1704759943496968

Individual insurance

Application

Life insurance
Critical illness insurance
Disability insurance

Mail to:
Individual Life, New Business, T-019

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17-8908 – 4/23

Application for

Do not use this application for My Par Gift.
If applying for My Par Gift, use:

- SimpleProtect
- New Business WebApp, or
- Application for life insurance (form 17-8921)

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Application for life, critical illness and disability insurance to The Canada Life Assurance Company

In this application, *owner* means the person (including an entity, e.g., company, partnership) proposed to be the owner of any policy issued. The terms *you* or *your* mean the proposed insured unless otherwise indicated. The term *adult insured* means the adult proposed insured. The term *child* means the child proposed insured. Where Quebec law applies, references to a child's legal guardian mean the child's *tutor* (usually, a parent or both parents of the child). The terms *we*, *us*, and *our* mean The Canada Life Assurance Company (Canada Life) unless otherwise indicated.

It's important you, whether as owner or proposed insured, provide truthful, accurate, and complete information for us to properly assess your application. If you're not sure whether some information is relevant, provide it anyway. If you fail to provide relevant information, future claims could be declined and any policy we've issued declared void.

1. General information

1.1 Language for policy and future correspondence: ☐ English ☐ French

1.2 Province application signed in: ______________________

1.3 Type of insurance: ☐ Personal: ______________________ ☐ Business: ______________________

1.4 Type of coverage (check all that apply):
☐ Life insurance
☐ Critical illness insurance
☐ Disability insurance (includes disability income, overhead expense, buy/sell and key person insurance)

1.5 Product information is provided in the illustration dated (day/month/year): ______________________
It is agreed that such information forms part of this application.

Life insurance

If applying for universal life insurance, check one of the following interest options for the withdrawal of monthly deductions:

a) ☐ Withdraw monthly deductions proportionately from all existing Interest options (default)

b) ☐ Withdraw monthly deductions entirely from interest option: ______________________
If there are insufficient funds in this option to cover monthly deductions, the balance will default to a) above.

2. First proposed insured information

First name: ______________________

Middle name: ______________________

Last name: ______________________

Date of birth (day/month/year): ______________________ Check one: ☐ Male ☐ Female

Social insurance number (SIN): ______________________

Province or state, and country of: Residence: ______________________

Birth: ______________________

Marital status: ☐ Single ☐ Married ☐ Common-law ☐ Widow or widower ☐ Separated ☐ Divorced

Home address (street number and name): ______________________

City: ______________________ Province: ____________ Postal code: ____________

The physical location of your residence, if your address is a P.O. box, RR# or general delivery:

____

2. First proposed insured (continued)

Preferred contact number (include area code):

☐ Home phone: ______________________

☐ Cell phone: ______________________

☐ Work phone: ______________________

Best time to call, if a customer interview is required: ☐ Day ☐ Evening
For information about the customer interview program, see section 26.

Form required for non-face-to-face

If the insured is not physically present when completing the application, **have the insured** complete the *Authorizations for Non-face-to-face* (form 17-8944).

Disability insurance

Name of current entity or employer: ______________________

Address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

3. Second proposed insured information

Life insurance

Use this section for joint proposed insureds for life insurance.

First name: ______________________

Middle name: ______________________

Last name: ______________________

Date of birth (day/month/year): ______________________ Check one: ☐ Male ☐ Female

Social insurance number (SIN): ______________________

Province or state, and country of: Residence: ______________________

Birth: ______________________

Marital status: ☐ Single ☐ Married ☐ Common-law ☐ Widow or widower ☐ Separated ☐ Divorced

Home address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

The physical location of your residence, if your address is a P.O. box, RR# or general delivery:

____

Preferred contact number (include area code):

☐ Home phone: ______________________

☐ Cell phone: ______________________

☐ Work phone: ______________________

Best time to call, if a customer interview is required: ☐ Day ☐ Evening
For information about the customer interview program, see section 26.

Form required for non-face-to-face

If the insured is not physically present when completing the application, **have the insured** complete the *Authorizations for Non-face-to-face* (form 17-8944).

4. Owner information

In this section, *you* and *your* refer to the owner or owners, if more than one. Questions must be answered by the owner.

4.1 Who will be the owner of the policy?

All products

Check one: ☐ First insured (default)
☐ Other individuals or entity named in 4.2 and 4.3

Life insurance

Check one: ☐ First insured (default)
☐ Second insured
☐ Both insureds (see 4.4)
☐ Other individuals or entity named in 4.2 and 4.3

Critical illness insurance Disability insurance

The owner of a critical illness or disability insurance policy must be age 18 or over.

Check one: ☐ First insured (default)
☐ Other individual or entity named in 4.2

If applying for disability income insurance

- The owner of any personal disability income insurance policy issued as a result of this application will be the insured.
- The owner of any policy issued under a wage loss replacement plan arrangement must be an entity.

If applying for buy/sell insurance

The owner will be:

☐ Corporation – provide full legal name of entity: ______________________

☐ Cross purchase for two partners/shareholders only – provide name (first, middle, last, or full legal name of entity): ______________________

☐ Trustee – provide name of trust or full name of individual trustees: ______________________

4.2 First owner

If owner is the same as the insured, always complete **4.2 d) and h)**, as applicable.

If applying for more than one type of insurance and more space is required in the naming of owners in **4.2**, provide details in *Special requests*, section 11.

a) Name of other individual or entity (first, middle, last; or full legal name of entity): ______________________

b) Date of birth (day/month/year): ______________ Check one: ☐ Male ☐ Female

Relationship to the insured: ______________

c) Address (street number and name): ______________________

City: ______________ Province: __________ Postal code: __________

The physical location of your residence, if your address is a P.O. box, RR# or general delivery: ______________________

d) Is this proposed insurance based on a recommendation made by your advisor following an analysis of your current financial situation and personal obligations? ☐ Yes ☐ No

Complete questions **4.2 e) through 4.4** for life insurance. Otherwise, **skip to 4.5**.

4. Owner information (continued)

4.2 (continued)

e) Provide applicable numbers for person or entity:

Social insurance number: ______________________

Federal business number: ______________________

Quebec enterprise number (NEQ) or Employer ID number: ______________________

f) Detailed occupation/title: ______________________
If retired, unemployed, homemaker or student, complete 4.2 g)

Employer/entityname: ______________________

Nature/type of business: ______________________

Annual earned income: $ ______________ Net worth: $ ______________

Income from other sources (list amount and sources): ______________________

g) **If retired or unemployed:** Income from other sources: ______________________

Prior occupation: ______________________

Prior employer/entity name: ______________________

Nature/type of business: ______________________

If homemaker or student: Income from other sources: ______________________

h) **Tax status** – answer both questions if you're applying for universal or participating life insurance

Are you a United States citizen or a U.S. resident for U.S. tax purposes? ☐ Yes ☐ No

If yes, provide U.S. taxpayer identification number (TIN): ______________________

Are you a resident for tax purposes in a country or region other than Canada or the United States? ☐ Yes ☐ No
If yes, provide:
Jurisdiction(s) of residence for tax purposes: ______________________

Taxpayer identification number (TIN): ______________________

If you do not have a TIN for a specific jurisdiction, check one reason:
☐ I will apply or have applied for a TIN, but have not yet received it. I will notify Canada Life when I have received it.
☐ My jurisdiction of tax residence does not issue TINs to its residents.
☐ Other reason: ______________________

If the owner is a corporation partnership, trust or other entity, complete the *International tax classification for an entity* (form 17-8945).

4.3 Second owner for life insurance, with more than one owner

a) Name of other individual or entity (first, middle, last; or full legal name of entity):

____

b) Date of birth (day/month/year): ______________ Check one: ☐ Male ☐ Female

Relationship to the insured: ______________________

c) Address (street number and name): ______________________

City: ______________ Province: ________ Postal code: ________

The physical location of your residence, if your address is a P.O. box, RR# or general delivery:

____

d) Is this proposed insurance based on a recommendation made by your advisor following an analysis of your current financial situation and personal obligations? ☐ Yes ☐ No

e) Provide applicable numbers for person or entity:

Social insurance number: ______________________

Federal business number: ______________________

Quebec enterprise number (NEQ) or Employer ID number: ______________________

4. Owner information (continued)

4.3 (continued)

f) Detailed occupation/title: ______
If retired, unemployed, homemaker or student, complete 4.3 g)

Employer/entityname: ______

Nature/type of business: ______

Annual earned income: $ ______ Net worth: $ ______

Income from other sources (list amount and sources): ______

g) **If retired or unemployed:** Income from other sources: ______

Prior occupation: ______

Prior employer/entity name: ______

Nature/type of business: ______

If homemaker or student: Income from other sources: ______

h) **Tax status** – answer both questions if you're applying for universal or participating life insurance

Are you a United States citizen or a U.S. resident for U.S. tax purposes? ☐ Yes ☐ No

If yes, provide U.S. taxpayer identification number (TIN): ______

Are you a resident for tax purposes in a country or region other than Canada or the United States? ☐ Yes ☐ No
If yes, provide:

Jurisdiction(s) of residence for tax purposes: ______

Taxpayer identification number (TIN): ______

If you do not have a TIN for a specific jurisdiction, check one reason:

☐ I will apply or have applied for a TIN, but have not yet received it. I will notify Canada Life when I have received it.

☐ My jurisdiction of tax residence does not issue TINs to its residents.

☐ Other reason: ______

If the owner is a corporation partnership, trust or other entity, complete the *International tax classification for an entity* (form 17-8945).

4.4 If the policy has more than one owner (life insurance)

Complete this section if the policy will be owned by more than one person. If the policy will be owned by two people, we've described below what can happen if one owner dies but the other owner and an insured person are still alive – meaning the policy continues. By signing this application, you choose the applicable default, unless you indicate otherwise:

☐ As indicated below **or**

☐ You'd like a successor/subrogated owner to own the policy – skip to 4.5

For policies where Quebec law does not apply – check one:

☐ You would like the deceased owner's interest in the policy to pass immediately to the owner who is still alive (meaning 'joint tenancy' ownership, with 'right of survivorship' between the owners). This will be the **default** if you don't check a box.

☐ You would like the deceased owner's interest in the policy to pass immediately to the estate of the owner who died (meaning 'tenants in common' ownership, with no 'right of survivorship' between the owners).

For policies where Quebec law does apply – check one:

☐ You would like ownership interest in the policy to pass immediately to the estate of the owner who died. This will be the **default** if you don't check a box.

☐ You would like the deceased owner's interest in the policy to pass immediately to the owner who is still alive (this means that each owner names the other as their 'subrogated owner').

Note: If you prefer, you may give us different set-up instructions for what is to happen to the ownership share of a deceased owner. If you want to do this, use a separate sheet and include it with this application.

4. Owner information (continued)

4.5 Naming a successor/subrogated owner

Complete the *Title change* (form 584) to appoint a successor/subrogated owner where permitted by law.

If, after the death of the owner (sole remaining owner, if applicable), the policy could continue in force because an insured person is still alive, you may name a successor owner below to replace that owner. That person will become the successor owner if alive at the owner's death. To name a successor owner (subrogated owner in Quebec), complete below.

If the owner is a corporation, partnership, trust or other entity, we don't recommend you name a secondary owner. If you wish to do so, you should obtain professional advice regarding any potential legal issues this may cause in the future.

Name of successor/subrogated owner (first name): ______________________

Middle name: ______________________ Last name: ______________________

Age: ________ Relationship to first insured ______________________

Life insurance

If applying for universal life insurance, complete **4.6** through **4.7**.

4.6 Owner identification

Identification must be authentic, valid and current government-issued photo ID that is verified in person by the advisor.

a) If the owner is an individual:

First owner

Choose one type of ID:

☐ Driver's licence

☐ Passport

☐ Other, specify type: ______________________

(excluding health insurance and social insurance cards)

Document number: ______________________

Jurisdiction of issue: ______________________

Issue date (day/month/year): ______________________

Expiry date (day/month/year): ______________________

Second owner

Choose one type of ID:

☐ Driver's licence

☐ Passport

☐ Other, specify type: ______________________

(excluding health insurance and social insurance cards)

Document number: ______________________

Jurisdiction of issue: ______________________

Issue date (day/month/year): ______________________

Expiry date (day/month/year): ______________________

b) Did you, the advisor, see the authentic, valid and current documentation and then record the information above in the physical presence of the owner?

☐ Yes, provide the date on which ID was verified in person (day/month/year):

First owner: ______________________ Second owner: ______________________

☐ No, in this case

- If the owner is a person, meet with them and complete the *Owner and third party identification* (form 17-8341).
- If you can't meet with the owner in person or if the owner doesn't have valid photo identification, use the dual process to verify the person's identity by completing the *Non-photo owner identification* (form 46-10771).

c) If the owner is a corporation, partnership, trust, or other entity, complete the following forms and attach to this application:

- *Questionnaire for applicants/owners that are entities* (form 17-8295)
- *International tax classification for an entity* (form 17-8945)

For corporations, also complete a *Certificate of Incumbency* (form 70-0060) or provide an equivalent document confirming that the corporate signing authorities who have signed the application, have power to bind the corporation.

Full legal name: ______________________

Address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

The physical location of entity, if address is a P.O. box, RR# or general delivery:

____

4. Owner information (continued)

4.6 c) (continued)

Incorporation or registration number

i) Incorporation number: ______________________

Jurisdiction of issue: ☐ Federal **or** ☐ Province/territory of: __________

ii) Other registration number for a non-incorporated entity: ______________________

Type of number: ______________________

Jurisdiction of issue: ☐ Federal **or** ☐ Province/territory of: __________

4.7 Third party determination and identification for universal life insurance

a) Will another person or entity (other than the owner) pay for this policy, have the use of or access to any policy values while the policy is in effect, or is another person or entity directing the owner to apply or signing on behalf of the owner?

☐ Yes, complete **4.7 b)** ☐ No

Note: If the owner is an entity, the person authorized to sign on behalf of the entity is **not** a third party and is instead identified on the *Questionnaire for applicants/owners that are entities* (form 17-8295).

b) If there's more than one third party, use a separate page to record the information requested for each additional third party.

Name of third party: ______________________

Date of birth (day/month/year): ______________________

Relationship to owner: ______________________

Phone number: ______________________

Physical address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

If a corporation or other entity, provide incorporation or registration number: ______________________

Jurisdiction of incorporation (province or state and country): ______________________

Third party's role(s): ☐ Under a power of attorney/Mandate ☐ Payor ☐ Trustee ☐ Executor/Estate representative

☐ Collateral assignee/hypothecary creditor ☐ Other: ______________________

Detailed occupation/nature of business of entity: ______________________

(if not working or no longer operating an entity, provide details on third party's previous occupation or principal entity)

Sources of income other than occupation/principal entity: ______________________

Employer/entity name: ______________________

Nature/type of business: ______________________

If retired or unemployed: Income from other sources: ______________________

Prior occupation: ______________________

Prior employer/entity name: ______________________

Nature/type of business: ______________________

c) Those signing for an owner (e.g., power of attorney), must be verified in person using government-issued photo ID that is authentic, valid and current. If you can't meet with those signing for an owner in person or if those signing for the owner don't have valid photo identification, use the dual process to verify the person's identity by completing the *Non-photo owner identification* (form 46-10771).

Name of signer: ______________________

Type of document:

☐ Driver's licence

☐ Passport

☐ Other, specify type: ______________________
(excluding health insurance and social insurance cards)

Document number: ______________________

Jurisdiction of issue: ______________________

Issue date (day/month/year): ______________________

Expiry date (day/month/year): ______________________

ID verified date (day/month/year): ______________________

5. Children for term life insurance rider

Life insurance

5.1 Children's information

Child	Child's name (first, middle, last)	Relationship to first insured	Check one	Date of birth (day/month/year)	Province or state, and country of residence **and** birth
1			☐ Male ☐ Female		
2			☐ Male ☐ Female		
3			☐ Male ☐ Female		
4			☐ Male ☐ Female		

6. Children for critical illness insurance

Critical illness insurance

6.1 Children's information

Child	Child's name (first, middle, last)	Check one	Date of birth (day/month/year)	Province or state, and country of residence **and** birth
1		☐ Male ☐ Female		
2		☐ Male ☐ Female		
3		☐ Male ☐ Female		
4		☐ Male ☐ Female		

6.2 Contact information for children

If more than one contact is required, provide the other contact's information in 15.29.

