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A SUMMARY OF CBAC BENEFITS

- **Sun Life Financial** is the Canadian Baptist Pension Plan's record keeper. 6% is deducted from your payroll, the employer matches the contribution for a total of 12% to be remitted monthly to Sun Life Financial.

- **Canada Life (new name)**
  - Basic Life Insurance - $60,000
  - Dependent Life Insurance - $20,000 spouse, $8,000 child
  - Long Term Disability – 67% of your ***reported*** income after 4 month waiting period
  - Employee and Family Assistance Program – FREE confidential counselling
  - Medical Dental Plan – see booklet under the insurance tab https://baptist-atlantic.ca/our-convention/departments/pension-benefits/

- **CHUBB**
  - Accidental Death & Dismemberment - $25,000

- **Optional Benefits** can be deducted from your payroll once additional application is approved
  - Optional Life Insurance – available for member & spouse & child
  - Optional Critical Illness – available for member & spouse
  - Optional Accidental Death & Dismemberment – available for member & family

YOUR BENEFITS…. YOUR RESPONSIBILITY

Members have only 31 days to notify your Benefits Coordinator if life changes happen**:**

a) Married – to add spouse to plan and to change name (if needed)

b) Beneficiary changes for any reason

c) Spouse loses medical dental coverage

d) Death of spouse or dependent child

e) Birth or adoption of a child

f) Move – address changes

These situations are the **MEMBERS** RESPONSIBILITY and need your **immediate attention** when they arise.

TO ENROLL INTO THE CBAC BENEFITS:

- Please complete each form and ***return all originals to your treasurer***.
- The treasurer is to retain the originals in a personnel file at the church. A copy is to be sent via email to Karen.gunn@baptist-atlantic.ca or faxed to 506-635-0366 or sent in the mail to:

PENSION AND BENEFITS BOARD at PO Box 6003, Moncton, NB E1C 0V7.

`

PLEASE COMPLETE ALL FORMS AND RETURN VIA EMAIL TO:
karen.gunn@baptist-atlantic.ca or fax: 506-635-0366

NAME: ______________________________

ADDRESS: ______________________________

____

____

PHONE NUMBER: ____________________

DATE OF BIRTH: ______________________ SEX: ___ Male ___ Female

SOCIAL INSURANCE NUMBER. ____________________

NAME OF CHURCH: ______________________________

Are you: Full-time _____ Part-time______ NUMBER OF HOURS A WEEK: ____________

OCCUPATION TITLE:______________________________

ANNUAL SALARY: ______________________________

DATE OF EMPLOYMENT: ______________________________

EFFECTIVE DATE OF COVERAGE: ______________________________

MARITAL STATUS: ☐ Married ☐ Single

IF MARRIED, Spouse's Full Name: ______________________________

IF MARRIED, Spouse's Date of Birth: ______________________________

DATE: ________________

APPLICANT SIGNATURE: ______________________________

APPLICANT'S EMAIL ADDRESS: ______________________________

CHURCH TREASURER: ______________________________

TREASURER'S EMAIL ADDRESS: ______________________________

`

** * CONFIDENTIAL INFORMATION SHEET * * *
for
LONG TERM DISABILITY & PENSION CALCULATIONS

Member's Name: ______________________ ID #: _________________________________
(last 6 digits of SIN # or old 4 digit ID)

Effective Date of Salary: ____________________________________

TOTAL GROSS SALARY, which includes either:

- Basic Salary PLUS Housing Allowance OR
- Basic Salary PLUS Fair Rental Value of Parsonage AND utilities, if paid by the church on behalf of the member $ _________________

OF PAY PERIODS (Weekly=52, Bi-weekly=26, Semi-monthly=24, Monthly=12) __________________

12% PENSION CONTRIBUTION PER PAY PERIOD =__________________
(Total Gross Salary multiplied by 12% divided by # of Pay Periods)

** Total Pension Contribution per month is determined by multiplying 12% Pension Contribution per Pay Period multiplied by the number of pays for the month. (ie: Bi-weekly have 10 months with 2 pays and 2 months with 3 pays). This contribution must be remitted to Sun Life Financial by the 10th of month following the deduction.*

**Long Term Disability Monthly premiums are determined by Canada Life however premiums can roughly be calculated using the following: Total Salary / 12 x .67 x .02342*

