Policy Change Application

APPLICATION NO.

Notice of Disclosures

Thank you for continuing to do business with *ivari*.

Before submitting this request to change your policy, ensure that you have carefully read each of the notices on this page and all other pages of this application. On receipt of this application, we will assess the eligibility of each Insured for the insurance or policy change requested. We assess each Insured primarily on the basis of the infor mation that is provided in this application, any other declaration made in connection with this application, and the information previously submitted by you in relation to the life insurance you already have or have had with *ivari*. Factors that we consider when underwriting an application for insurance or a policy change include, but are not limited to, information concerning the Insureds' medical history, physical condition, occupation or avocation, lifestyle and financial situation. Once we have determined the degree of risk that each Insured represents, we will determine if the insurance applied for or the change requested can be issued. Questions? Please contact your Independent Insurance Advisor or write to us at **Client Services Department, ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8.**

NOTICE REGARDING MIB, INC.

Information about your insurability will be treated as confidential. *ivari* or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, operating an information exchange on behalf of its members.

Personal information disclosed to MIB, Inc may include your name, birth jurisdiction, occupation and any other information used to determine your insurability. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. MIB, Inc. receives personal information, and the collection, use and disclosure of such information is governed by the **Personal Information Protection and Electronic Documents Act** (PIPEDA) and provincial laws.

MIB, Inc. has agreed to protect such information in a manner that is substantially similar to *ivari's* privacy and security practices, and in accordance with applicable laws. As a U.S.-based company MIB, Inc. is bound by and such personal information may be disclosed in accordance with applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations, provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws. If you have any questions about MIB, Inc.'s commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy Department at **privacy@mib.com.** Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. to seek a correction.

The address of MIB, Inc.'s information office is 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, tel. no. 416-597-0590. *ivari*, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at **www.mib.com.**

NOTICE REGARDING INVESTIGATIVE CONSUMER REPORTS AND COLLECTION

As part of our evaluation of your insurance application and claim analysis, we may request an investigative consumer report or credit report be completed. These reports, if requested, will be obtained from an investigative or consumer reporting agency or from a credit bureau.

Personal information collected may include information about your character, general reputation, personal characteristics, finances, credit and lifestyle. A representative who is employed to make such reports may contact you in person or by telephone in connection with this investigation. For more details about these reports, you may write to us at the Client Services department at the address noted above.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

ivari collects, uses and discloses your personal information as described in the sections of this application regarding MIB, Inc., investigative consumer reports and the personal information authorization. The personal information authorization section of this application can be found on page 25. In addition, we collect personal information about you from this application, any supplementary forms and questionnaires, as described in the above sections, and from the following **external sources:**

Your file already established with *ivari*; physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities; MIB, Inc. and other insurers and reinsurers; investigation, consumer and credit reporting agencies; motor vehicle and driver record authorities in any relevant jurisdictions; your independent insurance advisors, including the independent insurance advisor's report section of your application.

The information collected from these sources is used for the following **purposes: Evaluating your insurance application; servicing your policy; and investigation and claim analysis.** Your personal information may be shared with your independent insurance advisor and the managing general agencies, distributors and market intermediaries and their employees with which your advisor is associated for purposes identified above.

Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit payments. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

We collect your SIN for tax reporting purposes to the Canada Revenue Agency in accordance with federal legislation. Certain transactions requested under a universal life policy may require you to provide your SIN before processing.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. For example, personal information may be disclosed in response to demands or requests from government authorities, courts or law enforcement in these countries.

We may communicate with you about other insurance products and services. If we rely on a marketing service provider to communicate with you, we will disclose only your name, contact information, and your current insurance coverage, but not your health or financial information. *ivari* requires its service providers to safeguard the confidentiality of personal information consistent with *ivari's* privacy and security practices and in accordance with applicable laws.

We have safeguards to protect your personal information; however, in the event of an unauthorized access, disclosure or use of your personal information, there is a possibility that you may experience: identity theft, negative effects on a credit record, financial loss, embarrassment or damage to reputation. If *ivari* believes that you face a real risk of significant harm, *ivari's* Privacy Office will notify you of the data breach and suggest steps to reduce your risk of harm.

By signing and submitting this application on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this application.