Check all children to whom the information in 6.2 applies:

Child: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name of parent or legal guardian who has full knowledge of each child's personal and medical information:

First name: ______________________

Middle name: ______________________

Last name: ______________________

Preferred contact number (include area code):

☐ Home phone: ______________________

☐ Cell phone: ______________________

☐ Work phone: ______________________

Best time to call, if a customer interview is required: ☐ Day ☐ Evening

For information about the customer interview program, see section 26.

6. Children for critical illness insurance (continued)

6.3 Who will be the owner of any child policy issued?

Check one and complete as applicable: ☐ Adult insured named in 2.1 ☐ Other individual, as named below

First name: ______________________

Middle name: ______________________

Last name: ______________________

Date of birth (day/month/year): ______________________ Check one: ☐ Male ☐ Female

Home address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

Is the owner a Canadian citizen or permanent resident?

☐ Yes ☐ No, provide details: ______________________

6.4 Does the child live with the owner? If no, provide details below.

Child 1: ☐ Yes ☐ No Child 2: ☐ Yes ☐ No Child 3: ☐ Yes ☐ No Child 4: ☐ Yes ☐ No

Child	Name of individual child lives with	Relationship to child	Address (street number and name, city, province, postal code)
1			
2			
3			
4			

6.5 Product information is provided in the illustration dated (day/month/year): ______________________

It is agreed that such information forms part of this application.

7. Waiver of premium or automatic payment benefit

Life insurance

7.1 Who will be insured for waiver of premium or automatic payment benefit?

Check one: ☐ Same as first owner ☐ Other individual, as named below

First name: ______________________

Middle name: ______________________

Last name: ______________________

Date of birth (day/month/year): ______________________ Check one: ☐ Male ☐ Female

Social insurance number (SIN): ______________________

Relationship to first insured: ______________________

Province or state, and country of: Residence: ______________________

Birth: ______________________

Home address (street number and name): ______________________

City: ______________________ Province: __________ Postal code: __________

The physical location of your residence, if your address is a P.O. box, RR# or general delivery:

____

7. Waiver of premium or automatic payment benefit (continued)

Preferred contact number (include area code):

☐ Home phone: ______________________

☐ Cell phone: ______________________

☐ Work phone: ______________________

Best time to call, if a customer interview is required:

☐ Day ☐ Evening

For information about the customer interview program, see section 26.

Full underwriting evidence on the automatic payment benefit person is completed:

☐ Under second insured **or** ☐ On form 17-8911 underwriting evidence ID number CU – ______________________

8. Beneficiary information

In this section the terms *you* and *your* refer to the owner or owners, if there are more than one.

Setting up your beneficiaries

In this section you may designate (name) beneficiaries – primary and secondary – to receive the benefit paid out on the death of the proposed insured. Your designation(s) will form part of your contract with us, and be on the terms set out in this section. Any designation may be changed later, in accordance with applicable law and any required consent or authorization.

Wherever you name more than one primary or secondary beneficiary, percentages for each category of beneficiary must total 100%.

If you prefer, you may give us different set-up instructions for your beneficiaries (or for your trustee – see 8.5).

Choosing whether your beneficiaries are revocable or irrevocable

Any beneficiary you name in section 8 are automatically **revocable**, except where you check the **irrevocable** box for that beneficiary, or where Quebec law applies and the beneficiary is your spouse (see 8.1 below).

If a beneficiary is **irrevocable**, this means you cannot change the designation without the beneficiary's written consent or a court order. You may also require the consent of an irrevocable beneficiary to take other actions on your policy, like taking a policy loan.

8.1 Your spouse as beneficiary for Quebec law policies

If you name your spouse (married or civil union) as a **primary** beneficiary, the law makes that designation irrevocable unless you check the **revocable** box following his or her name in 8.2 or 8.4 as applicable.

If you name your spouse (married or civil union) as a **secondary** beneficiary anywhere in this application, the designation may be **irrevocable** unless you check this box: ☐ **Revocable**

Accidental death and dismemberment

Complete 8.2 to name your beneficiaries for accidental death and dismemberment rider under disability income insurance.

8.2 You name the following as **primary** and **secondary** beneficiaries in the event of an accidental death.

Primary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Check one	Relationship to first insured (in Quebec, relationship to owner)
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	

Secondary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Relationship to first insured (in Quebec, relationship to owner)

8. Beneficiary information (continued)

Critical illness insurance Disability insurance

Read 8.3 to name your beneficiaries for critical illness and disability insurance

8.3 To designate beneficiaries where permitted by law, complete a *Beneficiary designation* (form F544(CL)).
To direct payment of benefits where permitted by law, complete a *Direction to pay* (form F545(CL)).

Life insurance

Complete 8.4 a) through c) to name your beneficiaries for life insurance

8.4 Any beneficiaries you name in 8.4 a) will apply to all insurance coverages in this policy, except for: a child's term life insurance rider, and payment from the total account value under a joint last-to-die universal life insurance policy. You can name beneficiaries for these two in 8.4 b) and 8.4 c).

a) Beneficiaries for primary insureds
Check one of the boxes below:

☐ For a last survivor policy or a joint last-to-die policy: You name the estate of the joint proposed insured who dies last.

☐ For a joint first-to-die policy: You name the proposed insured who survives the other proposed insured.
If your policy will be governed by Quebec law and your spouse is one of the proposed insureds, the designation may be irrevocable unless you check this box: ☐ **Revocable**
Note: If the survivor dies while covered under any automatic temporary coverage as part of a survivorship benefit, we will pay the proceeds payable on death to the owner of the policy or his or her estate, or as the policy provides if different, unless you indicate otherwise in *Special requests*, section 11.

☐ You name the following **primary** and **secondary** beneficiaries:

Primary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Check one	Relationship to first insured (in Quebec, relationship to owner)
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	

Secondary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Relationship to first insured (in Quebec, relationship to owner)

b) Beneficiaries for child's term life insurance rider

Primary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Check one	Relationship to children (in Quebec, relationship to owner)
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	

Secondary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Relationship to children (in Quebec, relationship to owner)

8. Beneficiary information (continued)

8.4 (continued)

c) Beneficiaries for total account value on first death (joint last-to-die policy) under universal life insurance

☐ The surviving joint insured – if insureds are not also owners, provide relationship to owner:

First insured ______________________________

Second insured ______________________________

Note: If your policy will be governed by Quebec law and your spouse is one of the insureds, the designation may be irrevocable unless you check this box: ☐ Revocable

☐ The primary and secondary beneficiaries you name below:

Primary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Check one	Relationship to owner
			☐ Revocable ☐ Irrevocable	
			☐ Revocable ☐ Irrevocable	

Secondary beneficiaries Name (first, middle initial, last)	Age	% to be paid (total 100%)	Relationship to owner

How we pay death benefits

For beneficiaries you name in **8.2** and **8.4**.

We pay death benefit proceeds to your surviving beneficiaries (those surviving the insured person), depending on what's set out below:

- We first look to pay all the available proceeds to your primary beneficiaries named for the particular benefit, by separate payment to each beneficiary according to the beneficiary's percentage. However, if a primary beneficiary is not a survivor, we'll pay that primary beneficiary's share according to your instructions in section A below.
- If any available proceeds become payable to secondary beneficiaries, and if a secondary beneficiary is not a survivor, we'll pay that secondary beneficiary's share according to your instructions in section B below.

Section A – If a primary beneficiary is not alive

If a primary beneficiary is not a survivor, you want us to pay
out that deceased beneficiary's share in the following way (check either option 1 or 2 below):

☐ **Option 1**

Divide the share among your surviving primary beneficiaries (other than you or your estate, if named as a primary beneficiary). Check a box below to tell us how to divide it:

☐ Proportionately, based on their percentages, or

☐ Equally, regardless of their percentages

If there are no surviving primary beneficiaries other than you or your estate, then you want the share divided among your secondary beneficiaries based on their percentages (and depending on your instructions in section B). If there are no surviving secondary beneficiaries, or you didn't name any secondary beneficiaries, then you want the deceased primary beneficiary's share paid to you or your estate.

☐ **Option 2**

Divide the share among your secondary beneficiaries based on their percentages (and depending on your instructions in section B). If there are no surviving secondary beneficiaries, or you didn't name any secondary beneficiaries, then you want the deceased primary beneficiary's share paid to you or your estate.

8. Beneficiary information (continued)

How we pay death benefits (continued)

Section B – If a secondary beneficiary is not alive
If a secondary beneficiary is not a survivor, you want us to pay out that deceased beneficiary's share in the following way (check either option 1 or 2 below):

☐ **Option 1**

Divide the share among your surviving secondary beneficiaries (other than you or your estate, if named as a secondary beneficiary). Check a box below to tell us how to divide it:

☐ Proportionately, based on their percentages, or

☐ Equally, regardless of their percentages

If there are no surviving secondary beneficiaries other than you or your estate, then you want the deceased secondary beneficiary's share paid to you or your estate.

☐ **Option 2**

Pay the deceased secondary beneficiary's share to you or your estate.

8.5 Trustee for minor beneficiaries

Do not use this section if:

- A trust already exists (or is provided for under a will) for a minor beneficiary and the trust is (or will be) capable of receiving a death benefit payment, or
- Your policy will be governed by Quebec law (benefits in that case will be paid to a minor beneficiary's tutor, or to a trust established by law, outside of this section, to receive the benefits)

You appoint the following person as trustee for your minor beneficiaries (separate trust for each minor beneficiary), on the trust terms set out below:

Name of trustee:

First name: ____________________

Middle name: ____________________

Last name: ____________________

Relationship to first insured: ____________________

Trust terms

The trustee you name above is to receive in trust, on behalf of a minor beneficiary, that beneficiary's share of the applicable death benefit. The trustee may invest the trust funds prudently and use the funds, any investment and any investment returns for the education, support or other benefit of the minor. When the beneficiary reaches the age of majority, the trust ends and the trustee must transfer any remaining trust assets to the beneficiary.

☐ You don't want a trustee for minor beneficiaries.

9. Address for future notifications

☐ Same as first insured

☐ Same as first owner, **or**

Address (street number and name): ____________________

City: ____________________ Province: __________ Postal code: __________

The physical location of your residence or primary place of entity, if your address is a P.O. box, RR# or general delivery:

____

10. Replace existing insurance and transferring funds

Life insurance

In this section, *you* and *your* refer to the owner or owners of the existing policy.

If a Canada Life, London Life or Great-West Life policy is being replaced (in whole or in part), or if funds are being transferred from a Canada Life, London Life or Great-West Life policy, the owners must complete the information below. They must also complete the authorization in 17.2.

10.1 What do you want to do with the existing Canada Life, London Life or Great-West Life life insurance policies?

Name of insured: ______________________

Name of owner: ______________________

Policy number: ______________________

Surrender and replace

☐ **Replace entire policy**, and (select one):
- ☐ Transfer surrender proceeds to the new policy (default)
- ☐ Send surrender proceeds to the policy owner

☐ **Replace term rider only**, and (select one):
- ☐ Transfer surrender proceeds to the new policy (default)
- ☐ Send surrender proceeds to the policy owner

Transfer value from an existing inforce policy

☐ Paid up additional coverage $ ______________________

☐ Accumulated dividends $ ______________________

Name of insured: ______________________

Name of owner: ______________________

Policy number: ______________________

Surrender and replace

☐ **Replace entire policy**, and (select one):
- ☐ Transfer surrender proceeds to the new policy (default)
- ☐ Send surrender proceeds to the policy owner

☐ **Replace term rider only**, and (select one):
- ☐ Transfer surrender proceeds to the new policy (default)
- ☐ Send surrender proceeds to the policy owner

Transfer value from an existing inforce policy

☐ Paid up additional coverage $ ______________________

☐ Accumulated dividends $ ______________________

10.2 Why are you replacing your existing policy?

☐ Cost ☐ Advisor recommendation ☐ Better features/benefits ☐ More suitable to current needs

☐ Other (specify): ______________________

If the policy that's being applied for will replace (in whole or in part) an existing life insurance policy, you must follow the replacement disclosure requirements of the applicable province or territory. Where the law requires, you must provide us a copy of any replacement disclosures (for example, a Life Insurance Replacement Disclosure (LIRD) and any written explanation for the replacement, or, for Quebec, a Notice of Replacement of Insurance of Persons Contract).

11. Special requests

____

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which you may have had. You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

12. Conditions to qualify for temporary life insurance

Life insurance

Detach and give the *Temporary life insurance agreement*, section 24 to the owner.

Temporary insurance is **not** available for any proposed insured where:

1. Any question under section 12 for the proposed insured is answered *yes* or left blank. However, the application for life insurance may still be considered.
2. The actual age of the proposed insured is 71 or over (or under 15 days old).
3. The life insurance applied for involves any one of the following:
   - A group conversion,
   - The total underwriting risk is $5 million or greater,
   - Buying additional insurance by exercising an existing policy option.
4. The minimum payment has not been received.

12.1 Within the **past 12 months**, have you consulted or been treated by any healthcare provider for any known or suspected heart attack, stroke, cancer or the acquired immunodeficiency syndrome (AIDS) or ever tested positive for HIV, the virus that causes AIDS?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No
Children ☐ Yes ☐ No

12.2 Within the **past 30 days**, have you consulted or been treated by a healthcare provider (**for anything other than** an uncomplicated pregnancy or any minor condition for which no follow-up visit has been arranged or contemplated)?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No
Children ☐ Yes ☐ No

12.3 Within the **past 12 months**, have you been a proposed insured under any application for life insurance that was declined or postponed?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No
Children ☐ Yes ☐ No

If yes to any question in 12.1 through 12.3, provide name(s) of proposed insured(s) concerned:

---

13. Conditions to qualify for conditional critical illness and disability insurance (adult and child)

Critical illness insurance Disability insurance

Detach and give the *Conditional critical illness and disability insurance agreement*, section 25 to the owner.

Conditional insurance is **not** available for any proposed insured where:

1. Any question under section 13 is answered *yes* or left blank.
2. The actual age of the proposed insured is 61 or over (or under 60 days old for critical illness insurance, or under age 18 for disability insurance).
3. The proposed insured intends to travel outside of Canada and the United States within the next 3 months.
4. The minimum payment has not been received.

13. Conditions to qualify for conditional critical illness and disability insurance (continued)

If applying for disability insurance

(including disability income, overhead expense, buy/sell and key person insurance)

13.1 Within the **past 60 days**, have you been admitted or been advised to be admitted to a hospital or other healthcare facility for any reason, other than pregnancy? ☐ Yes ☐ No

13.2 Within the **past 2 years**, have you:

a) Been treated for or had any indication of heart disease, stroke or cancer? ☐ Yes ☐ No

b) Had any driver's licence suspended? ☐ Yes ☐ No

c) Had any application for life, disability, critical illness or long-term care insurance declined or postponed? ☐ Yes ☐ No

d) Been absent from work for **more than 15 consecutive days** for health reasons or injury? ☐ Yes ☐ No

e) Been treated for or had any indication of any disease or disorder of the back or mental health? ☐ Yes ☐ No

If applying for **adult** critical illness insurance

13.3 Within the **past 60 days**, have you been admitted or been advised to be admitted to a hospital or other healthcare facility for any reason, other than pregnancy? ☐ Yes ☐ No

13.4 Have you ever been treated for or had any indication of angina, abnormal ECG, transient ischemic attack (TIA), multiple sclerosis, Parkinson's disease, Alzheimer's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) or motor neuron disease? ☐ Yes ☐ No

13.5 Have you ever consulted a healthcare provider, received treatment or undergone tests for any of the following conditions: heart or circulatory disease, heart attack, chest pain, stroke, paralysis, blindness, diabetes, elevated blood pressure, chronic kidney disease, liver or lung disease, cancer, the acquired immunodeficiency syndrome (AIDS) or tested positive for HIV, the virus that causes AIDS? ☐ Yes ☐ No

13.6 Have you ever been a proposed insured under any application for life, disability, critical illness or long-term care insurance that was declined, postponed or modified medically in any way, excluding any policy where all modifications have been removed? ☐ Yes ☐ No

If applying for **child** critical illness insurance

The parent or legal guardian providing the following information about a child must have sufficient knowledge of the child to provide complete and accurate answers.