TREASURER

Name: ___________________________________

Address: ___________________________________

Postal Code: ________________________________

Church: ___________________________________

Phone No.: _________________________________

MEMBER

Name: ______________________________

Address: ______________________________

Postal Code: ___________________________

Phone No.: ____________________________

Date: ________________________________

IMPORTANT:

Return completed form to: Karen Gunn via email at karen.gunn@baptist-atlantic.ca,, fax 506-635-0366 or
Mail to: Pension and Benefits Board
PO Box 6003
Moncton, NB E1C 0V7

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OPTIONAL GROUP LIFE QUESTIONNAIRE

Optional Life Member & Optional Life Spouse

Members are encouraged to purchase additional coverage for themselves and\or their spouse. The monthly rates for each 10,000 unit are as follows to a maximum of $500,000:

Age	Male Non Smoker	Male Smoker	Female Non Smoker	Female Smoker
Under 29	$0.30	$0.60	$0.30	$0.40
30-34	$0.40	$0.60	$0.30	$0.50
35-39	$0.50	$0.90	$0.40	$0.60
40-44	$0.90	$1.50	$0.60	$1.00
45-49	$1.50	$2.80	$1.00	$1.90
50-54	$2.60	$4.70	$1.80	$3.20
55-59	$4.10	$7.40	$2.80	$5.00
60-64	$6.00	$10.90	$4.10	$7.30

- ❑ **YES**, I wish to apply for **OPTIONAL LIFE** for myself. Amount of Units: ____________________
- ❑ **YES**, I wish to apply for **OPTIONAL LIFE** for my spouse. Amount of Units: ____________________
- ❑ **No,** I do NOT wish to apply for **OPTIONAL GROUP LIFE INSURANCE**.

Optional Life Child

Monthly rate per unit of $2,000 to a maximum of $20,000 or 10 units =$0.31

- ❑ **YES**, I wish to apply for **OPTIONAL LIFE** for my child/children. Amount of Units: ____________________
- ❑ **No,** I do NOT wish to apply for **OPTIONAL INSURANCE FOR MY CHILD**.

Optional AD&D insurance

Insured	Coverage	Rate
Member Only	$10,000 unit to a maximum of $250,000 or 25 units	$0.20
Spouse	* 40% of member's amount * 50% if no child	$0.30
Child	* 10% of member's amount * 15% if no spouse	$0.30

- ❑ **YES**, I wish to apply for **OPTIONAL AD&D MEMBER ONLY**. Amount of Units: _______________
- ❑ **YES**, I wish to apply for **OPTIONAL AD&D FAMILY** . Amount of Units: ________________
- ❑ **No,** I do NOT wish to apply for **OPTIONAL AD&D INSURANCE**.

`

OPTIONAL CRITICAL ILLNESS QUESTIONNAIRE

Members and Spouses can apply for Optional Critical Illness which provides a Lump Sum Benefit in the event they are diagnosed with a critical illness. Coverage is available in units of $10,000 to a maximum of $250,000.

Optional Critical Illness (ENHANCED Coverage Only)

Basic Monthly Rates per $1000

	Male	Female		Male	Female
20	0.05	0.05	43	0.30	0.31
21	0.06	0.05	44	0.32	0.33
22	0.06	0.06	45	0.35	0.36
23	0.06	0.06	46	0.38	0.38
24	0.07	0.06	47	0.41	0.41
25	0.07	0.07	48	0.45	0.43
26	0.08	0.07	49	0.49	0.46
27	0.08	0.08	50	0.54	0.49
28	0.09	0.09	51	0.60	0.53
29	0.09	0.09	52	0.66	0.57
30	0.10	0.10	53	0.74	0.62
31	0.11	0.11	54	0.82	0.67
32	0.12	0.12	55	0.93	0.73
33	0.13	0.13	56	1.05	0.79
34	0.15	0.15	57	1.18	0.86
35	0.16	0.16	58	1.31	0.95
36	0.17	0.17	59	1.45	1.03
37	0.19	0.19	60	1.61	1.11
38	0.21	0.20	61	1.78	1.20
39	0.22	0.22	62	1.95	1.31
40	0.24	0.24	63	2.19	1.44
41	0.26	0.26	64	2.43	1.57
42	0.27	0.28			

- ❑ **YES**, I wish to apply for **OPTIONAL CRITICAL ILLNESS** for **myself**. Amount of Units: ______________
- ❑ **YES**, I wish to apply for **OPTIONAL CRITICAL ILLNESS** for **my spouse**. Amount of Units: ____________
- ❑ **No,** I do NOT wish to apply for **OPTIONAL CRITICAL ILLNESS INSURANCE**.