Upon receiving your application, *ivari* will add your personal information to your existing file, which will be accessible at our Head Office. Your file will be accessible to only those employees and authorized representatives of *ivari* responsible for administering your file, and other persons authorized by you or by law. Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Officer, ivari, 500-5000 Yonge Street, Toronto, Ontario, M2N 7J8. Your personal information will be collected, used, disclosed, shared and treated as described herein, or as otherwise described at or before the time of collection, use or disclosure, or as otherwise permitted by law. To review our privacy policy, visit **www.ivari.ca**.

DISCLOSURE OF COMPENSATION

The insurance product you are being offered is supplied by *ivari*, a company licensed to conduct business in all provinces and territories of Canada. The independent insurance advisor/distributor soliciting this insurance application is a licensed insurance Advisor representing *ivari* and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with *ivari*, the advisor/distributor or any other person or entity as a condition of this application.

Guidelines for the advisor

Use this application when applying for any changes to in force Life and Critical Illness policies such as:

- Addition of lives/coverage for Term and Critical Illness Protection insurance only
- Reinstatement
- Reduce or remove rating or change in risk classification
- Changes to non-smoker
- Addition of Children's Insurance Rider
- Change of Death Benefit Option (DBO)
- Increase in Face Amount
- Conversion with underwriting
- Change of Cost of Insurance (COI)
- Substitution of life
- Replacement of an existing *ivari* policy

For quicker processing:

1. The Notice of Disclosures (page i) must be given to the **Insured(s).**
2. Indicate the requested change on the following page and ensure you submit this page with the application.
3. ALL pages of the *Policy Change Application* must be submitted with the exception of page i.
4. For Term or Critical Illness Protection multi-life request with more than two Insureds (other than children under the Children's Rider), submit a second *Policy Change Application*.
5. For replacements of insurance contracts attach applicable disclosure forms, as per provincial legislation.
6. There is an administration fee per life for Cost of Insurance and Death Benefit Option changes if underwriting is required.
7. Complete the Insurance history section (page 6) for the following changes: Additions, Replacements, Reinstatements and Conversions with underwriting.
8. All Owner signatures are required even if only 1 Insured is applying for the change.
9. For Joint-Last-to-Die policies, evidence of insurability are required on all lives insured regardless who is applying for the change.

Health History questions

When a paramedical or a telephone interview is required, the Insured(s) do(es) not need to complete the health history questions 43–51.

Important for replacements or conversions to a universal life policy only:

1. Multi-life option is not available.
2. Submit a signed illustration and the *Supplement to the Insurance Application* for conversions and replacements.
3. Ensure all questions shown as **MANDATORY FOR UNIVERSAL LIFE POLICIES** are answered.
4. If the Policy Owner is an entity (i.e. a corporation, non-corporate entity or trust) please complete the *Policy Ownership for Corporate & Non-Corporate Entities or Trusts* form (IP-LP1747).

Requested change

Indicate the requested change and complete the required section for that change.