13.7 Within the **past 60 days**, has the child been admitted to a hospital or other healthcare facility?

Child 1 ☐ Yes ☐ No Child 2 ☐ Yes ☐ No Child 3 ☐ Yes ☐ No Child 4 ☐ Yes ☐ No

13.8 Has the child ever consulted a healthcare provider, received treatment or undergone tests for any of the following conditions: any indication of loss of speech or hearing, blindness, diabetes, heart disorder, cancer, the acquired immunodeficiency syndrome (AIDS) or tested positive for HIV, the virus that causes AIDS?

Child 1 ☐ Yes ☐ No Child 2 ☐ Yes ☐ No Child 3 ☐ Yes ☐ No Child 4 ☐ Yes ☐ No

13.9 Has the child ever had any congenital abnormalities, hereditary disorders, or have current medical problems requiring treatment or pending investigation?

Child 1 ☐ Yes ☐ No Child 2 ☐ Yes ☐ No Child 3 ☐ Yes ☐ No Child 4 ☐ Yes ☐ No

13.10 Has the child ever had any application for life or critical illness insurance that was declined, postponed or modified medically in any way, excluding any policy where all modifications have been removed?

Child 1 ☐ Yes ☐ No Child 2 ☐ Yes ☐ No Child 3 ☐ Yes ☐ No Child 4 ☐ Yes ☐ No

14. Personal/medical information for adult proposed insureds

Unless otherwise indicated, *you* and *your* refer to the insured.

General information

14.1 Do you speak and read English? If no, provide details.

First insured ☐ Yes ☐ No

Language used for this application (example: spoken, understood and relied upon by you): ____________

Translated by: ☐ Advisor **or** ☐ Name: ____________ Relationship to insured: ____________

Second insured ☐ Yes ☐ No

Language used for this application (example: spoken, understood and relied upon by you): ____________

Translated by: ☐ Advisor **or** ☐ Name: ____________ Relationship to insured: ____________

14.2 Are you physically present with the advisor as they record your answers to the questions in this application? If no, provide reason.

First insured ☐ Yes ☐ No ____________

Second insured ☐ Yes ☐ No ____________

Residency and travel

14.3 Are you a resident of Canada for Canadian income tax purposes? If no, provide full details.

First insured ☐ Yes ☐ No ____________

Second insured ☐ Yes ☐ No ____________

14.4 Are you a Canadian citizen or permanent resident?

First insured ☐ Yes ☐ No If no, have you applied for permanent resident status?

☐ Yes, provide a copy or acknowledgement of the application and date of application: ____________

☐ No, provide full details: ____________

Second insured ☐ Yes ☐ No If no, have you applied for permanent resident status?

☐ Yes, provide a copy or acknowledgement of the application and date of application: ____________

☐ No, provide full details: ____________

14.5 How long have you lived in Canada?

First insured ________ year(s) If under a year, ________ month(s)

Second insured ________ year(s) If under a year, ________ month(s)

14.6 Travel

a) Within the **past 12 months**, have you travelled, lived or worked outside of Canada and the United States? If yes, provide details including city or region, country, reason, frequency and duration.

First insured ☐ Yes ☐ No ____________

Second insured ☐ Yes ☐ No ____________

b) Within the **next 12 months**, do you intend to travel, live or work outside of Canada and the United States? If yes, provide details including city or region, country, reason, frequency and duration.

First insured ☐ Yes ☐ No ____________

Second insured ☐ Yes ☐ No ____________

If yes to 14.6, also complete *Foreign travel/Residence questionnaire* (form B0443A). If the questionnaire is required and not attached to the application, a customer interview will be completed to obtain this information.

Coverage information

14.7 Have you ever had an application for life, disability income, disability buy/sell, critical illness, long-term care or overhead expense insurance declined, post-poned, modified or accepted on a basis other than what you applied for? If yes, provide date, reason, insurer, type of insurance and decision.

First insured ☐ Yes ☐ No ____________

Second insured ☐ Yes ☐ No ____________

14. Personal/medical information for adult proposed insureds (continued)

14.8 Do you have any individual life, critical illness (CI), long-term care (LTC), overhead expense (OE) or disability buy/sell insurance; or do you have any individual, association, group, or other disability income (DI) insurance in force, pending or contemplated?

If yes, complete the chart below. Submit disclosure forms, as required.

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

Provide form names submitted here: __________

Insured person	Name of company	Type of insurance	Amount of insurance ($) **For CI, see note below***	**DI** Benefit period	**DI** Waiting period	**DI** Are the benefits taxable?	**Provide:** • Year issued • In force • Pending or • Contemplated	Purpose of insurance for **Life and CI**	**Will coverage be changed or replaced?** Provide details below.
☐ First ☐ Second	☐ Canada Life ☐ Other:	☐ Life ☐ CI ☐ DI/OE ☐ LTC ☐ DI buy/sell				☐ Yes ☐ No		☐ Personal ☐ Business	☐ No ☐ Changed ☐ Replaced
If changing, provide details: If replacing Canada Life, London Life or Great-West Life policy, provide policy number:									
☐ First ☐ Second	☐ Canada Life ☐ Other:	☐ Life ☐ CI ☐ DI/OE ☐ LTC ☐ DI buy/sell				☐ Yes ☐ No		☐ Personal ☐ Business	☐ No ☐ Changed ☐ Replaced
If changing, provide details: If replacing Canada Life, London Life or Great-West Life policy, provide policy number:									
☐ First ☐ Second	☐ Canada Life ☐ Other:	☐ Life ☐ CI ☐ DI/OE ☐ LTC ☐ DI buy/sell				☐ Yes ☐ No		☐ Personal ☐ Business	☐ No ☐ Changed ☐ Replaced
If changing, provide details: If replacing Canada Life, London Life or Great-West Life policy, provide policy number:									
☐ First ☐ Second	☐ Canada Life ☐ Other:	☐ Life ☐ CI ☐ DI/OE ☐ LTC ☐ DI buy/sell				☐ Yes ☐ No		☐ Personal ☐ Business	☐ No ☐ Changed ☐ Replaced
If changing, provide details: If replacing Canada Life, London Life or Great-West Life policy, provide policy number:									

*For critical illness insurance, if the coverage amount automatically increases, provide the ultimate amount.

Life insurance

Provide the total amount of accidental death benefit and waiver of premium currently in force with Canada Life and any other carrier: $ __________

Disability insurance

14.9 If applying for disability income insurance:

a) Is the group/complementer rider being applied for? ☐ Yes ☐ No
If yes, is the group coverage mandatory? ☐ Yes ☐ No

b) If applying for the accidental death and dismemberment optional benefit rider, do you have any accidental death and dismemberment insurance in force or pending? ☐ Yes ☐ No
If yes, provide details including the amount in force and/or pending, and if the in force coverage is to be replaced:

____

14. Personal/medical information for adult proposed insureds (continued)

Employment information

Life insurance **Critical illness insurance**

14.10 First insured

If retired, unemployed, homemaker or student, complete **14.10 d)**.

a) Occupation: ____________________

Nature/type of business: ____________________

b) Name and address of current entity or employer: ____________________

Address (street number and name): ____________________

City: __________ Province: __________ Postal code: __________ # of years: __________

c) Provide income details: (current year projected; earned income includes salaries and commissions)

Annual**:** Earned income $ __________ Bonus $ __________ Unearned income $ __________

Source of unearned income: ____________________

d) **If retired or unemployed:** Income from other sources: ____________________

Prior occupation: ____________________

If homemaker or student: Income from other sources: ____________________

On whom are you dependent? ____________________

Provide the following on that individual:

Occupation: ____________________

Annual: Earned income $ __________ Bonus $ __________ Unearned income $ __________

Source of unearned income: ____________________

Amount of in force coverage: Life insurance $ ____________________

Critical illness insurance $ __________ Disability insurance $ __________

Life insurance

Complete question **14.11** for life insurance.

14.11 Second insured

If retired, unemployed, homemaker or student, complete **14.11 d)**.

a) Occupation: ____________________

Nature/type of business: ____________________

b) Name and address of current entity or employer: ____________________

Address (street number and name): ____________________

City: __________ Province: __________ Postal code: __________ # of years: __________

c) Provide income details: (current year projected; earned income includes salaries and commissions)

Annual: Earned income $ __________ Bonus $ __________ Unearned income $ __________

Source of unearned income: ____________________

d) **If retired or unemployed:** Income from other sources: ____________________

Prior occupation: ____________________

If homemaker or student: Income from other sources: ____________________

On whom are you dependent? ____________________

Provide the following on that individual:

Occupation: ____________________

Annual: Earned income $ __________ Bonus $ __________ Unearned income $ __________

14. Personal/medical information for adult proposed insureds (continued)

Employment information (continued)

14.11 d) (continued)

Source of unearned income: ______________________

Amount of in force coverage: Life insurance $ ______________

Critical illness insurance $ ______________ Disability insurance $ ______________

Disability insurance

Complete questions **14.12 through 14.25** if applying for disability insurance.

14.12 Occupation: ______________________

14.13 Duties, percentage of time and description

Administrative/office: ______ % Description: ______________________

Manual/physical: ______ % Description: ______________________

Supervision: ______ % Description: ______________________

Sales: ______ % Description: ______________________

Other (specify):

______________ ______ % Description: ______________________

14.14 How long have you been the owner of the entity or employed by this employer? ________ years

14.15 What is the nature of the entity? ______________________

14.16 Number of hours worked per week: ________ Number of weeks worked per year: ________

14.17 What percentage of time is spent working in your home? ________ %

14.18 Do you plan to change your employer or occupation? ☐ Yes ☐ No

If yes, provide details: ______________________

14.19 Name of previous entity/employer and occupation: ______________________

14.20 Do you have any part-time or seasonal occupation? ☐ Yes ☐ No

If yes, provide details: ______________________

14.21 Are you covered by Employment Insurance (EI)? ☐ Yes ☐ No

14.22 Have you received EI benefits in the **past 2 years**? ☐ Yes ☐ No

If yes, provide details including dates: ______________________

14.23 If self-employed, complete the following: ☐ Sole owner ☐ Partnership ☐ Corporation

Percentage of ownership in the entity: ________ % Year entity was established: ________

Number of full-time employees: ________ Number of partners/shareholders (include yourself): ________

Number of part-time employees: ________ Number of employees directly supervised by you: ________

14.24 Use this space if you need to provide more details to questions 14.12 through 14.23.

Question number	Details

14. Personal/medical information for adult proposed insureds (continued)

Quality risk upgrade program

Complete 14.25 if applying for disability insurance for occupation classes A, 2A, and 3A only.

14.25 Initial occupation class: __________ (as per illustration or *Disability insurance advisor guide*)

Complete the categories below to determine if you qualify for an upgrade.

- An upgrade of **one** occupation class can occur from class A to 2A, 2A to 3A, or 3A to 4A.
- An upgrade of **two** occupation classes can occur from class A to 3A or 2A to 4A.
- Points can only be scored **once** in each category, and the total points scored will determine whether a higher occupation class is applicable.

Notes

- For real estate representatives, deduct 5 points from each earned income category.
- Canada Life requires financial evidence satisfactory to us for earned income points.
- Self-employed individuals may be able to enhance their insurable income by 20% to an annual maximum of $40,000. For more information, refer to the *Financial information – 20% enhancement of income* section, in the *Disability insurance advisor guide*.

Category 1

Earned income

Net after business expenses and before income tax (includes 20% gross-up if self-employed) in each of the past 2 years.

Possible points

$60,000 to $74,999 15
$75,000 to $119,999 25
$120,000 or more.................... 35

Points scored: __________

Category 2

Number of years in current occupation

Possible points

3 years............................... 15
4 years............................... 25
5 years or more...................... 35

Points scored: __________

Category 3

Return of premium

Possible points

Return of premium 50% rider 15

Points scored: __________

Total

If the total of all points is:

0 to 54 ....no upgrade
55 to 74................ upgrade 1 class
75 or more..........upgrade 2 classes

Total points scored: __________

Financial information

In the case of a proposed insured child (age 17 or under), complete questions 14.26 through 14.30 about the owner.

All products

14.26 Within the **past 5 years**, have you or the owner been insolvent, declared or petitioned into bankruptcy, or otherwise sought protection from creditors?

First insured ☐ Yes ☐ No

If yes, provide details: __________

Second insured ☐ Yes ☐ No

If yes, provide details: __________

If bankruptcy, has it been discharged?

First insured ☐ Yes ☐ No If yes, provide date of discharge (day/month/year): __________

If no, provide full details: __________

Second insured ☐ Yes ☐ No If yes, provide date of discharge (day/month/year): __________

If no, provide full details: __________

14. Personal/medical information for adult proposed insureds (continued)

Financial information (continued)

Life insurance

14.27 Why are you applying for this life insurance? (check all that apply)

First insured

Personal

☐ Income for survivor
☐ Mortgage/debt cancellation
☐ Last expenses
☐ Savings/retirement fund
☐ Estate conservation
☐ Charitable giving
☐ Other (specify): ____________________

Business continuance insurance

☐ Key person protection
☐ Business succession/equity purchase
- Sole proprietor purchase agreement
- Partnership buy/sell
- Shareholder cross purchase
- Share redemption

☐ Business loan protection (provide copy of agreement)
☐ Other (specify): ____________________

Second insured

Personal

☐ Income for survivor
☐ Mortgage/debt cancellation
☐ Last expenses
☐ Savings/retirement fund
☐ Estate conservation
☐ Charitable giving
☐ Other (specify): ____________________

Business continuance insurance

☐ Key person protection
☐ Business succession/equity purchase
- Sole proprietor purchase agreement
- Partnership buy/sell
- Shareholder cross purchase
- Share redemption

☐ Business loan protection (provide copy of agreement)
☐ Other (specify): ____________________

Critical illness insurance

14.28 Why are you applying for this critical illness insurance? (check all that apply)

☐ Personal/family protection
☐ Mortgage protection
☐ Business key person
☐ Business loan insurance
☐ Business buy-sell, share redemption or shareholder protection
☐ Other (specify): ____________________

All products

14.29

a) Personal net worth (personal assets minus liabilities):

First insured $ ____________________

Second insured $ ____________________

b) If purpose is estate conservation, estimated tax liabilities at death (capital gains, estate taxes, collapsed RSP, etc.):

First insured $ ____________________

Second insured $ ____________________

c) Is the amount of any outstanding mortgage on a principal residence or recreational property or both being insured?

First insured ☐ Yes ☐ No If yes, what is the total amount of the outstanding mortgage(s)? $ ____________________

Second insured ☐ Yes ☐ No If yes, what is the total amount of the outstanding mortgage(s)? $ ____________________

If applying for loan protection, what is the outstanding amount of the loan?

First insured $ ____________________

Second insured $ ____________________

14. Personal/medical information for adult proposed insureds (continued)

Financial information (continued)

14.30 If applying for insurance for business purposes, provide financial details on the entity:

a) Buy-sell insurance

Net worth (owner's equity, e.g., assets minus liabilities):

First insured $ ______________________

Second insured $ ______________________

Net annual income before taxes – last year:

First insured $ ______________________

Second insured $ ______________________

Gross annual revenue – last year (e.g., sales):

First insured $ ______________________

Second insured $ ______________________

Fair market value of entity:

First insured $ ______________________

Second insured $ ______________________

Indicate how fair market value was calculated:

First insured ______________________

Second insured ______________________

b) Business loan insurance

Amount of the outstanding business loan $ ______________________

Repayment terms ________ years

Date loan was approved (day/month/year): ______________________

Indicate other creditor insurance in force:

First insured ______________________

Second insured ______________________

c) Percentage of entity owned by each insured:

First insured ________ %

Second insured ________ %

d) Key person insurance

Explain why the insured is a key person:

First insured ______________________

Second insured ______________________

Annual salary and bonus (current year projected):

First insured $ ______________________

Second insured $ ______________________

e) Are all entity owners or key persons already insured or applying for life or critical illness insurance?