Once this questionnaire has been returned and you have indicated that you wish to apply for optional coverage, you will receive a Canada Life Evidence of Insurability form to fill in so that Canada Life can determine whether to grant your request. Therefore, please *DO NOT* forward any premiums until you receive a billing as acceptance of coverage.

NAME: ____

Date:__________________

For Canada Life Head Office Use Only

Canada Life Certificate Number

APPLICATION FOR GROUP COVERAGE

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 10 are to be completed by the plan member.

1. Plan sponsor section

This section is to be completed by the plan administrator.

Plan number: ____________ Division number: ____________ Benefit Class: ____________

Plan sponsor: ____________

Plan member ID: ____________ Cost centre (if applicable): ____________

Eligible date of employment: Month ______ Day ______ Year ______

Effective date of coverage: Month ______ Day ______ Year ______

Occupation: ____________ Earnings: $ ________ per ☐ year ☐ month ☐ week ☐ hour

Plan member province of residence: ____________ Plan member province of employment: ____________

2. Plan member information

This section is to be completed by the plan member.

Please print clearly in INK.

Plan member name (print): ____________
last name first name middle initial

Gender: ☐ Male ☐ Female ☐ Undisclosed ☐ Other Date of birth: Month ______ Day ______ Year ______

Plan member mailing address:

Street address: ____________

City: ____________ Province: ____________ Postal code: ____________

Do you have a spouse (married, common-law or civil union spouse)? ☐ Yes ☐ No

Do you have dependant children, including full time students or disabled adults? ☐ Yes ☐ No

How many dependants in total, including spouse? ______

3. Refusal of benefits

This section is to be completed by the plan member.

Note: Health and/or dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for ☐ myself and my dependants ☐ my dependants only
Dentalcare for ☐ myself and my dependants ☐ my dependants only

Spousal insurer's name: ____________ Plan number: ____________

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you and your dependants may be required to provide proof of insurability acceptable to Canada Life to be covered. If you are approved, coverage for dental benefits may be limited.

Please see your plan administrator for details.

4. Beneficiary designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original of this form will be required for a life claim.

Crossed out beneficiary designations must be initialed.

Please print clearly in INK.

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

Primary Beneficiary	Percent allocated	Relationship to plan member
last name first name middle initial		
last name first name middle initial		
last name first name middle initial		

To be divided as follows: ☐ As per the percentage indicated above, or
☐ In equal shares to the survivor(s)

CONTINUED ON NEXT PAGE

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5. Contingent beneficiary designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

If there are no surviving benficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Contingent Beneficiary			Percent allocated	Relationship to plan member
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

To be divided as follows: ☐ As per the percentage indicated above, or ☐ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Canada Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below.

I hereby make the above beneficiary designation:

☐ **Revocable, I may change this beneficiary designation at any time**

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. Before designating a trust, you should seek legal advice.

For All Other Applicants - If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes. Before designating a trustee, you should seek legal advice.

6. Trustee appointment

You may wish to appoint a trustee/administrator by completing this section

The original of this form will be required for a life claim.

Please print clearly, in INK.

DO NOT COMPLETE THIS SECTION IF YOU ARE A QUEBEC RESIDENT

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing this form. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

Do not complete this section if you have made another trustee/administrator appointment.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release The Canada Life Assurance Company from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

Trustee last name	first name	middle initial	Relationship to plan member

7. Dependant information

This section is to be completed by the plan member. Complete this section if the plan includes health and/or dental coverage and you have not refused such coverage for your dependants in section 3. If there are more than four dependants, please attach a separate list. Please print clearly, in INK.

Spouse Information

Last name	First name	Middle Initial	Date of birth mm/dd/yy	Gender
				☐ Male ☐ Undisclosed ☐ Female ☐ Other

What group benefits coverage does your spouse have through their employer?
Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

HEALTHCARE				DENTALCARE				VISIONCARE			
Single	Family	Waived	None	Single	Family	Waived	None	Single	Family	Waived	None
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dependant Information

Last name	First name	Middle Initial	Date of birth mm/dd/yy	Gender	Full time student	Disabled dependant
				☐ Male ☐ Undisclosed ☐ Female ☐ Other	☐	☐
				☐ Male ☐ Undisclosed ☐ Female ☐ Other	☐	☐
				☐ Male ☐ Undisclosed ☐ Female ☐ Other	☐	☐
				☐ Male ☐ Undisclosed ☐ Female ☐ Other	☐	☐

CONTINUED ON NEXT PAGE

8. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

9. Authorizations and declarations

This section must be signed and dated in INK by the plan member.