CHANGE TYPE (SELECT ALL THAT APPLY)	LIFE INSURED 1	LIFE INSURED 2	PAGES AND SECTIONS TO BE COMPLETED	ADDITIONAL REQUIREMENTS	NON-FACE TO FACE ACCEPTED? YES OR NO
Conversion with face increase or Conversion with class of risk change	☐	☐	Pages **1, 2,** (**3** if Insured is juvenile), **4, 6** to **9** (sections 18 to 22), **14** to **21** (questions 33 to 51), **25** to **27**	• Signed Illustration and Supplement to the Insurance Application • If Owner is an entity, complete (IP-LP1747) form	**NO** **YES** if paramedical is required **NO** if premium is $10K and over or owned by an entity
Replacement of your existing policy	☐	☐	Pages **1, 2,** (**3** if Insured is juvenile), **4, 6** to **8** (sections 18 to 21), **10** (section 23), **14** to **21** (questions 33 to 51), **25** to **27**	• Signed Illustration and Supplement to the Insurance Application • Replacement form or LIRD • Order requirements(s) based on Age and amount chart • If Owner is an entity, complete (IP-LP1747) form	**YES** if replacing to TERM For UL, **YES** if paramedical is required **NO** if premium is $10K and over or owned by an entity
Change to Non-Smoker rates	☐	☐	Pages **1, 2, 4, 10** (section 24), **14** to **21** (questions 33 to 51), **25** to **27**	• Order Urine/HIV	**YES**
Reduce or remove a rating or change in risk classification	☐	☐	Pages **1, 2,** (**3** if Insured is juvenile), **4, 10** (section 25), **14** to **21** (questions 33 to 51), **25** to **27**	• For avocation and travel ratings, submit avocation or travel questionnaire (pages 13 to 18 not required)	**YES**
Reinstatement	☐	☐	Pages **1, 2,** (**3** if Insured is juvenile), **4, 6** to **8** (sections 18 to 21), **11** (section 26), **14** to **21** (questions 33 to 51), **25** to **27**	• Submit all back premiums to current date Note: All pages and sections must be answered and completed. Reinstatement cannot be approved with a delivery requirement.	**NO**
Change the Cost of Insurance	☐	☐	If Net amount at Risk increases, Pages **1, 2,** (**3** if Insured is juvenile), **4, 11** (section 27), **14** to **21** (questions 33 to 51), **25** to **27**	• Include administration fee of $150 for each Insured being underwritten	**NO**
Change the Death Benefit Option	☐	☐	If Net amount at Risk increases, Pages **1, 2,** (**3** if Insured is juvenile), **4, 11** (section 28), **14** to **21** (questions 33 to 51), **25** to **27**	• Include administration fee of $150 for each Insured being underwritten	**NO**
Addition of a rider/ coverage	☐	☐	Pages **1, 2,** (**3** if Insured is juvenile), **4, 6** to **8** (sections 18 to 21), **12** (sections 30 and 31), **14** to **21** (questions 33 to 51), **25** to **27** If adding children's insurance rider, complete page **23** (questions 52 to 60)	• Order requirement(s) based on Age and amount chart	**NO** **YES**, if paramedical is required
Decrease in Face Amount/Benefit	☐	☐	Complete Policy Service Application (PS339) – Sections 1, 2 and sign in Section 12		N/A
Cancellation of Rider or Coverage	☐	☐	Complete Policy Service Application (PS339) – Sections 1, 3 and sign in Section 12		N/A

Policy Change Application

Policy no. _____

TO BE COMPLETED IN ALL CASES

○ **EXISTING INSURED** ○ **NEW INSURED** (for term & critical illness protection only)

MAIN PURPOSE OF INSURANCE: **MANDATORY FOR UNIVERSAL LIFE POLICIES**

☐ Buy and sell ☐ Key person insurance ☐ Retirement planning ☐ Critical illness protection
☐ Estate planning ☐ Life protection ☐ Partnership ☐ Other _____

1 Insured 1 PLEASE PRINT IN BLOCK LETTERS

○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Other _____

First name	Middle initial	Last name

MANDATORY FOR UNIVERSAL LIFE POLICY

Identification document†	Identification document number†	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

† ***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB,PEI, ON and MB), driver's licence or Age of Majority.***

2 Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female Smoking class: ○ Smoker ○ Non-smoker

Country and province of birth: _____ Former/Maiden name: _____

SIN: _____ – _____ – _____ *(Complete only if you are the Owner and applying for a universal life policy)*

Driver's licence number: _____ Province: _____

3 Current address: *(Number and street name):*

_____ Apt./Suite: _____

City: _____ Province: _____ Postal code: _____

Home telephone: _____ Mobile telephone: _____ Business telephone: _____

4 I understand the language in which this application is written: ○ Yes ○ No If ***"no,"*** have the details of this application been fully explained to you in your preferred language and are they completely understood? ○ Yes ○ No

5 a) What is the Insured's residency status?

○ Canadian citizen
○ Landed immigrant/Permanent resident Number of years/months residing in Canada: _____ years _____ months
○ Contract worker *(provide copy of work permit)* Number of years/months residing in Canada: _____ years _____ months
○ Other *(current status)* Number of years/months residing in Canada: _____ years _____ months

Provide details: _____

b) Are you a resident for Canadian income tax purposes? ○ Yes ○ No

6 a) Is the Insured a student? ○ Yes ○ No If ***"yes"*** ○ Full time ○ Part time

b) Is the Insured currently employed? ○ Yes ○ No

If ***"no,"*** provide details: _____

c) Name of employer: _____ # of years: _____

Employer's address: _____

d) Occupation: _____ In what industry are you employed?* _____

Employer's address: _____

Duties: _____ Annual income: $ _____ (Canadian Income) Total net worth: $ _____ (Canadian net worth)