First insured ☐ Yes ☐ No

If yes, number of partners/key persons: ________ Amount of coverage for each partner/key person $ ______________________

If no, provide reason: ______________________

Second insured ☐ Yes ☐ No

If yes, number of partners/key persons: ________ Amount of coverage for each partner/key person $ ______________________

If no, provide reason: ______________________

14. Personal/medical information for adult proposed insureds (continued)

Financial information (continued)

Disability insurance

Complete questions 14.31 through 14.46 if applying for disability insurance.

14.31 Why are you applying for this disability insurance? (check all that apply)

☐ Disability income
☐ Overhead expense
☐ Buy/sell
☐ Key person (also complete *Key person disability insurance supplement* (form C6005A)

14.32 What is your employment status?

a) Complete as applicable:

☐ Employee – check one: ☐ Salaried ☐ Commissioned

Annual earned income (as declared for income tax purposes)	Current year (projected) ($)	Last year (actual) ($)
Salary before taxes (based on T4)		
Commissions (after business expenses and before taxes)		
Other taxable income or benefits (specify):		

☐ Incorporated business owner

Date of incorporation (month/year): ____________________

Annual earned income (as declared for income tax purposes)	Last year (actual) ($)	Previous year (actual) ($)
Salary before taxes (based on T4)		
Your share of pre-tax corporate profits		
Other taxable income or benefits (specify):		
Gross revenue of business		

☐ Unincorporated business owner (sole proprietor or partner)

Annual earned income (as declared for income tax purposes)	Last year (actual) ($)	Previous year (actual) ($)
Your share of business' net income (after business expenses and before taxes)		
Gross revenue of business		

b) For required financial documentation, refer to the DI Illustration or the *Financial underwriting for disability insurance* (form 46-9017):

☐ Documentation is attached to the application
☐ Documentation will follow

14.33 Does your unearned income (net annual income that will continue while disabled, e.g., investments, rent, royalties, pension, and similar sources) exceed $24,000/year or $2,000/month? ☐ Yes ☐ No

14.34 Does your net worth exceed $5 million? ☐ Yes ☐ No

14.35 Does the total amount of disability income insurance applied for and in force exceed $8,000/month? ☐ Yes ☐ No

14. Personal/medical information for adult proposed insureds (continued)

14.36 If yes to any question in 14.33 through 14.35, complete the information below:

Assets	**Amount ($)**	**Liabilities**	**Amount ($)**
Cash		Mortgages – Principal residence	
Real estate – Principal residence		Mortgages – Other	
Real estate – Other		Loans	
Business equity		Other liabilities (specify):	
Business(es) considered as investment(s)			
Stocks and bonds			
Personal			
Other assets (specify):			
Total assets		**Total liabilities**	
		Net worth (total assets minus total liabilities)	

Unearned income (net annual income that will continue while disabled)	**Year-to-date ($)**	**Last year ($)**
Dividend and interest income		
Real estate income (net after mortgages and expenses)		
Income from business(es) considered as investments(s)		
Other taxable income or benefits (specify):		
Total unearned income		

For overhead expense insurance

14.37 Outline in detail any special technical qualifications and skills the proposed insured provides and why these are of such a nature that the entity could not be properly maintained in the event of disability:

____

____

14.38 Date entity established (month/year): ______________

14.39 Do you share your office facilities? ☐ Yes ☐ No If yes, provide details (use of equipment, staff, etc.) :

____

____

14.40 What percentage of office expenses are you personally responsible for? __________%

14.41 List your share of the average monthly expenses incurred in the operation of your office or entity:

a) Salaries and benefits – include salaries of support employees only whose duties or technical skills do not generate income for the entity, excluding remuneration for yourself or any member of your profession $ __________

Complete the chart below for the employees whose salaries are being insured:

Name	**Duties**	**Monthly salary ($)**

14. Personal/medical information for adult proposed insureds (continued)

14.41 (continued)

- **b)** Telephone, communication services – excluding long distance charges $ ______
- **c)** Other taxes – business, payroll $ ______
- **d)** Leasing costs for furniture or equipment $ ______
- **e)** If furniture or equipment is owned, interest plus the greater of scheduled depreciation or scheduled loan principal payment $ ______
- **f)** Accounting and legal services $ ______
- **g)** Membership fees $ ______
- **h)** Business insurance premium $ ______
- **i)** Utilities* – electricity, heat, water $ ______
- **j)** Property taxes* $ ______
- **k)** Rent* $ ______
- **l)** If premises are owned, mortgage interest plus the greater of scheduled depreciation or scheduled mortgage principal payment – use only the portion that applies to the space used in the operation of your office or entity* $ ______
- **m)** Other fixed monthly expense – itemize if greater than 10% of total:

______ $ ______

______ $ ______

______ $ ______

______ $ ______

Total monthly expense **$** ______

*If your office is located in the home, these expenses, plus any other expenses are related to the home, are not eligible.

For buy/sell insurance

14.42 Names of all partners/shareholders

Names of all partners/shareholders	% ownership

14.43 Are all partners/shareholders presently insured or being insured for buy/sell purposes? ☐ Yes ☐ No

If no, provide reasons and percentage of ownership:

______

14.44 Is there life insurance in force or applied for on the proposed insured to fund a buy/sell agreement? ☐ Yes ☐ No

If yes, provide details: ______

14.45 Is the proposed insured working a minimum of 30 hours per week in the business being insured? ☐ Yes ☐ No

If no, provide details: ______

14.46 Is the proposed insured aware of the need to have in place a legally enforceable disability buy/sell agreement that coincides with the provisions of the buy/sell insurance and that insurance benefits will be paid only if such an agreement is in place at time of claim? ☐ Yes ☐ No

Personal information

14.47 Within the **past 5 years**, have you used any tobacco or nicotine product, cannabis or hashish?

First insured

☐ Yes, provide details below ☐ No

Product (check **all** that apply)	Number used	Frequency of use	Date last used (day/month/year)
☐ Cigarettes or e-cigarettes		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigarillos		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Pipe		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigars		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cannabis or hashish		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Nicotine patch or gum		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Other, specify (example chewing tobacco, snuff, betel nuts, vaping, etc.):		☐ Day ☐ Week ☐ Month ☐ Year	

Second insured

☐ Yes, provide details below ☐ No

Product (check **all** that apply)	Number used	Frequency of use	Date last used (day/month/year)
☐ Cigarettes or e-cigarettes		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigarillos		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Pipe		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cigars		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Cannabis or hashish		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Nicotine patch or gum		☐ Day ☐ Week ☐ Month ☐ Year	
☐ Other, specify (example chewing tobacco, snuff, betel nuts, vaping, etc.):		☐ Day ☐ Week ☐ Month ☐ Year	

14.48 Alcohol and drug questions

a) Do you drink alcoholic beverages?
If yes, provide the number of drinks consumed weekly.

First insured ☐ Yes ☐ No Wine: ______ Beer: ______ Liquor: ______

Second insured ☐ Yes ☐ No Wine: ______ Beer: ______ Liquor: ______

b) Have you ever used any non-prescribed drugs or narcotics (e.g., cocaine, LSD, barbiturates, amphetamines, etc.)?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

c) Have you ever been treated, counselled or attended meetings for alcohol or drug abuse, or has it been recommended that you seek treatment or counselling or reduce your alcohol or drug consumption?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

If yes to **14.48 b) or c)**, complete *Alcohol use questionnaire* (form B0430B) and/or *Drug questionnaire* (form B0426A).
If a questionnaire is required and not attached to the application, a customer interview will be completed to obtain this information.

14. Personal/medical information for adult proposed insureds (continued)

Personal information (continued)

14.49 Within the **past 5 years**, have you flown, or do you expect to fly at any time in the future as a pilot, student pilot or crew member on any type of aircraft?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

If yes, complete *Aviation questionnaire* (form 17-8321). If the questionnaire is required and not attached to the application, a customer interview will be completed to obtain this information.

14.50 Within the **past 2 years**, have you participated in, or do you plan to participate in, any hazardous sport, activity or hobby (e.g., racing, scuba-diving, hang-gliding, parachuting, bungee-jumping, ballooning, climbing, helicopter/CAT skiing, back-country/out-of-bounds skiing, martial arts, etc.)?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

If yes, complete *Hazardous sports/Avocations questionnaire* (form 17-8322). If the questionnaire is required and not attached to the application, a customer interview will be completed to obtain this information.

Driving and other background information

14.51 Driving record

a) Within the **past 3 years**, have you been convicted of, or are you currently charged with, any moving traffic violation(s), or has your driver's licence been under suspension or revoked?
If yes, provide dates and details.

First insured ☐ Yes ☐ No ____________________

Second insured ☐ Yes ☐ No ____________________

b) Within the **past 10 years**, have you been convicted of either impaired driving or refusal to provide a breath sample?
If yes, date of conviction(s).

First insured ☐ Yes ☐ No (day/month/year): ____________________

Second insured ☐ Yes ☐ No (day/month/year): ____________________

c) **If yes to 14.51 a) and/or b)**, provide the following:

First insured
Driver's licence number: ____________________ Issue date (day/month/year): ____________________

Issuing jurisdiction: ____________________ Expiry date (day/month/year): ____________________

Second insured
Driver's licence number: ____________________ Issue date (day/month/year): ____________________

Issuing jurisdiction: ____________________ Expiry date (day/month/year): ____________________

Note: If you live in British Columbia, Manitoba, Quebec, Northwest Territories or Yukon (or any other jurisdiction where the requirement might apply), you must also complete a *Motor Vehicle Report Authorization* form, or equivalent form granting us authorization to obtain your driving record.

14.52 Criminal record questions

a) Within the **past 10 years**, have you been convicted of, or charged with, any criminal offences in Canada or elsewhere?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

b) Do you have any criminal charges pending?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

If yes to 14.52 a) and/or b), provide details, dates and nature of offence(s), probation end-date(s) and jail sentence: (include exact dates)

First insured ____________________

Second insured ____________________

14. Personal/medical information for adult proposed insureds (continued)

Height and weight

14.53

a) First insured

Height: ______ feet ______ inches **or** ___________ centimetres

Weight: ______________ pounds **or** ___________ kilograms

Second insured

Height: ______ feet ______ inches **or** ___________ centimetres

Weight: ______________ pounds **or** ___________ kilograms

b) Within the **past 12 months**, have you had a weight loss of more than 10 pounds (4.5 kilograms)?

First insured

☐ Yes ☐ No If yes, amount: ________ pounds **or** ________ kilograms

Reason: ____

Second insured

☐ Yes ☐ No If yes, amount: ________ pounds **or** ________ kilograms

Reason: ____

Pregnancy information

14.54

a) Are you currently pregnant? If yes, provide due date.

First insured ☐ Yes ☐ No (day/month/year): ______________________

Second insured ☐ Yes ☐ No (day/month/year): ______________________

b) Have you ever had infertility investigations or treatments, miscarriage or bleeding, preeclampsia or any other complication of pregnancy? If yes, provide full details.

First insured ☐ Yes ☐ No

____

Second insured ☐ Yes ☐ No

____

Medical history

14.55 Is a full paramedical or medical examination being completed?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

If a medical or paramedical is an age and amount requirement, do not complete questions **14.56 to 14.59**, **14.62 to 14.82**. Always complete **14.60** (**14.61**, as required), **14.83 to 14.86** (if applying for loss of independent existence rider) and life insurance (70 or over).

14.56 Have you ever had, or do you now have, elevated (high) cholesterol or triglycerides?

First insured ☐ Yes ☐ No

If yes, have you been treated by medication and/or diet, or been advised to seek treatment? ☐ Yes ☐ No

If yes, provide date(s) and details: ____

Second insured ☐ Yes ☐ No

If yes, have you been treated by medication and/or diet, or been advised to seek treatment? ☐ Yes ☐ No

If yes, provide date(s) and details: ____

14. Personal/medical information for adult proposed insureds (continued)

Medical history (continued)

14.57 If yes to any question in 14.57 or 14.58, provide details in the chart in **14.59**.

Have you ever been treated for or had any known indication of disease or disorder of:

a) **The heart**, such as:

- High blood pressure
- Heart murmur
- Irregular heart beat
- Abnormal ECG
- Pacemaker
- Bypass or angioplasty
- Heart attack
- Shortness of breath
- Angina
- Chest pain
- Any other disease or disorder of the heart

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

b) **The blood vessels**, such as:

- Aneurysm
- Stroke
- Arteriosclerosis
- Transient ischemic attack (TIA)
- Peripheral vascular disease
- Blood clot
- Circulatory problems
- Swollen ankles
- Any other disease or disorder of the blood vessels

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

c) **The endocrine system, blood or glands**, such as:

- Diabetes
- Gestational diabetes
- Abnormal blood sugar
- Anemia
- Enlarged lymph glands
- Disease or disorder of the adrenal, pituitary or thyroid glands
- Any other disease or disorder of the glands, blood or endocrine system

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

d) **Cancer, cyst, polyp, tumour, growth, lesion or lump of any type?**

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

e) **The skin**, such as:

- Dermatitis
- Keratosis
- Moles
- Psoriasis
- Dysplastic nevus syndrome
- Skin sores or ulcers
- Any other disease or disorder of the skin

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

f) **The brain or nervous system**, such as:

- Epilepsy
- Seizures
- Convulsions
- Tremors
- Dizziness or fainting
- Paralysis
- Loss of sensation
- Weakness of the extremities
- Loss of balance
- Loss of speech
- Headaches
- Migraines
- Numbness or tingling
- Multiple sclerosis
- Motor neuron disease
- Neuritis
- Memory loss or impairment
- Alzheimer’s disease
- Parkinson’s disease
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease)
- Any other disease or disorder of the brain or nervous system

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

g) **The lungs or respiratory disease or disorder**, such as:

- Chronic bronchitis
- Persistent cough or pleurisy
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Emphysema
- Tuberculosis
- Blood spitting
- Sleep apnea or other sleep disorder
- Sarcoidosis
- Any other disease or disorder of the lungs or respiratory system

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

h) **The gastrointestinal or digestive tract**, such as:

- Ulcerative colitis
- Recurrent indigestion
- Rectal bleeding
- Crohn’s disease
- Ulcers
- Hernia
- Any disease or disorder of the mouth, throat or esophagus
- Any other disease or disorder of the stomach, intestines or rectum

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

i) **Mental health**, such as:

- Nervous or mental disorder
- Burnout or stress
- Schizophrenia
- Anxiety or depression
- Bipolar disorder
- Other psychological, behavioural, eating or emotional disorder
- Developmentally disabled
- Any other psychiatric disease or disorder

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

14. Personal/medical information for adult proposed insureds (continued)

14.57 (continued)

Have you ever been treated for or had any known indication of disease or disorder of:

j) The immune system, such as:

- Acquired immunodeficiency syndrome (AIDS) or tested positive for HIV, the virus that causes AIDS
- Lupus
- Scleroderma
- Any other disease or disorder of the immune system

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

k) The ears, eyes, nose, or throat, such as:

- Deafness
- Blindness
- Optic neuritis or other visual disturbance
- Allergies
- Any other disease or disorder of the eyes, ears, nose, or throat

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

l) The pancreas, gall bladder or liver, such as:

- Pancreatitis
- Gall stones
- Jaundice
- Hepatitis or hepatitis carrier
- Cirrhosis of the liver
- Any other disease or disorder of the pancreas, gall bladder or liver

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

m) The kidney, bladder, breast or reproductive organs, such as:

- Sugar, albumin, pus or blood in the urine
- Nephritis
- Abnormal pap or mammogram
- Elevated prostate specific antigen (PSA)
- Breast lump
- Venereal disease or other sexually transmitted infection
- Kidney stones
- Any other disease or disorder of the kidney, bladder, prostate, breast or reproductive organs

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

n) The spine, back, neck, muscles or bones including soft tissue disorders or injuries, such as*:

- Fibromyalgia
- Chronic fatigue
- Chronic pain
- Polio
- Osteoarthritis
- Rheumatoid arthritis
- Repetitive strain injury
- Conditions causing crippling, limited motion, or requiring adaptive devices
- Any other disease or disorder of the back, muscles or bones including joints, neck and spine or a hip, knee, or other joint replacement

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

***If yes** to any disease or disorder relating to the back, complete *Back pain questionnaire*, questions 14.72 through 14.82.