I hereby apply for coverage under the group benefits plan issued by Canada Life.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

- my plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable;
- Canada Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: ______________________ **Date:** ____________

Defined Contribution Pension Plan (DCPP) Enrolment form

Sun Life Assurance Company of Canada, Group Retirement Services
227 King Street South PO Box 1601, Waterloo ON N2J 4C5
www.sunlife.ca

Plan Sponsor information

Name of Plan Sponsor	Client ID	Plan	Policy number	Product
Convention of Atlantic Baptist Churches (NB), Division 4	C0S4D	04	65894-G	DCPP

Classifications	This information is to be completed by Plan Sponsor	
Subdivision	Payroll ID	User field
001	Payroll Division ___________	☐ Minister/Executive ☐ Other

Please PRINT clearly.
Nota: La version française de ce document est également disponible.

1 Personal information

You, as group plan member, will be the owner of the account.

Your name (first, middle initial, last)		Social insurance number	
Address (street number and name, apartment or suite)		Identification number	
City	Province	Postal Code	
Telephone number (day) ( )	Telephone number (evening) ( )	Date of birth (d / m / y)	Sex M F
E-mail address			
Date of enrolment (d / m / y)	Date of employment (d / m / y)	Province of employment	

Were you at any time before a participant in the pension plan and you still have assets within the plan?
☐ Yes
☐ No

2 Beneficiary designation

Complete this section to designate a beneficiary(ies) for your account. Otherwise, your beneficiary designation will be defaulted to your estate.

The following caution is required by Manitoba law. It may also be applicable in other jurisdictions.

Caution: Your designation of a beneficiary by means of a designation form will not be changed or revoked automatically by any future marriage or divorce. Should you wish to change or revoke your beneficiary in the event of a future marriage or divorce, you have to do so by means of a new designation.

This designation only applies to those pension plan death benefits which are not, by law or by pension plan rules, payable to the surviving spouse.

I, the owner, revoke any previous beneficiary designations and name as beneficiary for benefits due on my death:

Name of beneficiary	Relationship to you	Percentage of benefits
Name of beneficiary	Relationship to you	Percentage of benefits
Name of beneficiary	Relationship to you	Percentage of benefits

Note:

If you have a spouse when you die, the law may stipulate that the death benefit be paid to the spouse. If you wish your spouse to receive all benefits, please ensure that you complete the above beneficiary designation.

To appoint a trustee or administrator for a beneficiary who is a minor, please complete the 'Appointment of Trustee or Administrator for a minor beneficiary' form.

Where Quebec law applies, a married or civil union spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ Revocable

3 Marital / Relationship status declaration

Note: If your spousal status changes in the future, please complete a 'Change of records form' and also notify your Plan Sponsor.

I certify, at the time of this declaration, based on the definition of spouse under applicable pension legislation:

☐ I have a spouse.

Name of Spouse (first, middle initial, last)

☐ I do not have a spouse.

4 Payroll deduction authorization

Required contributions:

Your employer will deduct the required contribution as defined under the plan and remit along with required employer contribution.

Voluntary contributions:

☐ I authorize my employer to deduct ________ % or $________ per pay to be deposited into the plan.

☐ I will not be making voluntary contributions at this time.

5 Allocation of your contributions

I request Sun Life Assurance Company of Canada to allocate 100% of my plan contributions to the one fund I have selected below by checking the appropriate box. I acknowledge this instruction applies to all future contributions, until the point in time when I choose to make a change to my fund allocation. I also acknowledge by checking more than one box, it will void my instructions and my contributions will be directed to the default fund.

Asset Allocation Select the pre-built portfolio that matches your Investor Risk Profile.	Percentage allocation
Canadian Baptist Aggressive Portfolio Fund (QMQ)	☐
Canadian Baptist Balanced Portfolio Fund (QMR)	☐
Canadian Baptist Moderate Portfolio Fund (QMS)	☐
Canadian Baptist Conservative Portfolio Fund (QMT)	☐
Sun Life Financial Money Market Segregated Fund (X21)	☐

- **If a selection has not been made or if more than one box has been checked, Sun Life Assurance Company of Canada reserves the right to invest the entire amount in the Canadian Baptist Balanced Portfolio Fund, chosen as the default fund by your plan sponsor.**

6 Your signature of authorization

I hereby authorize Sun Life Assurance Company of Canada, its agents and service providers, to obtain, use and transmit to the Plan Sponsor, its agents and service providers, personal information about me for the purpose of plan administration.