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

7 Insured 2 PLEASE PRINT IN BLOCK LETTERS

○ **EXISTING INSURED** ○ **NEW INSURED** (for term & critical illness protection only)

○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Other _____

First name	Middle initial	Last name

MANDATORY FOR UNIVERSAL LIFE POLICY

Identification document†	Identification document number†	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

† ***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.***

8 Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female Smoking class: ○ Smoker ○ Non-smoker

Country and province of birth: _____ Former/Maiden name: _____

SIN: _____ – _____ – _____ *(Complete only if you are the Owner and applying for a universal life policy)*

Driver's licence number: _____ Province: _____

9 Current address: *(Number and street name):*

_____ Apt./Suite: _____

City: _____ Province: _____ Postal code: _____

Home telephone: _____ Mobile telephone: _____ Business telephone: _____

10 I understand the language in which this application is written: ○ Yes ○ No If ***"no,"*** have the details of this application been fully explained to you in your preferred language and are they completely understood? ○ Yes ○ No

11 a) What is the Insured's residency status?

○ Canadian citizen

○ Landed immigrant/Permanent resident Number of years/months residing in Canada: _____ years _____ months

○ Contract worker *(provide copy of work permit)* Number of years/months residing in Canada: _____ years _____ months

○ Other *(current status)* Number of years/months residing in Canada: _____ years _____ months

Provide details: _____

b) Are you a resident for Canadian income tax purposes? ○ Yes ○ No

12 a) Is the Insured a student? ○ Yes ○ No If ***"yes,"*** ○ Full time ○ Part time

b) Is the Insured currently employed? ○ Yes ○ No

If ***"no,"*** provide details: _____

c) Name of employer: _____ # of years: _____

Employer's address: _____

d) Occupation: _____ In what industry are you employed?* _____

Employer's address: _____

Duties: _____ Annual income: $ _____ Total net worth: $ _____

Canadian Income Canadian net worth

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

Juvenile Insured – Additional information

JUVENILE INSURED IS LESS THAN 16 YEARS OF AGE

In addition to the Insured section (pages 1 and 2) complete the following sections for juveniles.

13 Juvenile Insured 1

If the Insured is less than 2 years old, was the child born prematurely? ..... ○ Yes ○ No

If ***"yes,"*** provide details: _____

_____

_____

Does this Insured live with the Owner? ..... ○ Yes ○ No

If ***"no,"*** who does this Insured live with? _____ Relationship: _____

Current year annual income of the parent or legal guardian: $ _____

Total amount of life and critical illness insurance on both parents or legal guardian:

Parent 1: Life $ _____ Parent 2: Life $ _____ Legal guardian: Life $ _____

CI $ _____ CI $ _____ CI $ _____

Does the Insured have any siblings? ..... ○ Yes ○ No

If ***"yes,"*** do the siblings have any life or critical illness insurance in force or pending? ..... ○ Yes ○ No

If ***"yes,"*** what is the amount of life or critical illness insurance on each sibling?

Sibling # 1: $ _____ Sibling # 2: $ _____

Sibling # 3: $ _____ Sibling # 4: $ _____

If ***"no,"*** provide details: _____

_____

_____

14 Juvenile Insured 2

If the Insured is less than 2 years old, was the child born prematurely? ..... ○ Yes ○ No

If ***"yes,"*** provide details: _____

_____

_____

Does this Insured live with the Owner? ..... ○ Yes ○ No

If ***"no,"*** who does this Insured live with? _____ Relationship: _____

Current year annual income of the parent or legal guardian: $ _____

Total amount of life and critical illness insurance on both parents or legal guardian:

Parent 1: Life $ _____ Parent 2: Life $ _____ Legal guardian: Life $ _____

CI $ _____ CI $ _____ CI $ _____

Does the Insured have any siblings? ..... ○ Yes ○ No

If ***"yes,"*** do the siblings have any life or critical illness insurance in force or pending? ..... ○ Yes ○ No

If ***"yes,"*** what is the amount of life or critical illness insurance on each sibling?

Sibling # 1: $ _____ Sibling # 2: $ _____

Sibling # 3: $ _____ Sibling # 4: $ _____

If ***"no,"*** provide details: _____

_____

_____

15 Current Owner THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNERS

The current Owner(s) must sign the Declaration on page 25.

