REGISTERED EDUCATION SAVINGS PLAN (RESP) **APPLICATION**

CDSPI ADVICE. INSURANCE. INVESTMENTS.

RESP

New Account Application

CDSPI ADVICE. INSURANCE. INVESTMENTS.

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, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4
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.

Unique Number

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*):

	Subscriber	Co-subscriber*
• English	☐	☐
• French	☐	☐

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.

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

! _____ Day Month Year
Subscriber Signature *(required)*

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

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

	Subscriber	Co-subscriber*
• No	☐	☐
• Yes†	☐	☐

** 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. If you wish them to only have access for authorizing transfers between investment funds, you must fill out and return an Investment Fund Transfer Authorization. These forms are available by phoning CDSPI or at www.cdspi.com.

SECTION 4 SUBSCRIBER(S) FINANCIAL INFORMATION

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

A. Investment Knowledge (*check <u>one</u> for each subscriber**):

	Subscriber	Co-subscriber*
• **Low** (I am just beginning to learn about markets and investments)	☐	☐
• **Modest** (I have some familiarity with markets and investments, but not any in-depth knowledge)	☐	☐
• **Average** (I am familiar with the various types of investments and their relative risk profiles. I am comfortable selecting investment funds)	☐	☐
• **High** (I am very knowledgeable about the markets and types of investment available. I am very comfortable assembling my own portfolio)	☐	☐

B. Approximate Personal Net Worth (*check <u>one</u> for each subscriber**):

	Subscriber	Co-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	☐	☐

C. Annual Income (*check <u>one</u> for each subscriber**):

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

** 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** (*Complete 6 below*) Specified Plan* ☐ Yes ☐ No

☐ **Family Plan** — Each beneficiary must be connected to the Subscriber by blood relationship (as defined in the Income Tax Act) or adoption. (*Complete 7 below*)

** 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".*)

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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 Day Month Year
(required)

! _____ ☐☐ ☐☐ ☐☐☐☐
Signature of Joint Bank Account Holder Day Month Year
(if applicable)

SECTION 11 NOTICE ON PRIVACY AND CONFIDENTIALITY

CDSPI and CDSPI Advisory Services Inc. collect, use and disclose your personal information on this application for purposes that include: determining your eligibility for our plans; administering and providing investment and financial services to you; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; marketing and to advise you of other related products and services. We limit access to your personal information in our files to our employees, authorized agents and third-party service providers, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You may request to review the personal information your file contains and make corrections by sending a written request to: CDSPI, Attn: The Chief Privacy Officer, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4. To find out more about our privacy practices, visit www.cdspi.com/privacy.

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:

(i) benefits paid out under the Plan may constitute taxable income under the *Income Tax Act (Canada)* and any other applicable provincial income tax legislation;

(ii) 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;

(iii) 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;

(iv) deposits for each Beneficiary under a Family Plan must cease on or before the date the individual beneficiary attains the age of 31; and

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(v) the Plan must terminate (i.e., the Assets of the Plan must be paid out) on or before December 31 of the 35th year following the year in which the Plan is established.

I/we request the Plan Trustee to apply on my/our behalf for grants available to me/us through the Canada Education Savings Act.

I/we apply for this Investment Program and appoint the Program Sponsor and Promoter of the ESP, CDSPI and its affiliate, CDSPI Advisory Services Inc., to act as my/our agent under the terms of the Program.

I/we acknowledge that it is **solely my/our responsibility** (and **not** the responsibility of any other person or organization including CDSPI, CDSPI Advisory Services Inc. or Sun Life Assurance Company of Canada) to, where applicable, make all investment decisions concerning my/our account.

I/we agree to be bound by the terms of each of the Group Plans in which I/we choose to participate. I/we certify that the information given in this application is true and complete and that Sun Life Assurance Company of Canada, Sun Life Financial Trust Inc., CDSPI and CDSPI Advisory Services Inc. may rely on that information until the undersigned person(s) give(s) written notice of any significant changes.

By submitting this application, I/we authorize CDSPI, CDSPI Advisory Services Inc. and their affiliates to exchange and use personal information about me/us for the purpose of performing investment-related services, including account and plan administration on my/our behalf, and for the purpose of providing to me/us reports, statements and information on financial products and services. I/we also authorize Sun Life Assurance Company of Canada and its affiliates to obtain, use, exchange with and transmit to CDSPI and CDSPI Advisory Services Inc. personal information about me/us for the purpose of plan administration.

I/we acknowledge having read and confirm my/our agreement with the Notice on Privacy and Confidentiality set out above.

I/we consent to the use of my/our Social Insurance Number to complete the government information requirements as required by the Canada Revenue Agency or other governmental authorities, and for identification and administration purposes related to the Program.

I/we acknowledge that non-payment of the annual provincial or territorial association membership fee (in Quebec, the CDA membership fee) by the eligible dentist specified in Section 1 (where applicable) will prevent me/us from making any new investments in the plans of the Program until that membership fee has been paid.

Subscriber's Signature (*required*) Day Month Year

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

Signed at City Province

(OFFICE USE ONLY) ACCEPTANCE

CONFIRMATION OF ACCEPTANCE OF APPLICATION

Per _____ Day Month Year
(Authorized signature)