14.58 Have you ever received treatment or counselling or had any time off work for any disease or disorder listed in question **14.57 i)**?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

14.59 If yes to any question in 14.57 or 14.58, provide details in the chart below.

Insured person	Question number	Conditions/symptoms, duration, tests, results and treatment	Date (month/year)	Name and address of healthcare provider, clinic and/or hospital
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				

14. Personal/medical information for adult proposed insureds (continued)

Health information

14.60 First insured

a) Do you have a regular healthcare provider or do you regularly visit a particular clinic? ☐ Yes ☐ No

If yes, name of your regular healthcare provider or the clinic you visit regularly:

____

Address (street number and name): ______________________________

City: ____________________ Province: __________ Postal code: __________

Name of the healthcare provider or clinic that has your most recent medical history, if different from your regular healthcare provider or clinic:

____

Address (street number and name): ______________________________

City: ____________________ Province: __________ Postal code: __________

Phone number: ____________________

b) Date of last visit to a healthcare provider or clinic (month/year): ____________________

What was the reason for this visit? (check one)

☐ Annual physical

☐ Other (specify): ______________________________

Provide details including diagnosis, treatment and results: ______________________________

____

c) Are the records with your healthcare provider or the clinic under the same name as indicated for you in this application?

☐ Yes ☐ No, provide details: ______________________________

Life insurance

14.61 Second insured

a) Do you have a regular healthcare provider or do you regularly visit a particular clinic? ☐ Yes ☐ No

If yes, name of your regular healthcare provider or the clinic you visit regularly:

____

Address (street number and name): ______________________________

City: ____________________ Province: __________ Postal code: __________

Name of the healthcare provider or clinic that has your most recent medical history, if different from your regular healthcare provider or clinic:

____

Address (street number and name): ______________________________

City: ____________________ Province: __________ Postal code: __________

Phone number: ____________________

b) Date of last visit to a healthcare provider or clinic (month/year): ____________________

What was the reason for this visit? (check one)

☐ Annual physical

☐ Other (specify): ______________________________

Provide details including diagnosis, treatment and results: ______________________________

____

c) Are the records with your healthcare provider or the clinic under the same name as indicated for you in this application?

☐ Yes ☐ No, provide details: ______________________________

14. Personal/medical information for adult proposed insureds (continued)

Health information (continued)

14.62

a) Within the **past 3 months**, have you undergone a medical or diagnostic test (other than a genetic test) for which you have not received the results?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

b) Are you currently scheduled for, or have you ever been advised to have, any testing (other than a genetic test) or procedure that has not been completed?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

c) Other than for a regular annual checkup, are you currently scheduled for or have you been advised to return for a follow-up visit?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

14.63 Within the **past 5 years**, have you:

a) Had a check-up, illness, surgery, injury or disease not mentioned elsewhere in this application?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

b) Had a consultation with a healthcare provider, chiropractor, psychologist or therapist not mentioned elsewhere in this application? If chiropractor, also complete *Back pain questionnaire*, questions 14.72 through 14.82.

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

c) Had an electrocardiogram, X-ray, blood test or other diagnostic tests (other than a genetic test) not part of a routine examination and not mentioned elsewhere in this application?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

d) Been a patient in a hospital, clinic, or other healthcare facility not mentioned elsewhere in this application?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

14.64 Are you aware of any signs, symptoms or complaints for which you have not yet consulted a healthcare provider or received treatment?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

14.65 Have you consulted with more than one healthcare provider or clinic in the **past 5 years**?

First insured ☐ Yes ☐ No Second insured ☐ Yes ☐ No

14.66 Are you currently, or within the **past 5 years**, have you been absent from work for **more than 15 consecutive days** for health reasons or injury? If yes, provide reason, date(s) and duration.

First insured ☐ Yes ☐ No ____________________

Second insured ☐ Yes ☐ No ____________________

14.67 If yes to any questions in 14.62 through 14.66, provide details in the chart below.

Insured person	Question number	Conditions/symptoms, duration, tests, results and treatment	Date (month/year)	Name and address of healthcare provider, clinic and/or hospital
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				

14. Personal/medical information for adult proposed insureds (continued)

Family history

14.68 Have any of your immediate family members (father, mother, brothers or sisters) had any of the following: heart disease, cancer (specify type), stroke, high blood pressure, elevated cholesterol, diabetes (specify type 1 or 2), kidney disease, Huntington's chorea, polycystic kidney disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), motor neuron disease, Parkinson's disease, multiple sclerosis, Alzheimer's disease, dementia or any other hereditary disease or disorder?

If yes, provide details in **14.71**.

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

14.69 If yes to family history of breast or ovarian cancer in 14.68 above, have you seen a healthcare provider for a breast examination, mammogram or other form of surveillance?

If yes, provide details.

First insured ☐ Yes ☐ No ____________________

Second insured ☐ Yes ☐ No ____________________

14.70 If yes to family history of colon cancer in 14.68 above, have you had a colonoscopy?

If yes, provide details.

First insured ☐ Yes ☐ No ____________________

Second insured ☐ Yes ☐ No ____________________

14.71 If yes to question 14.68, provide details below.

Insured person	Family member	Conditions/full details	Age at onset	Age if living	Age at death	Cause of death
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					
☐ First insured ☐ Second insured	☐ Father ☐ Mother ☐ Brothers ☐ Sisters					

14. Personal/medical information for adult proposed insureds (continued)

Back pain questionnaire – complete if yes to 14.57 n) or 14.63 b)

14.72 Date of first episode

First insured Month: ________ Year: ________ Duration of discomfort: ________

Second insured Month: ________ Year: ________ Duration of discomfort: ________

14.73 Date of last episode

First insured Month: ________ Year: ________ Duration of discomfort: ________

Second insured Month: ________ Year: ________ Duration of discomfort: ________

14.74 Longest duration of discomfort of any other episode

First insured Month: ________ Year: ________ Duration of discomfort: ________

Second insured Month: ________ Year: ________ Duration of discomfort: ________

14.75 Date of last treatment

First insured Month: ________ Year: ________

Second insured Month: ________ Year: ________

14.76 Give diagnosis, if known

First insured ________

Second insured ________

14.77 What is the frequency of your back pain?

First insured ☐ Once a year ☐ 2 to 5 times a year ☐ Over 5 times a year

Second insured ☐ Once a year ☐ 2 to 5 times a year ☐ Over 5 times a year

14.78 What area(s) of the back was involved?

First insured ☐ Neck (cervical) ☐ Middle (thoracic) ☐ Low (lumbosacral)

Second insured ☐ Neck (cervical) ☐ Middle (thoracic) ☐ Low (lumbosacral)

14.79 Does the pain radiate?

First insured ☐ Yes ☐ No If yes, where does it radiate to? ________

Second insured ☐ Yes ☐ No If yes, where does it radiate to? ________

14.80 Do you currently have any restriction of back movement?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

14.81 In relation to your back pain, have you ever:

a) Undergone any X-rays or other investigation of your back?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

b) Had or been advised to have surgery?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

c) Been hospitalized for any back complaints?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

d) Been disabled or unable to work because of your back discomfort?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

e) Had chiropractic, physiotherapy or other treatment(s) for your back?

First insured ☐ Yes ☐ No

Second insured ☐ Yes ☐ No

14.82 If yes to any question in 14.81, provide full name of healthcare providers, chiropractors or therapists consulted and dates:

First insured ________

Second insured ________

14. Personal/medical information for adult proposed insureds (continued)

Daily activities

Life insurance **Critical illness insurance**

The following questions are for:

- **Life insurance** (age 70 or over)
- **Critical illness insurance** (for all ages if applying for the critical condition plus rider)

14.83 For physical or psychological reasons, do you currently need or use the help or supervision of another person to perform any of the following activities: driving, arranging transportation, using the telephone, managing finances, doing housework or laundry, shopping or meal preparation?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

14.84 Are you currently, or within the **past 5 years**, have you been:

a) Unable to perform activities of daily living on your own, such as bathing, dressing, toileting, eating, transferring from bed to chair, or controlling bladder or bowel function?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

b) In receipt of home care or adult care, or confined to a home for the aged, nursing home or other institution, or recommended to receive any such care?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

c) A user of any medical equipment such as a respirator, oxygen device, walker, wheelchair, cane or any other type of mobility assistance?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

14.85 Have you fallen or been injured in the **past 3 years**?

First insured ☐ Yes ☐ No
Second insured ☐ Yes ☐ No

14.86 **If yes** to any questions in **14.83 through 14.85**, provide details in the chart below.

Insured person	Question number	Conditions/symptoms, duration, tests, results and treatment	Date (month/year)	Name and address of healthcare provider, clinic and/or hospital
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				
☐ First insured ☐ Second insured				

15. Personal/medical information for proposed insured children

The parent or legal guardian providing information about a child insured must have sufficient knowledge of the child to provide complete and accurate answers.

Complete this section for:
- Child life insurance – coverage over $100,000, otherwise complete section 16.
- Child critical illness insurance – coverage over $25,000, otherwise complete section 16.

15.1 Is the parent or legal guardian, who has sufficient knowledge about the child and is providing the information, physically present as the advisor is recording all the answers to the questions?

☐ Yes
☐ No, provide the reason: ______________________________

Coverage information

15.2 Do either or both parents, or the legal guardian have any critical illness, long-term care, or any individual, association, group or other life, disability income or overhead expense insurance in force or pending?

☐ Yes, provide details below
☐ No, provide full details: ______________________________

Parents or guardian	Name of company	Type of insurance	Amount of insurance ($)	Policy number
☐ Father ☐ Mother ☐ Legal guardian				
☐ Father ☐ Mother ☐ Legal guardian				
☐ Father ☐ Mother ☐ Legal guardian				
☐ Father ☐ Mother ☐ Legal guardian				
☐ Father ☐ Mother ☐ Legal guardian				
☐ Father ☐ Mother ☐ Legal guardian				

15.3 Is the parent or legal guardian a Canadian citizen or permanent resident?

☐ Yes ☐ No

If no, has the parent or legal guardian applied for permanent resident status?

☐ Yes, provide a copy or acknowledgement of the application and date of application:

(day/month/year): ____________________

☐ No, provide full details: ______________________________

15.4 Annual earned income of the parent or legal guardian $ ____________________

15. Personal/medical information for proposed insured children (continued)

Coverage information (continued)

15.5 Does the child have in force, pending or contemplated life or critical illness (CI) insurance?

☐ Yes, provide details below
☐ No

Child	Name of company	Type of insurance	Amount of insurance ($) For CI, see note below*	Provide: • Year issued • In force • Pending or • Contemplated	Will coverage be changed or replaced?	If changing, provide details. If replacing Canada Life, London Life or Great-West Life policy, provide policy number.
☐ 1 ☐ 2 ☐ 3 ☐ 4					☐ No ☐ Changed ☐ Replaced	
☐ 1 ☐ 2 ☐ 3 ☐ 4					☐ No ☐ Changed ☐ Replaced	
☐ 1 ☐ 2 ☐ 3 ☐ 4					☐ No ☐ Changed ☐ Replaced	
☐ 1 ☐ 2 ☐ 3 ☐ 4					☐ No ☐ Changed ☐ Replaced	

*For critical illness insurance, if the coverage amount automatically increases, provide the ultimate amount.

15.6 Why are you applying for child insurance? (check all that apply)

☐ As part of an overall financial plan
☐ Preserve the children's insurability
☐ Family protection
☐ Other (specify): ______________________________

15.7 Does the child have any siblings?

☐ Yes, provide details below ☐ No, **skip to 15.8**

Do the siblings have any critical illness or life insurance in force or pending?

☐ Yes ☐ No, explain why: ______________________________

If yes, is the type of coverage (critical illness or life insurance) on the sibling(s) basically equal, i.e., the same face amount or premium?

☐ Yes, provide amounts below
☐ No

Life insurance $ ____________________

Critical illness insurance $ ____________________

15. Personal/medical information for proposed insured children (continued)

Residency and travel

15.8 Is the child a Canadian citizen or permanent resident?

Child	**a)** Canadian citizen or permanent resident?	**b)** If 15.8 a) is no, has the child applied for permanent resident status?	**c)** If 15.8 b) is yes, provide the date of application and attach copy of the application or acknowledgement for permanent resident status. (day/month/year)	**d)** If 15.8 b) is no, provide reason why the child hasn't applied for permanent resident status.
1	☐ Yes ☐ No	☐ Yes ☐ No		
2	☐ Yes ☐ No	☐ Yes ☐ No		
3	☐ Yes ☐ No	☐ Yes ☐ No		
4	☐ Yes ☐ No	☐ Yes ☐ No		

15.9 How long has the child lived in Canada?

Child	Year(s)	If under a year, provide number of month(s)
1		
2		
3		
4		

15.10 During the **past 12 months**, has the child travelled or lived, or is it intended that he or she travel or live in the **next 12 months** outside of Canada and the United States?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

Personal information

15.11 Have any applications for life or critical illness insurance ever been declined, postponed or modified in any way?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.12 Within the **past 5 years**, has the child between the ages of 16 and 17 used any tobacco or nicotine product, cannabis or hashish? If yes, provide details.

Child	Check one	Product(s) used	Number used	Frequency of use per:	Date last used (day/month/year)
1	☐ Yes ☐ No			☐ Day ☐ Week ☐ Month ☐ Year	
2	☐ Yes ☐ No			☐ Day ☐ Week ☐ Month ☐ Year	
3	☐ Yes ☐ No			☐ Day ☐ Week ☐ Month ☐ Year	
4	☐ Yes ☐ No			☐ Day ☐ Week ☐ Month ☐ Year	

15. Personal/medical information for proposed insured children (continued)

Personal information (continued)

15.13 Does the child drink alcoholic beverages?

Child	Check one	If yes, provide the number of drinks consumed weekly
1	☐ Yes ☐ No	Wine: ________ Beer: ________ Liquor: ________
2	☐ Yes ☐ No	Wine: ________ Beer: ________ Liquor: ________
3	☐ Yes ☐ No	Wine: ________ Beer: ________ Liquor: ________
4	☐ Yes ☐ No	Wine: ________ Beer: ________ Liquor: ________

15.14 Whether or not prescribed by a healthcare provider, has the child ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or any drug such as cannabis, cocaine, amphetamines or barbiturates?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.15 Has the child ever been treated or counselled for alcohol or drug abuse, or has it been recommended that he or she seek treatment or counselling to reduce alcohol or drug consumption?

Child	Check one	If yes, check one and provide details
1	☐ Yes ☐ No	☐ Alcohol ☐ Drug abuse
2	☐ Yes ☐ No	☐ Alcohol ☐ Drug abuse
3	☐ Yes ☐ No	☐ Alcohol ☐ Drug abuse
4	☐ Yes ☐ No	☐ Alcohol ☐ Drug abuse

15.16 During the **past 3 years**, has the child participated in motor or other vehicle racing, parachute-jumping, hang-gliding, scuba-diving, martial arts, mountain climbing or other hazardous sports or avocation? Are any of these activities contemplated?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.17 If the child is within the legal driving age, has he or she ever been convicted of, or has he or she been charged with any moving traffic violation(s), or has their driver’s licence been under suspension or revoked?