Note: To designate a beneficiary, or to change a current beneficiary designation, complete the *Change of Beneficiary* form (PS367). To change the Owner complete the *Notice of Transfer of Ownership* form (PS371).

a) **Select the Policy Owner(s) below:**

☐ Insured 1 – only complete question 15 b) when applying for Universal Life

☐ Insured 2 – only complete question 15 b) when applying for Universal Life

☐ Owners as identified below:

- Individual(s) other than Insured(s) – must complete Owner section below and question 15 b) when applying for Universal Life
- Corporation, non-corporate entity or trust – must complete Owner section below and when applying for Universal Life the *Policy Ownership for Corporate & Non-corporate Entities or Trusts* form (IP-LP1747)

OWNER 1 Legal name (First, middle initial, last and/or legal company/entity name)

Date of birth (DD/MM/YYYY)	Relationship to Insured	SIN (Complete only if you are applying for a universal life policy) – –
Occupation	In what industry are you employed?*	
Current address (Number and street name)		Apt./Suite
City	Province	Postal code
Home phone number	Mobile phone number	Business phone number
Identification document†	Identification document number†	Document expiry date (MM/YYYY) / Issuing jurisdiction and country

† ***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.***

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ Yes ○ No

If ***"no,"*** provide details of current status: _____

OWNER 2 Legal name (First, middle initial, last and/or legal company/entity name)

Date of birth (DD/MM/YYYY)	Relationship to Insured	SIN (Complete only if you are applying for a universal life policy) – –
Occupation	In what industry are you employed?*	
Current address (Number and street name)		Apt./Suite
City	Province	Postal code
Home phone number	Mobile phone number	Business phone number
Identification document†	Identification document number†	Document expiry date (MM/YYYY) / Issuing jurisdiction and country

† ***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.***

*For a list of valid industries refer to https://ivari.ca/tools-and-resources/administration/ and search for form number (IP-LP1971).

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ Yes ○ No

If ***"no,"*** provide details of current status: _____

b) **Declaration of tax residency**

Instructions:
- Must be completed by the Policy Owner(s) when applying for a Universal Life policy
- If the Insured(s) is/are the Owner(s); in completing the table below, the Insured 1 is considered Owner 1 and Insured 2 is considered Owner 2.

MANDATORY FOR UNIVERSAL LIFE POLICIES

Declaration of tax residency

	OWNER 1 YES	OWNER 1 NO	OWNER 2 YES	OWNER 2 NO
Please answer the following three statements. Depending on your situation, you may answer ***"yes"*** to more than one.				
a) **I am a tax resident of Canada.**	○	○	○	○
b) **I am a tax resident or a citizen of the United States.**	○	○	○	○
Please provide your taxpayer identification number (TIN) from the United States: **Owner 1** _____ **Owner 2** _____				
If you do not have a TIN from the United States, have you applied for one?	○	○	○	○
c) **I am a tax resident in a country other than Canada or the United States.**	○	○	○	○

If ***"yes,"*** to statement c), provide your country of tax residence and taxpayer identification numbers (TIN). If you do not have a TIN for a specific country, give the reason using one of these choices:

Reason 1: I will apply or have applied for a TIN but have not yet received it.

Reason 2: My country of residence does not issue TINs to its residents.

Reason 3: Other reason, provide details.

	COUNTRY OF TAX RESIDENCE	TAXPAYER IDENTIFICATION NUMBER (TIN)	IF NO TIN, PROVIDE REASON 1, 2 OR 3
OWNER 1			

	COUNTRY OF TAX RESIDENCE	TAXPAYER IDENTIFICATION NUMBER (TIN)	IF NO TIN, PROVIDE REASON 1, 2 OR 3
OWNER 2			

16 Policy Owner's consent to receive emails

Canada's anti-spam legislation regulates the distribution of email messages to consumers. To comply with this law, *ivari* is required to obtain your consent for the purposes of sending you email messages regarding policy information, product information and marketing material.

By providing your email address below, you consent to receiving email messages as outlined above from *ivari*.

