist, Dental Assistant or Employee
Name of Employer _____
Name of Hygienist, Dental Assistant or Employee: _____
Last Name _____ First Name _____ Initial(s) _____

Specify Relationship _____

- OR
C. Association Staff
 Eligible Family Member[†] of Association Staff
Name of Association _____
Name of Association Staff Member: _____
Last Name _____ First Name _____ Initial(s) _____

Specify Relationship _____

[†] Eligible Family Members of an eligible participant include his or her spouse (or common law or same-sex partner), children, parents, brothers, sisters, grandchildren, grandparents and in-laws.

SECTION 2 SUBSCRIBER/CO-SUBSCRIBER INFORMATION

Information for Subscriber

- A. Title (check one): Dr. Mr. Mrs. Miss Ms.

Name _____
Last Name First Name Initial(s)

- B. Gender Male Female

C. Date of Birth _____
Day Month Year

- D. Occupation (if not shown in Section 1) _____

E. Social Insurance Number _____

- F. Mailing Address (check one): Home Business

Street Number and Name, Apartment or Suite

City Province Postal Code

G. Home Telephone No. () _____

H. Business Telephone No. () _____

I. E-Mail Address _____

J. Fax No. () _____

Information for Co-Subscriber (if applicable — must be spouse of Subscriber)

- A. Title (check one): Dr. Mr. Mrs. Miss Ms.

Name _____
Last Name First Name Initial(s)

- B. Gender Male Female

C. Date of Birth _____
Day Month Year

- D. Occupation (if not shown in Section 1) _____

E. Social Insurance Number _____

- F. Mailing Address (check one): Home Business

Street Number and Name, Apartment or Suite

City Province Postal Code

G. Home Telephone No. ()

H. Business Telephone No. ()

I. E-Mail Address

J. Fax No. ()

SECTION 3 SERVICE PREFERENCES

A. Language Preference (check one):

- English
French
Subscriber
Co-subscriber*

B. QUEBEC SUBSCRIBERS ONLY

(check if selecting English language preferred)

I, the Subscriber, require that this application and documents issued thereunder be drawn up in English and that future communications relating to my participation in the Plan be in English.

- Subscriber
Co-subscriber*

C. Instructions: I hereby authorize and direct CDSPI and CDSPI Advisory Services Inc. to accept instructions given by me to staff of CDSPI and CDSPI Advisory Services Inc. by phone, Internet and/or facsimile.

- No
Yes (if "Yes" provide signature and date)
Subscriber
Co-subscriber*

Subscriber Signature (required) Day Month Year

Co-subscriber* Signature (if applicable) Day Month Year

D. Additional Access: I wish another individual to have access to my account.

- No
Yes†
Subscriber
Co-subscriber*

* Complete this information only if a co-subscriber is named on the account.
† If you wish another individual to have total access you must fill out and return a Power of Attorney form along with this application.

SECTION 4 SUBSCRIBER(S) FINANCIAL INFORMATION

(This "Know Your Client" information is used to help tailor your investment strategy)

A. Investment Knowledge (check one for each subscriber*):

- Low
Modest
Subscriber
Co-subscriber*

Subscriber Co-subscriber*

- Average
High
Subscriber
Co-subscriber*

B. Approximate Personal Net Worth (check one for each subscriber*):

- under \$25,000
\$25,000 to \$49,999
\$50,000 to \$99,999
\$100,000 to \$199,999
\$200,000 to \$500,000
over \$500,000
Subscriber
Co-subscriber*

C. Annual Income (check one for each subscriber*):

- under \$25,000
\$25,000 to \$49,999
\$50,000 to \$74,999
\$75,000 to \$125,000
over \$125,000
Subscriber
Co-subscriber*

* Complete this information only if a co-subscriber is named on the account.

(OFFICE USE ONLY) INVESTMENT PROFILE:

- Risk Tolerance (as a percentage totaling 100%): High
Medium
Low
Time Horizon (choose one):
less than 1 Year
1 to 3 Years
3 to 7 Years
greater than 7 Years

SECTION 5 APPLICATION FOR:

(Check one):

- Individual Plan
Family Plan
Specified Plan*
Yes
No

* A "specified plan" is a plan for a disabled beneficiary which meets certain requirements set out in the Income Tax Act.

SECTION 6 INDIVIDUAL PLAN — DESIGNATION OF BENEFICIARY*

The following person is designated as Beneficiary entitled to receive educational assistance payments under this Plan (Subscribers have the right to change the Beneficiary at any time):

Name _____
(as shown on the Social Insurance Number card)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

Gender Male Female

Date of Birth _____
Day Month Year

Social Insurance Number _____

Relationship to Subscriber _____

Name of Parent/Guardian/Public Primary Caregiver
(if Beneficiary is under 19)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

SECTION 7 FAMILY PLAN — DESIGNATION OF BENEFICIARIES*

The following person(s) is (are) designated as Beneficiary (Beneficiaries) entitled to receive educational assistance payments under this Plan (Subscribers have the right to change the Beneficiary(ies) and/or apportionment of contributions at any time):

A. Name _____
(as shown on the Social Insurance Number card)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

Gender Male Female

Date of Birth _____
Day Month Year

Social Insurance Number _____

Relationship to Subscriber _____

Name of Parent/Guardian/Public Primary Caregiver
(if Beneficiary is under 19)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

B. Name _____
(as shown on the Social Insurance Number card)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

Gender Male Female

Date of Birth _____
Day Month Year

Social Insurance Number _____

Relationship to Subscriber _____

Name of Parent/Guardian/Public Primary Caregiver
(if Beneficiary is under 19)

Address _____
Street Number and Name, Apartment or Suite

City Province Postal Code

C. Apportionment of Contributions into the Plan (For Family Plan Only):

Equally among all Beneficiaries; or

Name of Beneficiary	Percentage
A. _____ % Last Name First Name Initial(s)	
B. _____ % Last Name First Name Initial(s)	

Note: If more than two Beneficiaries will be designated, list additional Beneficiaries and parent/guardian information on a separate form marked "Schedule A". This form is available by phoning CDSPI and at www.cdspi.com.