Child	Check one	If yes, provide details and driver’s licence number
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15. Personal/medical information for proposed insured children (continued)

Health information

15.18 Name and address of regular healthcare provider or clinic (if more than one consulted in the **past 5 years**, list in 15.29):

Child	Healthcare provider or clinic name and address
1	
2	
3	
4	

Child	Provide date last consulted (month/year), reason, diagnosis, treatment and results
1	
2	
3	
4	

15.19 What is the child's actual height and weight (not estimated)?

Child	Height	Weight	Within the **past 12 months**, has the child lost any weight?
1	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
2	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
3	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
4	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:

15.20 Have any of the child's biological immediate family members (father, mother, brothers or sisters) had heart disease, stroke, high blood pressure, elevated cholesterol, cancer (specify type), diabetes (specify type 1 or 2), kidney disease, Huntington's chorea, motor neuron disease, multiple sclerosis, cystic fibrosis, muscular dystrophy or any other hereditary disease?

☐ Yes, complete the family history below ☐ No

If the children have different biological family members, indicate which children the family member is biologically related to:

Family member	Biologically related to child	Condition	Age at onset	Age if living	Age at death	Cause of death
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					

15. Personal/medical information for proposed insured children (continued)

Health information (continued)

15.21 If either parent is **under age 40**, complete the grandparents' family history below, as it applies to the conditions in 15.20. If the child has different biological grandparents, include which child(ren) the grandparent is biologically related to.

Family member	Biologically related to child	Condition	Age at onset	Age if living	Age at death	Cause of death
☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Maternal grandmother ☐ Maternal grandfather ☐ Paternal grandmother ☐ Paternal grandfather	☐ 1 ☐ 2 ☐ 3 ☐ 4					

15.22 If the child is **less than one year old**, was the child born premature by **more than 4 weeks**?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

Is there any known indication of failure to thrive or failure to grow?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.23 Has the child ever been treated for or had any known indication of any of the following conditions?
If yes, provide details in 15.29.

a)
- Coma
- Epilepsy
- Head or brain injuries
- Loss of consciousness
- Meningitis
- Seizure or stroke
- Any other disease or disorder of the brain or nervous system

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

b)
- Asthma
- Chronic cough
- Cystic fibrosis
- Persistent fever
- Any other disease or disorder of the lung or respiratory system

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

15. Personal/medical information for proposed insured children (continued)

Health information (continued)

15.23 (continued)

c)
- Heart murmur
- Irregular heart beat
- Investigation for high blood pressure
- Any other disease or disorder of the heart

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

d)
- Disease or disorder of the kidney
- Disease or disorder of the urinary tract or bladder

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

e)
- Diabetes
- Thyroid, adrenal or pituitary gland disorder
- Abnormal blood sugar
- Any other disease or disorder of the endocrine system, blood or glands

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

f)
- Arthritis
- Polio
- Any other disease or disorder of the muscles, joints, limbs or spine

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

g)
- Acquired immunodeficiency syndrome (AIDS)
- Tested positive for HIV, the virus that causes AIDS
- Any other disease or disorder of the immune system

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

h)
- Loss of speech
- Loss of hearing
- Blindness
- Any other disease or disorder of the eye or ear
- Any other disease or disorder of the nose, throat or mouth

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

i)
- Cancer
- Cyst
- Tumour
- Growth
- Lesion
- Polyp
- Mole
- Dysplastic nevus syndrome
- Or lump of any type

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

j)
- Hemophilia
- Leukemia
- Persistent anemia
- Any other disease or disorder of the blood or circulatory system

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

k)
- Liver disease
- Celiac disease
- Hepatitis
- Chronic diarrhea
- Inflammatory bowel disease
- Any other disease or disorder of the gastrointestinal or digestive tract

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

l)
- Cerebral palsy
- Congenital abnormality
- Down syndrome
- Multiple sclerosis
- Muscular dystrophy
- Any hereditary disorder or any other motor neuron disease

Child 1: ☐ Yes ☐ No
Child 2: ☐ Yes ☐ No
Child 3: ☐ Yes ☐ No
Child 4: ☐ Yes ☐ No

15. Personal/medical information for proposed insured children (continued)

Health information (continued)

15.24 Has the child ever received treatment or counselling for psychiatric disorder(s) including anxiety, depression, attention deficit hyperactivity disorder, developmental delay (mental or physical), intellectual disability, autism or mental or nervous illness?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.25 Other than previously disclosed, has the child ever had an electrocardiogram, X-ray, ultrasound, blood test(s), or other diagnostic test(s), or been a patient in a hospital, clinic, or healthcare facility, or been advised to have any diagnostic test(s) or surgery which have not been completed?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.26 Does the child now have any disability, disease or health problem or is the child under treatment by medicine, diet or other means not mentioned elsewhere in this application?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.27 Other than previously disclosed, within the **past 12 months**, has the child been ill for **more than 10 consecutive days** or been hospitalized for **more than 7 days**?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15. Personal/medical information for proposed insured children (continued)

Health information (continued)

15.28 Other than previously disclosed, is there any reason to believe the child may not be in good health and not free from symptoms, disease, or disorder?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

15.29 Use this space if you need to provide more details to questions 6.2 as well as 15.1 through 15.28.
Indicate the question and to which child the details apply.

Child	Question number	Details
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		
☐ 1 ☐ 2 ☐ 3 ☐ 4		

16. Short health information for children

Complete this section only if one of the following conditions apply, otherwise complete section *15. Personal / medical information for proposed insured children*:

- Child critical illness insurance for ages 60 days to 17 years and amounts of $25,000 or less.
- Child life insurance for ages 17 and under and amounts of $100,000 or less. For amounts over $100,000, complete section *15. Personal / medical information for proposed insured children*.
- Child's term life insurance rider for ages under 18.

The parent or legal guardian providing information about a child insured must have sufficient knowledge of the child to provide complete and accurate answers.

16.1 What is the child's actual height and weight (not estimated)?

Child	Height	Weight	Within the **past 12 months**, has the child lost any weight?
1	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
2	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
3	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:
4	☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Yes ☐ No If yes, amount and reason:

16.2 When did the child last see a health care provider?

Child	Date (day/month/year)	Reason for visit, details of tests, results and any treatment prescribed
1		
2		
3		
4		

16.3 Have any applications for life or critical illness insurance ever been declined, postponed or modified in any way?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

16. Short health information for children (continued)

16.4 Has the child been diagnosed or treated for, or had any known indication of, or undergone investigation for: asthma, the acquired immunodeficiency syndrome (AIDS) or a positive test for HIV (the virus that causes AIDS), aortic surgery, aplastic anemia, autism, bacterial meningitis, benign brain tumour, cancer, cerebral palsy, congenital heart disease, cystic fibrosis, diabetes, disorder of the arteries, epilepsy, hemophilia, heart attack, a heart murmur, heart valve replacement, (chronic) hepatitis, (chronic) kidney disease or failure, major organ failure, muscular dystrophy, permanent paralysis, seizure, stroke or developmental problems (physical or mental), any congenital abnormality or hereditary disorder?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

16.5 Other than previously disclosed, does the child now have any disability, disease or health problem or is the child under treatment by diet, medicine or other means or is there any reason to believe the child may not be in good health and not free from symptoms, disease or disorder?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

16.6 Have any of the child's biological immediate family members (father, mother, brothers or sisters) had heart disease, stroke, high blood pressure, elevated cholesterol, cancer (specify type), diabetes (specify type 1 or 2), kidney disease, Huntington's chorea, motor neuron disease, multiple sclerosis, cystic fibrosis, muscular dystrophy or any other hereditary disease?

☐ Yes, complete the family history below ☐ No

If the children have different biological family members, indicate which children the family member is biologically related to:

Family member	Biologically related to child	Condition	Age at onset	Age if living	Age at death	Cause of death
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					
☐ Father ☐ Mother ☐ Brothers ☐ Sisters	☐ 1 ☐ 2 ☐ 3 ☐ 4					

16. Short health information for children (continued)

16.7 Is there any intention for the child to live or travel outside of Canada and the United States within the **next 12 months**?

Child	Check one	If yes, provide details
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	

16.8 Why are you applying for child insurance? (check all that apply)

☐ As part of an overall financial plan

☐ Preserve the children's insurability

☐ Family protection

☐ Other (specify): ____________________

17. Premium payments

17.1 Initial premium payment

- ☐ Cheque for $ ____________________
- ☐ Electronic funds transfer
- ☐ Pay on contract delivery
- ☐ Dividends – complete 17.2
- ☐ Cash surrender value – complete 17.2
- ☐ Paid-up additional coverage – complete 17.2

To be applied as follows:

- ☐ Life insurance $ ____________________
- ☐ Critical illness insurance $ ____________________
- ☐ Disability insurance $ ____________________

If there will be:

- an initial scheduled payment of $100,000 or more, or
- an unscheduled payment of $100,000 or more, then

Complete a *Politically exposed person (PEP) determination* (form 17-8294) for each owner and any person paying for this policy.

Life insurance

17.2 Authorization to replace existing insurance and transfer funds for life insurance

In this section, *you* and *your* refer to the owners. *We*, *our* and *us* refer to Canada Life.

By signing below:

As the owners, you understand and agree:

- You're authorizing us to transfer funds according to the option you've chosen in section 10. The option you've chosen will only take effect if and when we place the policy in force.
- If you've asked us to cancel your existing policy and transfer the net cash value, this will end all your rights and coverage under that existing policy.
- If you've asked us to transfer money from your existing policy but keep it in force, you may have less life insurance coverage under that policy. You may also have to pay additional premiums to keep the policy in force.
- Some of the options in section 10 may result in taxable income for you that we're required to report to the government.

As an irrevocable beneficiary and assignee (in Quebec, hypothecary creditor), you understand and agree:

- You authorize the options chosen by the owners in section 10.
- You will not have any status and rights regarding the new policy, unless arranged with the owners of the new policy.

Signed at
City or town: ____________________ Province: ________ Date (day/month/year): ____________________

Signature of **owner**
(if entity, authorized person to sign and indicate title)
X

Signature of **owner**
(if entity, authorized person to sign and indicate title)
X

If owner is an entity, provide full legal name of entity:

If owner is an entity, provide full legal name of entity:

Signature of **preferred or irrevocable beneficiary** and **assignee/hypothecary creditor** giving up rights (if two policies are listed in section 10, indicate for which one, if not for both)

17. Premium payments (continued)

17.3 Request for the pre-authorized debit plan

If you want to use different accounts for the life, critical illness and disability insurance policies, then record details for the life policy below and complete the *Request for pre-authorized debit plan* (form 320 CAN) for critical illness and disability insurance policies.

Complete this section to make premium payments by pre-authorized monthly withdrawal from the account holder's financial institution.

Choose from the following options and sign as applicable in section 20 after reading section *22. Pre-authorized debit agreement*.

☐ Concurrent application number: ____________________

☐ Account details below

Does the account require more than one account holder signature? ☐ Yes ☐ No

If yes, the account holders required to authorize this pre-authorized debit plan must sign in section 22.

Name of account holder: ____________________

Name of joint account holders, if any: ____________________

Name of financial institution: ____________________ Transit number (Scotiabank only): ____________

Address: ____________________

Transit number (5 digits): ____________ Bank code (3 digits): ____________ Account number: ____________

Type of account: ☐ Chequing ☐ Savings ☐ Business

The premium withdrawal day will be the same day every month as the policy effective date, unless you specify a different day:

☐ Use a different withdrawal day (not available for a universal life insurance policy)

Specify which day of the month: withdrawal day (1 to 28): ______

Universal life insurance

Complete question 17.4 if applying for universal life insurance.

If the payor is someone other than the owner, be sure to complete *4.7 Third party determination and identification*.

17.4 Indicate the source of funds for this policy

☐ Borrowed funds:

Name of lender: ____________________

Relationship to applicant: ____________________

☐ Gifted funds:

Name of giver: ____________________

Relationship to applicant: ____________________

☐ Inherited funds

☐ Salary or income earned

☐ Sale of physical property or business

☐ Other (specify): ____________________

18. Wage loss replacement plan rider acknowledgement and agreement

Disability insurance

Read this section if you're applying for disability income insurance intended to form part of a wage loss replacement plan.
In this section, *you* and *your* refer to the owner. *We*, *our* and *us* refer to The Canada Life Assurance Company.

By signing in section 20, you and the proposed insured understand and agree to the following:

- You intend for the individual disability insurance you've applied for to form part of a group sickness or accident plan acceptable to the Canada Revenue Agency (CRA) for income tax purposes. This is called a wage loss replacement plan. If this plan does not already exist, you must implement it immediately.
- You are responsible for implementing and maintaining the wage loss replacement plan in compliance with all CRA requirements, including the requirement that any monthly benefit is payable to the insured person.
- If a policy is issued, you are responsible for paying the premium due under the policy. We will report any monthly benefit amount payable as taxable income of the insured person.
- If a wage loss replacement plan is not properly implemented or maintained:
  - The CRA may retroactively deny claiming the premium as a tax deductible expense.
  - The CRA may require the insured person to retroactively include the amount of premium paid as a taxable employee or shareholder benefit in calculating his or her personal income taxes.
  - Interest and penalties may apply.
- A wage loss replacement plan rider with terms as set out below will form part of any policy issued.

Wage loss replacement plan rider

Terms Used

This rider is issued by us as part of the policy to which it is attached and is subject to the provisions of the policy, except as may be modified or amended by this rider. Any modification or amendment made by this rider is only in effect while this rider is in force. The terms used in this rider have the same meaning as indicated in the policy, unless otherwise specified or required in the context of the following rider provisions.

Rider Date

The Rider Date will be the same as the Policy Date, if this rider is included in the policy when it is first issued by us. Otherwise, the Rider Date will be such later date as established by the amendment to the contract to include this rider. The Rider Date is used to determine duration, premium due dates, anniversaries and your age with respect to this rider.

Wage Loss Replacement Plan

Wage Loss Replacement Plan means an arrangement of individual disability insurance policies, properly implemented and maintained by the Owner, in order to constitute a group sickness or accident plan acceptable to the Canada Revenue Agency for income tax purposes.

Return of Premium Benefit

Despite anything to the contrary, if a rider providing for a return of premium benefit is in effect, any return of premium benefit payable in cash under the terms of such rider will be paid to the Owner.

Notification to Canada Life

The Owner must immediately notify us in writing if you are not, or cease for any reason, to be a member of a Wage Loss Replacement Plan.

Evidence

Upon notification to us of such an event, we reserve the right to require evidence, in a form satisfactory to us, of your earnings and eligibility for coverage under the Employment Insurance Act.

Reduction in Benefits

Despite anything to the contrary including, but not limited to, the terms of the Non-Cancellable provision, we reserve the right, based on any such evidence received, to:

a) reduce the Monthly Disability Benefit, lengthen the Waiting Period, or both, in accordance with our published summary of issue and participation limits then in effect, or that were in effect on the Policy Date, whichever is more favourable to you; and

b) reduce the premium, if applicable, to the amount that we would have required for any such reduction as determined under this provision. We will refund the excess premium paid, if any.

Any change to the policy made in accordance with this provision will become effective as of the date of notification to us. We will notify the Owner of any such change.

Overpayment of Benefits

If you are Disabled on the date of notification to us, you must repay to us the amount of any Monthly Disability Benefit paid in excess of the amount that would otherwise have been paid in accordance with the Reduction in Benefits provision. We will notify you of any such amount.

Rider Termination

Subject to the provisions of the basic policy and any riders and benefits included in the contract, this rider will terminate on the earlier of the following dates:

a) the date of your death; and

b) the date on which the policy terminates for any other reason.

19. Consent to release additional information to your advisor

In this section, *you* and *your* refer to the proposed insured(s), including any minor child insured. *We*, *our* and *us* refer to The Canada Life Assurance Company.

Responding **yes** or **no** in this section will not affect the processing of the application.

Consent to release information, if you choose **yes** below.

You give us consent to release to your advisor "additional information," here meaning detailed information about you and your insurance application that is in addition to what we would ordinarily provide your advisor during the underwriting process. The advisor, by signing this application, agrees to use the additional information to help discuss your insurance options and explain underwriting decisions, and for no other purpose.