Owner 1 email address: _____

Owner 2 email address: _____

You may withdraw your consent at any time by contacting us at *ivari*:

500-5000 Yonge Street, Toronto, ON M2N 7J8. Telephone: 1-800-846-5970 or Fax: 416-883-5520 or 1-877-767-0477

17 Politically Exposed Persons and Head of International Organization **MANDATORY FOR UNIVERSAL LIFE POLICIES**

Is a premium and/or lump sum payment equal to or greater than $100,000 being made or to be made? ..... ○Yes ○No

If the answer is ***"yes"***, each Owner must complete the *Politically Exposed Persons and Head of International Organization* form (IP-LP1165) and submit it along with the application.

Insurance history

COMPLETE THE INSURANCE HISTORY SECTION FOR THE FOLLOWING CHANGES: ADDITIONS, REPLACEMENTS, REINSTATEMENTS AND CONVERSIONS WITH UNDERWRITING.

			INSURED 1		INSURED 2	
			YES	NO	YES	NO
18	a)	Has any application, reinstatement, modification for life, critical illness, long term care or disability insurance ever been rated, declined, postponed, cancelled, rescinded or modified in any way?	○	○	○	○
	b) i)	Is this Insurance intended to replace, or will it cause a change, in any existing Life or Critical Illness insurance? If ***"yes",*** for Life, attach completed Replacement/Comparison Disclosure forms, LIRD (where applicable).	○	○	○	○
	ii)	Will the insurance applied for in this application replace an existing *ivari* policy/coverage? If ***"yes",*** provide policy number: **INSURED 1:** ______________ **INSURED 2:** ______________	○	○	○	○
	iii)	Does the Owner instruct *ivari* to cancel the above stated policy/coverage only when the new policy/coverage being applied for is in force? (To ensure continuous coverage the premium under the existing policy/coverage is required until this new policy/coverage is in force. Failure to do so will result in a lapse/termination of insurance coverage resulting in the inability to offer a reinstatement.) **Note:** Only the Policy Owner of the above stated policy has the right to cancel the existing policy/coverage. If there is a change in ownership, you must submit a Transfer of Ownership signed by the original Owners of the policy being replaced.	○	○	○	○
	c)	Do you have any of the following insurance in force or pending: life insurance, critical illness, disability, long term care with *ivari* or any other company? If ***"yes",*** complete the table in question 19.	○	○	○	○

If ***"yes",*** to questions 18 a), b) or c), provide additional information in the **remarks section**.

19 Insurance in force

INSURED 1	INSURED 2	COMPANY	AMOUNT OF INSURANCE	TYPE OF INSURANCE PLAN				PERSONAL/ BUSINESS		ISSUE YEAR	REPLACING	IN FORCE	PENDING
				LIFE	CI	DI	LTC	P	B				
○	○		$	○	○	○	○	○	○		☐	○	○
○	○		$	○	○	○	○	○	○		☐	○	○
○	○		$	○	○	○	○	○	○		☐	○	○
○	○		$	○	○	○	○	○	○		☐	○	○
○	○		$	○	○	○	○	○	○		☐	○	○
○	○		$	○	○	○	○	○	○		☐	○	○

REMARKS – Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

QUESTION #	INSURED #	DETAILS

Financial information

20 Personal Insurance

Complete this section when the insurance coverage applied is over $500,000 for life and $150,000 for critical illness.

CURRENT DEBT

CANADIAN FINANCIAL DETAILS	INSURED 1	INSURED 2	WHERE THE OWNER IS NOT THE INSURED
Mortgage: (Amount owing to the financial institution)	$	$	$
Personal Loan: (Amount owing to the bank)	$	$	$
Car Loan: (Amount owing to the bank)	$	$	$
Line of Credit: (Amount owing to the bank)	$	$	$
Funeral Expense: (should not be more than $35,000)	$	$	$
Other Expenses: _____	$	$	$

CURRENT CANADIAN ASSETS

CANADIAN FINANCIAL DETAILS	INSURED 1	INSURED 2	WHERE THE OWNER IS NOT THE INSURED
Cash and savings on hand	$	$	$
Non-registered savings	$	$	$
Registered savings	$	$	$
TFSA (Tax-free savings account)	$	$	$
Other investments: _____	$	$	$

INCOME

CANADIAN FINANCIAL DETAILS	INSURED 1	INSURED 2	WHERE THE OWNER IS NOT THE INSURED
Current Canadian Annual Income	$	$	$

IMPORTANT: If the coverage applied for exceeds the allowable on any section suggested, information/explanation is required in the details section with a copy of tangible proof of income/assets/investments.