Check here if Schedule A is attached.

* Each designated Beneficiary must have a social insurance number and be a Canadian resident, at both the time of designation and any time when a contribution is being made for the Beneficiary. Exceptions may apply for transfers from other RESPs.

SECTION 8 TERMINATION DATE OF THE PLAN

A. Last Date for Deposits into the Plan: _____
Day Month Year
(No more than 31 years after the end of the year in which the plan was established.)

B. Termination Date of the Plan: _____
Day Month Year

(No more than 35 years after the end of the year in which the plan was established or no more than 40 years if the plan is a "specified plan".)

SECTION 9 ASSET ALLOCATION

A. Form of initial contribution (check one):

- Deposit
 Transfer from another RESP

(If transferring from an existing RESP, you must complete and submit an RESP Transfer Request Form with this application. The transfer form is available by phoning CDSPI and at www.cdspi.com.)

B. Invest my contribution as indicated (If listing Guaranteed Funds please specify term (1 to 5 years). Please refer to the CDSPI Fund Descriptions sheet or visit www.cdspi.com for the list of CDSPI Funds.):

Investment Fund Name	Amount or Percentage
1. _____	\$ _____ %
2. _____	\$ _____ %
3. _____	\$ _____ %
4. _____	\$ _____ %
5. _____	\$ _____ %
6. _____	\$ _____ %
7. _____	\$ _____ %
8. _____	\$ _____ %
(please make cheque payable to CDSPI)	Total \$ _____ %

SECTION 10 PRE-AUTHORIZED CHEQUING (PAC) AGREEMENT

(Optional: for automatic contributions.)

A. Account to be debited is (choose one):

- Personal
 Name(s) on the Account: _____
- Business
 Business Name on the Account: _____

Financial Institution _____

Institution No. (must be 3 digits):

Transit No. (must be 5 digits):

Canadian Dollar Account No. (up to 11 digits):

Please attach a blank cheque marked "VOID".

B. Deductions Please deduct a contribution of \$ _____

- Weekly on the 7th, 14th, 21st and 28th of the month
 Semi-Monthly – 1st and 15th OR
 15th and 28th
 Monthly on the _____ day of the month
 and invest it into the Fund(s) indicated in Section 9.

(Note: the 29th, 30th and 31st are not allowed as PAC withdrawal dates. If the date is not specified, the automatic withdrawal will be made once a month on the 1st day of the month.)

C. Starting On
 Day Month Year

D. Authorization: I/We hereby authorize CDSPI and the financial institution designated above to begin deductions against the account specified. (This agreement must be signed by all persons whose signature is required to sign on the above account.) This authorization will remain in effect until CDSPI receives written notice (at least 48 hours prior to next scheduled payment date) to cancel the agreement.

I/we may obtain more information about my/our right to cancel a pre-authorized chequing agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information about these recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.



Signature of Bank Account Holder
(required)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	Month	Year			



Signature of Joint Bank Account Holder
(if applicable)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	Month	Year			

SECTION 11 NOTICE ON PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on this application form is required to process this application and provide to you investment related services. CDSPI and CDSPI Advisory Services Inc. will restrict access to this information to those employees, mandataries, administrators or agents of CDSPI and CDSPI Advisory Services Inc. who are responsible for providing investment services and the marketing and administration of services and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file by writing to: Information Access Officer, 155 Lesmill Road, Toronto, ON M3B 2T8. The Sun Life Financial Privacy Policy is available for your review on the Sun Life Financial website, www.sunlife.ca.

SECTION 12 APPLICATION AND AUTHORIZATION

I/we hereby apply for an education savings plan (the "Plan") to be established under the terms of the Program's ESP. I/we request that application be made by CDSPI for registration of the Plan as a Registered Education Savings Plan under the *Income Tax Act (Canada)* and any other applicable provincial income tax legislation.

I/we acknowledge that I/we have read and agree to comply with the provisions of the Terms and Conditions governing the Plan and this Application and declare that the information given in this Application is true, correct and complete in every respect.

I/We understand that:

- benefits paid out under the Plan may constitute taxable income under the *Income Tax Act (Canada)* and any other applicable provincial income tax legislation;
- I am/we are responsible for determining the permitted amounts that may be contributed to the Plan and the suitability of the investments made by the Plan;
- any overpayments to the Plan may result in the payment of a penalty tax on the excess as prescribed under the *Income Tax Act (Canada)* and that payment of any such penalty tax is my/our sole responsibility;
- deposits for each Beneficiary under a Family Plan must cease on or before the date the individual beneficiary attains the age of 31; and