Your additional information we may share with the advisor could include the following:

- Results of medical/laboratory testing
- Personal information about illness, including mental illness, infectious diseases, other medical conditions, medication usage; drug or alcohol use and rehabilitation
- Information about your health discovered during the application process, even if not known by you at that time
- Employment history and personal finances
- Records of criminal activity
- Other facts about your life and how they might affect our decision to insure you

You also agree to the following:

- You have the right to withdraw your consent at any time. When we receive your request, no further additional information will be provided to your advisor.
- This consent, unless withdrawn earlier, remains valid from the date you sign this application until 60 days after the date we issue an insurance policy or the date we send you an application decline or cancellation notice, whichever date is applicable.

Indicate whether additional information may be shared with the advisor:

First proposed insured ☐ Yes ☐ No
Second proposed insured ☐ Yes ☐ No
Minor child insured(s) ☐ Yes ☐ No

If no choice is made between yes and no, the default is **no**.
The parent or legal guardian (tutor in Quebec) signing the application on behalf of a minor child indicates the choice for that child.

Signature of **first proposed insured**	Signature of **parent(s) or legal guardian** for each minor insured
X	X
Signature of **second proposed insured** for life insurance	Signature of **witness**
X	X

20. Agreements and signatures

In this section, *you* and *your* refer to the owner and to the proposed insured, including any minor child, as applicable. *We*, *our* and *us* refer to The Canada Life Assurance Company and our reinsurers.

If you're a parent or legal guardian (tutor in Quebec) applying for or consenting to insurance on behalf of, or on, one of your minor children, you speak for that child when you sign below.

By signing below, you understand and agree to the following:

Information relating to the application

You have read this application and confirm the statements in it are truthful, accurate, and complete to the best of your knowledge. If they're not, future claims could be declined and any policy we've issued declared void.

Your application for insurance includes the statements you give us in this application and any related forms. It also includes any information you give us in interviews (interviews include any questionnaire completed with your advisor). If we provide you with a copy of the information you gave us in any interview, you agree to review it immediately and to contact us if anything is missing or incorrect. Otherwise you agree the copy accurately records all the information you gave us.

This application and other documents you provide us are our property, unless we agree otherwise. You also agree we're under no obligation to return or keep original documents or provide copies, unless we're required by law or have agreed to do so, and that documents provided to us may be converted into other media or formats (e.g., a paper document may be converted into an electronic document).

A proposed insured will undergo any medical exams or tests we request in order to process the application. You understand that processing is required to determine coverage eligibility and applicable premium rates.

You will let us know immediately if the insurability of a proposed insured changes after you sign this application. This includes the proposed insured's health.

If you're applying for participating or universal life insurance, you understand there are policy values and certain features that are not guaranteed.

If you've applied for universal life insurance

You will notify Canada Life as soon as possible if there are any changes to your personal information, including your name, address, occupation, purpose or intended use of the policy. If you are an entity, please notify Canada Life of any changes in your beneficial ownership and authorized signing officers. Providing updated information will ensure you receive important communications about your policy and will allow Canada Life to remain compliant with applicable laws while servicing your policy. **You authorize us to obtain a consumer or credit report for identification purposes, if you have not provided us with sufficient ID.**

If you're replacing or changing another insurance policy

Questions 14.8 and 15.5 ask if the policy you're applying for will replace, or if you will change, another insurance policy you have. If you answered yes and do not go ahead with the replacement or change after we've issued your new policy, we may not pay any benefits under the new policy.

If you're replacing an existing Canada Life, London Life or Great-West Life policy, or exercising an option in an existing policy, the information you provided in your application for that policy forms a basis to this application.

Temporary insurance and conditional insurance

If we're providing temporary life insurance or conditional critical illness or disability insurance while we process your application, you have received, understood and agreed to the terms of that insurance.

20. Agreements and signatures (continued)

When your policy comes into effect

Your policy comes into effect when all requirements have been met.

How we collect, use and protect your personal information

For us to process your application, manage your relationship with us (including any policy resulting from the application), respond to claims, and for any purpose directly related to any of those preceding, you agree and authorize that, as allowed or required by law:

- We will collect, store, use and disclose your personal information.
- Where you have provided your social insurance number (for a corporate owner, your business number), we will keep it on record and may use it for tax reporting, identification and record-keeping purposes.
- We may request an insurance underwriting report about you, as described in the notice called Notice about insurance underwriting report.
- When required, we'll make a brief report of your information to MIB, LLC., as described in the Notice regarding MIB, LLC.
- We may release your medical results to the regular healthcare provider or clinic named in this application.
- You authorize any healthcare provider, medical practitioner, hospital or medically related facility, insurance company, MIB, LLC., motor vehicle department or any other organization or person that has information about you or your health to give that information to us.
- You understand why we've asked for your authorization regarding personal information, that we've asked for it in accordance with applicable laws, and the benefits and risks of giving (or not giving, or withdrawing) your authorization.
- If underwriting evidence, dated before the date of this application, is being submitted by you as an alternative to completing parts of this application, you agree that such information is still true, accurate, and complete as of the date of this application, and is to be considered part of it.
- Your authorizations, including agreements, will take effect on the date you sign this application and will remain in effect as long as we require them, which may continue past your death (for example, in responding to a claim). At any time, you may withdraw your authorizations that had been required by law, by telling us in writing, as long as there are no legal reasons preventing your withdrawal.

Important notices

You've received, understood, and agree with the notices in the separate section we've given you called Important notices.

Pre-authorized debit agreement

In the following sub-section, *you* and *your* refer to the holder (or holders) of the account from which payments will be made.

- You've read section *22. Pre-authorized debit agreement* and agree to the terms and conditions.
- You've agreed to make payments from your account using pre-authorized debit.
- You authorize us to make deductions from your account according to the instructions you've given us.

You understand if the pre-authorized debit agreement is suspended, we may change the method of payment and the owner will remain responsible for paying the premiums. If the owner wants the pre-authorized debit payments to resume, we may require a new agreement.

20. Agreements and signatures (continued)

A copy of this agreement is as valid as the original.

Signed at
City or town: ______________________ Province: ________ Date (day/month/year): ________________

Signature of **owner** for life insurance
(if entity, authorized person to sign and indicate title)

X

If owner is an entity, provide full legal name of entity:

Signature of **owner** for life insurance
(if entity, authorized person to sign and indicate title)

X

If owner is an entity, provide full legal name of entity:

Signature of **owner** for critical illness and disability insurance
(if entity, authorized person to sign and indicate title)

X

If owner is an entity, provide full legal name of entity:

Signature of **first proposed insured** if age 16 (18 in Quebec) or over, if other than owner

X

Signature of **second proposed insured** if age 16 (18 in Quebec) or over, if other than owner

X

Signature of **account holder**, if other than owner
(if entity, authorized person to sign and indicate title)

X

Signature of other **joint account holder(s)**, if required for account (if entity, authorized person to sign and indicate title)

X

Signature of **insured for payor benefits**, if not signing as an owner

X

Signature of **parent(s) or legal guardian** for each minor insured, if other than owner

X

Signature of **witness**

X

Name of witness (first, middle initial, last):

21. Advisor's report

The Advisor's report does not form part of the application. In this section *you*, *your* and *I* refer to the advisor.

21.1 Who started negotiations for this application?
☐ Advisor ☐ Proposed insured ☐ Owner ☐ Cold call

21.2 How long have you known the proposed insured(s)? ________ years
How well? ☐ Not at all ☐ Casually ☐ Well

Life insurance

Complete question **21.3** for life insurance.

21.3 ☐ Even premium (maintain premium if preferred class or ratings are applicable)

21.4 Did you personally assess the owner/proposed insured's goals, needs and priorities considering their current financial situation, existing coverage, and other necessary information?
☐ Yes ☐ No

If yes, have you attached a copy of the needs analysis? ☐ Yes ☐ No, check all that apply:
☐ Refused to go through needs analysis process
☐ Knew amount of coverage they wanted/needed
☐ Other (specify): ____________________

21.5 Did you explain and document in the client file how the type of insurance coverage, amount of insurance, possible guarantees, and option features and benefits will fulfill their needs?
☐ Yes ☐ No, answer the following questions:

Were other products or options considered or discussed with the client? ☐ Yes ☐ No

Is the amount, type, benefits/features of the insurance being applied for based on your recommendations? ☐ Yes ☐ No

What amount of insurance was determined through the needs analysis? $ ____________________

What amount of insurance did you recommend? $ ____________________

21.6 In your opinion, the owner's decision was:
☐ Based on insurance needs, combined with ability to pay premiums
☐ Limited by their ability or willingness to pay premiums
☐ Part of a plan which is to be implemented over time
☐ Based on a specific strategy or concept. If so, please provide the name of the strategy:

____

☐ Other (specify): ____________________

21.7 Tell us any other relevant information that may be useful in reviewing this application including the following: special policy date, special requests, or if 4.7 was answered no and you have reasonable grounds to believe there's a third party.

Attach a sheet if more space is required (include application number, date and your signature).

____
____
____
____
____
____
____
____

21. Advisor's report (continued)

21.8 Concurrent applications

Is any owner applying for any other insurance on one or more of the following? ☐ Yes ☐ No

If yes, check all that apply and complete the table below:

☐ Self, or another proposed insured
☐ Member of the same household (life or critical illness insurance)
☐ As part of a group for business insurance

Name of insured (first, last)	Date of birth (day/month/year)	Type of insurance	Company	Application or policy number
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	
		☐ Life ☐ Critical illness ☐ Disability	☐ Canada Life ☐ Other:	

21.9 Will this policy be owned by the advisor or a related party? ☐ Yes ☐ No

Disability insurance

Complete question **21.10** and **21.11, if applying for disability income insurance**.

21.10 Is the insurance applied for intended to:

a) Form part of a wage loss replacement plan arrangement? ☐ Yes ☐ No
If yes, did you review section *18. Wage loss replacement plan rider acknowledgement and agreement* with the insured? ☐ Yes ☐ No

b) Form part of a group other than a wage loss replacement plan? ☐ Yes ☐ No

21.11 If yes to question 21.10, provide details of other policies or applications associated with this group below:

Name of insured (first, last)	Date of birth (day/month/year)	Application or policy number

21. Advisor's report (continued)

21.12 Advisor information – the advisor listed first will be the servicing advisor.

Advisor's name (first, middle, last)	Advisor code	Product solutions centre	% share of commission

21.13 Additional individuals authorized by the advisor to receive daily and weekly emails on this application only:

Name (first, middle, last)	Relationship to advisor	Email address

21.14 Requirements to be ordered by:

- ☐ Canada Life
- ☐ Advisor (indicate paramedical company below)
- ☐ Obtain from another insurance company (specify): ____________________

First insured

- ☐ Non-medical
- ☐ Paramedical
- ☐ Medical exam
- ☐ Resting ECG
- ☐ Stress ECG
- ☐ Vitals
- ☐ Chest X-ray
- ☐ Blood profile
- ☐ Urine specimen

Provide name of paramedical facility or examiner: ____________________

If available, date to be completed (day/month/year): ____________________

Second insured

- ☐ Non-medical
- ☐ Paramedical
- ☐ Medical exam
- ☐ Resting ECG
- ☐ Stress ECG
- ☐ Vitals
- ☐ Chest X-ray
- ☐ Blood profile
- ☐ Urine specimen

Provide name of paramedical facility or examiner: ____________________

If available, date to be completed (day/month/year): ____________________

21.15 I certify, by my signature below, that: (1) I have asked all questions and fully recorded all the answers given by each proposed insured and the parent or legal guardian of any child on the application, (2) I know nothing that is material to the insurability of each proposed insured or child that has not been recorded on the application or in my report; and, (3) I have provided the following information in writing to the owner:

a) The company or companies I represent
b) That I receive compensation (such as commissions) for the sale of life and health insurance products
c) That I may receive additional compensation in the form of bonuses, conferences, or other incentives
d) Any actual or potential conflicts of interest I may have with respect to this transaction

Signed at
City or town: ____________________ Province: __________ Date (day/month/year): ____________________

Signature of **advisor**

X ____________________

22. Pre-authorized debit agreement ("agreement")

Detach and give to the owner. If the account holder is not the owner, the advisor is to make a copy of this agreement and give it to the account holder.

In this section, *you* and *your* refer to the account holder (or holders) from whose account the withdrawals will be made. *We* and *us* refer to The Canada Life Assurance Company.

By signing at the bottom of section 20, you understand and agree to the following terms:

Your personal information

We may collect, store, use and disclose your personal information as needed with regard to this agreement. If you're not the owner of the policy, we may share any information about this agreement with the owner, including payment information.

Your authorization for regular withdrawals

You authorize us and your financial institution you named in 17.3 to withdraw from your account any monthly payments you've agreed to make, including payments that may vary from one withdrawal to the next, and regardless of any change in policy ownership. Withdrawals may increase or decrease as the insurance policy is administered. You release us from any requirement to let you know in advance of these increases or decreases.

Payments are subject to the provisions of the policy being applied for. If the premium due date in the policy is different than the withdrawal date shown in this agreement, the fact that they're not the same doesn't change the premium due date.

You agree to review your account information regularly. If you find a transaction made under this agreement doesn't match your records, you have 90 days from the date of the transaction to contact us. After that, we'll consider the transaction to be correct.

If a pre-authorized withdrawal is refused by your financial institution

If any pre-authorized withdrawal is refused by your financial institution, for example because there are insufficient funds in your account (NSF), we may suspend this agreement. We also have the option of making a second attempt to withdraw the amount, but if we still cannot make the withdrawal, we'll suspend this agreement.

You'll be responsible for any NSF fees charged by your financial institution if they reject a withdrawal.

If we suspend this agreement and the owner later wants pre-authorized debit payments to resume, we may require a new pre-authorized debit agreement.

Your rights with respect to unauthorized withdrawals

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. To obtain more information on your recourse rights, contact your financial institution or visit payments.ca.

Account changes

If your account information changes, you must tell us in writing at least 14 days before the next withdrawal is to be made. However, we may agree to accept verbal instructions from you to change account information if the account holder remains the same.

Cancelling this agreement

You (or the owner) may cancel this agreement by giving us 30 days' written notice. Or if we decide to cancel the agreement, we'll give you (or the owner) 30 days' written notice. Contact your financial institution or payments.ca for a sample cancellation form or for information about cancellation rights.

For more information about this agreement, contact us at 1-888-252-1847 or write to us at:

The Canada Life Assurance Company
Individual Insurance
255 Dufferin Ave
London ON N6A 4K1

A copy of this agreement is as valid as the original.

Visit **canadalife.com**
Toll-free phone: **1-888-252-1847**

Canada Life and design are trademarks of The Canada Life Assurance Company.

23. Receipt

Make cheque payable to Canada Life.

Amount paid with this application $ ____________________

Paid by

First name: ____________________

Middle name: ____________________

Last name: ____________________

The above payment is to be applied as follows:

☐ $ ____________________ toward life insurance

☐ $ ____________________ toward critical illness insurance

☐ $ ____________________ toward disability insurance

Total $ ____________________

Receipt of payment with this application will not cause insurance to start or continue under a temporary life insurance, conditional critical illness or conditional disability insurance agreement, or issue a policy. You must meet all applicable terms and conditions before we'll provide coverage or issue any policy.

Signed at
City or town: ____________________ Province: ________ Date (day/month/year): ____________________

Signature of **advisor**

X ____________________

Visit **canadalife.com**
Toll-free phone: **1-888-252-1847**

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24. Temporary life insurance agreement

Detach and give to the owner.

In this agreement, *you* and *your* refer to the owner or owners, if more than one. *We*, *our* and *us* refer to The Canada Life Assurance Company.

Temporary life insurance is not available if you're:

- Converting from a group insurance policy
- Buying additional insurance by exercising an existing policy option
- Applying for life insurance totaling $5 million or more

What this agreement provides

This agreement can provide life insurance coverage while we process your application. If a person who qualifies for this temporary life insurance dies while this agreement is in effect, we'll pay the benefit provided by this agreement to the beneficiaries you've named in this application for benefits payable on that person's death, according to the beneficiary instructions you've given us and the terms set out below. However, no coverage is provided under this agreement regarding any waiver of premium or automatic payment benefit.