Unless I indicate otherwise in the space provided below, information about me may also be collected, used by and shared among the members of the Sun Life Financial group of companies*, their agents and service providers to provide me with investment and insurance products and services that will help me meet my lifetime financial objectives. Information may also be shared with agents and service providers of my Plan Sponsor to allow them to provide me with personal, financial advisory services.

☐ No, I refuse permission

*The companies in the Sun Life Financial group of companies mean only those companies identified in the Sun Life Financial Privacy Policy which is available on the Sun Life Financial Web site, www.sunlife.ca.

Owner signature	Date (d / m / y)
X	

Keeping Your Information Confidential

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third party providers and reinsurers who, in some instances, may be located in jurisdictions outside Canada. Your personal information may be subject to the laws of those foreign jurisdictions. Sun Life Financial's operations worldwide and our third party providers are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To view our current privacy policy, please visit **www.sunlife.ca**

investment risk profiler

This tool will help you determine what kind of investor you are and how much risk you are comfortable with as you save.

Answer each of the following questions, keeping your objective in mind.

1. Which statement best describes your comfort level with fluctuations in the value of your investments?

a. I'd be very upset if my investments dropped in value over any period of time. **1 point**

b. I'm willing to accept a lower, more predictable rate of return as long as fluctuations in the value of my investments are small. **10 points**

c. I'm willing to accept some fluctuations in the value of my investments as I'm seeking a higher rate of return. **20 points**

d. I want the highest rate of return possible, and understand the value of my investments can fluctuate significantly. **30 points**

2. How long will you leave this money invested before you'll need a significant portion of it for your stated objective?

a. Less than 5 years **1 point**

b. 5-10 years **10 points**

c. 11-20 years **20 points**

d. More than 20 years **30 points**

3. How likely is it that you'll need access to a large portion of this money earlier than expected? (E.g. taking early retirement)*

a. Very likely **1 point**

b. Somewhat likely **10 points**

c. Unlikely **20 points**

d. I won't need access to any of the money in this plan early. **30 points**

** Early retirement is defined by pension legislation and can vary by jurisdiction.*

4. Which of the following pattern of returns would you be most comfortable with? Assume an initial amount of $5,000 invested for 10 years.

a. Your investment grows without losses to $8,100. However, in one of the years the value of your portfolio does not increase. **1 point**

b. Your investment grows to $10,100 in year 10, but slightly declines in value in two of the years. **10 points**

c. Your investment grows to $12,400, but significantly declines in value in three of the years and was worth only $3,500 after the first year. **20 points**

5. With the four results below, how would you invest $10,000?

a. A guaranteed return of $500. **1 point**

b. The potential of earning $800 but the risk of earning only $300. **10 points**

c. The potential of earning $1,200 but the risk of earning nothing. **20 points**

d. The potential of earning $2,500 but the risk of losing $1,000. **30 points**

6. If your investment dropped in value by 20% in one month, how would you react?

a. I'd cash in my investment immediately. **1 point**

b. I'd make no changes until the value recovers and then re-evaluate. **10 points**

c. I'd do nothing. I understand my investments will fluctuate from day to day, but believe they will grow over the long term. **20 points**

d. I'd invest more while the prices are low. **30 points**

7. How would you describe your investing personality?

a. I don't like risk and can only tolerate moderate losses. **1 point**

b. I'm willing to take some risk and can tolerate one year of poor returns. **10 points**

c. I can tolerate more than one year of poor returns. **20 points**

8. Which of the following statements best describes your investment knowledge?

a. I'm a novice investor. **1 point**

b. I have some knowledge. **10 points**

c. I have good working knowledge. **20 points**

d. I consider myself an investment pro. **30 points**

Add up your points for your total score:

My total score is

Match your total score to one of the four portfolios described below.

0 – 20

Sun Life Financial Money Market Segregated Fund

21 – 45

Canadian Baptist Conservative Portfolio Fund

46 – 114

Canadian Baptist Moderate Portfolio Fund

115 – 190

Canadian Baptist Balanced Portfolio Fund

191 +

Canadian Baptist Aggressive Portfolio Fund

On your Enrolment Form note your selected investment portfolio in Section 5, Allocation of Contributions. **If you do not make a selection, your funds will be directed to the Balanced Portfolio Fund**.