Who is eligible for temporary life insurance?

If temporary life insurance is available, a proposed insured is eligible if he or she:

- Is under actual age 71 (and at least 15 days old), and
- Answers no to all the temporary insurance questions

When does this agreement start?

This agreement starts for a proposed insured on the date this application is signed, as long as the following three conditions are met on that date:

- This application is completed.
- The proposed insured answers no to all the temporary insurance questions.
- We received payment equal to at least the first monthly premium or 1/12th of the estimated annual premium, based on the insurance applied for and our standard rates. The payment must be submitted with the application and cannot be post-dated.

How much life insurance coverage does this agreement provide?

The coverage for each person who qualifies for temporary life insurance is the same as the amount of life insurance you've applied for on that person in this application, up to the maximum described below. However, in the case of joint coverage, a benefit will only be payable according to the plan you've applied for (joint-first-to-die or joint last-to-die).

Maximum amount we'll pay

The total amount we'll pay for all proposed insureds together who qualify for temporary life insurance under this agreement is limited to $1 million.

However, if there is more than one temporary life insurance agreement with us covering the proposed insured, and claims are made under the separate agreements, the maximum amount we'll pay for all the claims together regarding the proposed insured is $1 million. If the maximum would be exceeded, and if there is more than one claimant under the separate agreements, we'll allocate the amount we pay (in this case, $1 million) among the claimants on an equitable basis as we determine.

24. Temporary life insurance agreement (continued)

Exclusion – suicide

If a proposed insured covered by this agreement commits suicide, whether sane or insane, we will not pay a death benefit on that person's death. We'll cancel this agreement and your life insurance application, effective as of that death, and refund to you the payment made with the application.

When does this agreement end?

This temporary life insurance agreement may last up to 90 days from the date this application is signed. However, it ends immediately if any of the following happens before the end of the 90 days:

- The policy you're applying for comes into effect.
- You ask us to cancel your application.
- We cancel or decline your application.
- A person covered by this agreement commits suicide, whether sane or insane, even if there are other people covered under this agreement.

If we have not finished processing your application by the end of the 90-day period we may continue processing it, but the temporary life insurance coverage will no longer be in effect. We'll retain any payment made with the application and apply it to your policy, or refund it to you if we don't issue the policy.

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Toll-free phone: **1-888-252-1847**

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25. Conditional critical illness and disability insurance agreement

Detach and give to the owner.

In this agreement, *you* and *your* refer to the owner. *We*, *our* and *us* refer to The Canada Life Assurance Company. *Disability insurance* means disability income insurance, overhead expense insurance, key person or buy/sell insurance or any combination of these.

What this agreement provides

This agreement can provide insurance coverage on those who qualify for critical illness or disability insurance while we process your application. Depending on what you've applied for, if a person who qualifies for conditional insurance suffers a covered critical illness or disability while this agreement is in effect, and meets the required conditions set out below, we'll pay the applicable conditional insurance amount.

However, in the case of critical illness insurance, this conditional insurance agreement does not provide coverage for cancer or a benign brain tumour.

This agreement is also subject to the terms and conditions of any critical illness insurance policy or disability insurance policy we issue.

Who is eligible for conditional insurance?

Conditional insurance is available for the proposed insured if he or she:

- Is under actual age 61 (and at least 60 days old for critical illness insurance, age 18 for disability insurance)
- Has answered no to all the conditional insurance questions for the type of insurance applied for (13.1 – 13.10, as applicable)
- Does not intend to travel outside of Canada and the United States within the next three months
- Is insurable on the terms applied for or other terms offered by us that are acceptable to you

You will not be eligible for conditional insurance if you applied for a Lifestyle protection disability insurance plan and as a result of processing your application we offer you the Independence plan.

When does this agreement start?

This agreement starts for the proposed insured, if eligible, on the date when all three of the following conditions are met:

- This application is completed and signed.
- We received payment equal to at least the first monthly premium or 1/12th of the estimated annual premium, based on the insurance applied for and our standard rates. The payment must be submitted with the application and cannot be post-dated.
- The proposed insured completes the initial medical exams and tests we require.

How much conditional insurance can this agreement provide?

The amount of coverage this agreement provides, for a type of insurance applied for on the proposed insured, is the lesser of the following amounts:

- The amount of coverage (monthly coverage, in the case of disability income and overhead expense) of that type you've applied for on the proposed insured, and
- The amount of coverage (monthly coverage, in the case of disability income and overhead expense) we would approve on the proposed insured, if issuing a policy of that type, subject to the following maximums for each type of insurance:
  - Critical illness (adult) – $500,000
  - Critical illness (child) – $250,000
  - Disability income and overhead expense – $5,000 a month
  - Partner buy-out – $500,000
  - Accidental death and dismemberment – $100,000

25. Conditional critical illness and disability insurance agreement (continued)

Maximum amount we'll pay if the proposed insured is covered by more than one conditional insurance agreement

If there is more than one conditional insurance agreement with us covering the proposed insured, and claims with regard to a particular type of insurance are made under the separate agreements, the maximum amount we'll pay for all these claims, taken together, is the highest amount under any one agreement. If there are different claimants under the separate agreements, we'll allocate the amount we pay among the claimants, on an equitable basis as we determine.

When does this agreement end?

This conditional insurance agreement may last up to 90 days from the date this application is signed. However, it ends immediately if any of the following happens before the end of the 90 days:

- The policy you're applying for comes into effect.
- You ask us to cancel your application.
- We cancel or decline your application.

If we have not finished processing your application by the end of the 90-day period we may continue processing it, but the conditional insurance coverage will no longer be in effect. We'll retain any payment made with the application and apply it to your policy, or refund it to you if we don't issue the policy.

Visit **canadalife.com**
Toll-free phone: **1-888-252-1847**
Canada Life and design are trademarks of The Canada Life Assurance Company.

26. Important notices

Detach and give to the owners and those being insured under the policy.

Notice regarding your personal information

(in this notice, *you* and *your* also apply to the owner, if not the same as the proposed insured)

Protecting your personal information is important to Canada Life. When an application is submitted to us, we create a confidential file containing your personal information. The file is kept in the offices of Canada Life or third parties we authorize. Directly, or through others, in or from Canada or elsewhere, we handle your personal information – i.e., collect, store, use and disclose it – to, as applicable, provide you with financial products and services, respond to claims, help you plan for financial objectives, and otherwise as legally required or as you have authorized. We limit access to the information in your file to our staff and others, including your advisor and service providers, who need it to perform their duties. This includes our reinsurers. In some cases, we may engage service providers outside of Canada to assist us with the handling of your personal information. In such cases your personal information will be subject to the laws, including public authority access laws, of other countries.

If you'd like to review and correct your personal information in our file, or if you have further questions about how we handle and protect your personal information, including with regard to service providers, and would like a copy of our privacy guidelines, write to us at:

Canada Life's Chief Compliance Officer
255 Dufferin Avenue
London ON N6A 4K1

Or visit canadalife.com

Important information about the contract package

If we issue a policy, the contract package we provide includes personal information about the owner and the person being insured. If you're the person to be insured but not the owner, you agree your personal information will be shared with the owner. We may also give a copy of the contract package to any subsequent owner, beneficiary, estate representative, or someone who provides a loan in exchange for rights to the policy, as the law or your agreement with that person requires. If an owner or person to be insured later decides to withdraw from the application, that person's information will still be part of any copy of the contract package we provide, unless they give us written instructions to remove it.

Notice regarding MIB, LLC.

Canada Life treats the information about your insurability as confidential. However, we and our reinsurers may make a brief report to MIB, LLC., a not-for-profit organization of life and health insurance companies operating an information exchange on behalf of its members. If you apply for insurance coverage or submit a claim to another MIB, LLC. member company, MIB, LLC. will, on request, supply that company with the information in its file.

If you apply to another insurance company for life or health insurance, or if you submit a claim to another company, we or our reinsurers may also share information in your file directly with that company. Your personal information will be stored by MIB, LLC. outside Canada. An individual's consumer file at MIB, LLC. may be accessible to U.S. law enforcement and U.S. national security authorities for investigations against terrorist and clandestine intelligence activities; provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws.

You may ask to see your personal information on file with MIB, LLC. and correct anything that's inaccurate or incomplete. For more information about MIB, LLC., call 1-866-692-6901 or write:

MIB, LLC.
400-50 Braintree Hill Park
Braintree MA 02184-8734

Or visit Canadadisclosure@mib.com

26. Important notices (continued)

Notice about insurance underwriting report

As part of processing your application, we may request an insurance underwriting report to obtain additional credit and personal information about you. If you'd like a more detailed description of the nature of this investigation and the information we receive, write to:

Individual Insurance
255 Dufferin Ave
London ON N6A 4K1

About our customer interview program

To complete your application, the proposed insured may receive a telephone call from one of our authorized representatives to obtain personal and financial information. The interview normally takes 30 minutes and will be conducted at a time convenient to the proposed insured. If the proposed insured is not in when the interviewer calls, the interviewer will leave a name and toll-free number to return the call.

Summary of critical illness and disability insurance benefits

If you're applying for critical illness or disability insurance, your policy may be subject to certain exceptions and benefit adjustments. We'll send you a summary explaining the features and benefits with your policy. The summary will also list any exemptions or limitations to your coverage. You can also get this information from your advisor.

About tax treatment

Any tax information we provide is for general information only. It should not be relied on as providing tax or legal advice. Any person seeking such advice should consult with a tax or legal professional.

Visit **canadalife.com**
Toll-free phone: **1-888-252-1847**

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Advisor code

Supplement to the application for universal life insurance

Interest option selection for allocation of funds

Application / policy number

Name of owner (print):

First name	Middle name	Last name

Instructions and information

- For New Business, use this form in conjunction with the *Application for life insurance* (form **17-8921**), *Application for life, critical illness and disability insurance* (form **17-8908**) or the *Telephone application for life, critical illness and disability insurance* (form **17-8909**).
- For Client Service, use this form in conjunction with the *Simplified conversion and guaranteed issue application* (form **17-8345**), or *Application for policy change* (form **17-8217**).
- Indicate in **number 1** how you want your premiums allocated. **The default account is a daily interest option**.
- We will allocate all money deposited to your policy as indicated on this form until you advise us otherwise, in writing or by completing a *Universal life financial transaction application* (form **17-8165**).
- On each policy anniversary we will check if your policy is tax exempt without corrective action. If it is not, we will transfer the amount required for your policy to remain exempt into a side account. This account will use the five-year compound guaranteed interest option, unless you indicate otherwise in **number 2**. The transfer will be a disposition for income tax purposes.
- You may change your allocations at any time. However, a market value adjustment may apply on owner-initiated withdrawals and fund transfers from the guaranteed interest option(s).
- Deposits to your guaranteed interest option(s) exceeding a total of $1,000,000 require Canada Life's approval.
- A *Politically exposed person (PEP) determination* (form **17-8294**) is required for each person who is the owner and/or payor:
  - If the initial scheduled payment is $100,000 or more. It is not required for subsequent scheduled payments.
  - For any **unscheduled** payment of $100,000 or more.

1. Premium allocations

a) Scheduled premium payment of $ _______________

b) Payment frequency – check **one**: ☐ Monthly pre-authorized debit premium payment ☐ Annual payment

c) Additional premium (lump sum) **payment** of $ _______________ Check **one**:

☐ As indicated in the *Additional premium* column in the chart

☐ To the side account (can only deposit directly once the estimated maximum premium for the policy year has been paid)

d) Deposit premiums – check **one**:

☐ Directly to the interest options indicated in the chart

☐ **First** to the daily interest option, **then** to the interest options, indicated in the *Scheduled premium* column, when the daily interest option reaches a balance of $ _______________ or more.

Notes:

- This amount must be at least $25 for each interest option you select
- You can't make this choice if you want to allocate to the daily interest option or to any *ABC* variable interest options

e) Indicate all interest option choices using the following guidelines:

- Maximum of 10 selections
- Minimum allocations may not be less than 5% (and no less than $25) to any one fund, **subject to the following minimum amounts:** $500 for any *ABC* variable interest options **or** $25 for any other interest option you select.
- **If no selections are made**, your premium will be credited to the daily interest option.

f) Elect interest options for the withdrawal of monthly deductions

☐ i) Withdraw monthly deductions proportionately from all existing interest options **(default)**

☐ ii) Withdraw monthly deductions entirely from _______________________________________ interest option

You may choose only one interest option. **ABC accounts may not be used.** If there are insufficient funds in this option to cover monthly deductions, the balance will default to i) above.

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Application / policy number:

Daily & guaranteed interest options	Allocation Scheduled premium	Allocation Additional premium		Allocation Scheduled premium	Allocation Additional premium
Daily interest (**default**)	______%	______%			
Guaranteed interest option - 1 year, compound interest	______%	______%	Guaranteed interest option - 5 year, compound interest	______%	______%
Guaranteed interest option - 3 year, compound interest	______%	______%	Guaranteed interest option - 10 year, compound interest	______%	______%
Variable interest options **Index-linked options**					
Canadian Equity	______%	______%	Sciences and Technology	______%	______%
American Equity	______%	______%	European Equity	______%	______%
Global Equity	______%	______%	Japanese Equity	______%	______%
Canadian Bond	______%	______%	American Small Cap	______%	______%
Real Return Bond	______%	______%			
Fund-linked variable interest options **Fixed income-linked options**					
Franklin Bissett Core Plus Bond	______%	______%	Mackenzie Corporate Bond	______%	______%
Equity fund-linked options					
Canadian Equity			Invesco Canadian Premier Growth Class	______%	______%
ABC Fundamental-Value	______%	______%	Mackenzie Canadian Resource	______%	______%
Invesco Canadian	______%	______%	AGF Canadian Equity	______%	______%
Franklin Bissett Canadian Equity	______%	______%	CI Harbour	______%	______%
Mackenzie Canadian Large Cap Dividend	______%	______%	Dynamic Power Canadian Growth	______%	______%
U.S. Equity			AGF American Equity	______%	______%
ABC American-Value	______%	______%	Mackenzie U.S. All Cap Growth	______%	______%
Global and International Equity Options			Invesco Global Companies	______%	______%
Mackenzie Global Growth Class	______%	______%	Dynamic International Equity	______%	______%
Fidelity Global	______%	______%	Fidelity NorthStar®	______%	______%
Templeton International Equity	______%	______%			
Canadian Balanced Funds					
CI Harbour Growth & Income	______%	______%	Fidelity Canadian Asset	______%	______%
ABC Fully-Managed	______%	______%	Fidelity Monthly Income	______%	______%
Profile / Asset allocation accounts					
Conservative Profile	______%	______%	Advanced Profile	______%	______%
Moderate Profile	______%	______%	Aggressive Profile	______%	______%
Balanced Profile	______%	______%			
Total allocations must equal 100%	______%	______%		______%	______%

2. Side account – owned by the owner of the policy and is not part of the policy

- A side account will be set up automatically.
- Any interest earned in this account is taxable.
- Owner-initiated withdrawals from the five-year compound guaranteed interest option are subject to market value adjustments. Automatic transfers to the policy are not.
- **If no selection is made, allocations will automatically be credited to the five-year compound guaranteed interest option.**

Transfers from the policy to this account are to be allocated to the:

☐ Daily interest option **or** ☐ Five-year compound guaranteed interest option

This supplement is being submitted in connection with, and forms part of the application. I request that The Canada Life Assurance Company (Canada Life) allocate my funds as indicated above. To the extent of any inconsistencies between this supplement and the application, the information in this supplement will govern.

Signed at (city or town, province)	Date (day/month/year)
Signature of **owner** (if entity, authorized person to sign **and indicate title**) X	If **owner is an entity**, print full legal name of entity
Signature of **owner**, if more than one owner (if entity, authorized person to sign **and indicate title**) X	Signature of **witness** to all signatures X