PLANNED PREMIUM PAYMENT (JUSTIFICATION)

CANADIAN FINANCIAL DETAILS	INSURED 1	INSURED 2	WHERE THE OWNER IS NOT THE INSURED
Total Annual planned premium per the illustration	$	$	$
Calculation of percentage of premium deposit vs income declared **Formula:** Annual planned premium ÷ income Should not be more than following %: • If income between $10,000 to $20,000, should not be more than 7% • If income between $21,000 to $40,000, should not be more than 15% • If income > $41,000, should not be more than 20%	$	$	$

FUTURE NEEDS

CANADIAN FINANCIAL DETAILS	INSURED 1	INSURED 2	WHERE THE OWNER IS NOT THE INSURED
Emergency Funds (should not be more than 6 months of annual income)	$	$	$
Current Child Care Expenses (According to CRA maximum $19,000/year)	$	$	$
Education Fund **Formula:** Annual amount x Years x Numbers of Children Estimate per child $5,000/year if living at home and $12,000/ year if away from home	$	$	$
Other future needs: _____	$	$	$

21 Business Insurance

This section must be completed for all business insurance purpose, or when the Owner or Beneficiary is a corporation, a non-corporate entity or a Trust.

a) Name of business: _____

b) Nature of the business: _____

c) Financial details:

Assets of the Entity: $ _____ Liabilities/expense of the Entity: $ _____

Revenue of the Entity: $ _____ Net worth of the Entity: $ _____

Fair market value of the Entity: $ _____ What is the book value of the Entity: $ _____

d) Percentage of ownership held by the Insured:

INSURED 1 _____ **%** **INSURED 2** _____ **%**

e) Percentage of ownership held by the Policy Owner or Beneficiary.

Details: _____

f) Are there other partners, owners and executives? If yes provide their full name, role in the Entity and are they being insured?

_____

g) Insurance of other partners of the business:

NAME/TITLE/OCCUPATION	LIFE INSURANCE		CRITICAL ILLNESS INSURANCE		% OF BUSINESS OWNERSHIP
	IN FORCE	PENDING	IN FORCE	PENDING	
	$	$	$	$	
	$	$	$	$	
	$	$	$	$	

Financial statement: ○ enclosed ○ to follow Letter of explanation: ○ enclosed ○ to follow

Additional comments: _____

It is understood and agreed that we may require, in addition to the completion of the Health history section of this application, any other evidence of insurability as we may deem necessary before approving the requested change.

Note: A conversion/replacement will be effective on the policy's monthly anniversary date closest to the date the policy/coverage was approved.

22 Conversion with a ○ Class of risk change or ○ Increase in insurance coverage

Complete this section and questions 18 to 21 and 33 to 51 if the Insured is 16 years of age or greater. If the Insured is less than 16 years of age, complete this section as well as questions 18 to 21 and 37 to 51. All lives insured under a Joint Last-to-Die coverage must also complete these requirements. **Note:** For universal life policies, submit a signed Illustration and *Supplement to the Insurance Application.*

NOTE ON BENEFICIARY DESIGNATIONS:

For Life and Critical Insurance policies: The beneficiary on your current policy will be carried over to the new policy unless a *Change of Beneficiary* form (PS367) is submitted.

For Critical Illness Protection Riders converting to a Critical Illness Protection policy: If you named a specific beneficiary on your original Critical Illness Rider, it will be carried over to the new policy only if the legislation in your province allows you to name a beneficiary. Otherwise, the Critical Illness Benefit and Early Detection Benefit Beneficiary for the new policy will be the Insured. If the Insured is a minor, the beneficiary will be the Owner, if living, or the Owner's estate, if deceased. Return of Premium on Death proceeds on the new policy will be payable to the Owner, if living, or the Owner's estate, if deceased.

NOTE ON CHANGE OF OWNERSHIP: If there is a change in ownership, you must submit a *Notice of Transfer of Ownership for Insurance Products* form (PS371) signed by the original Owner(s) and the new Owner(s) otherwise the original Owner(s) will be carried over to the new policy.

INSURED 1 Current plan to be converted	Current Face amount/benefit	New Face amount/benefit	New plan name
☐ Base plan	$ _____	$ _____	_____
☐ Additional rider/coverage	$ _____	$ _____	_____
INSURED 2 Current plan to be converted	Current Face amount/benefit	New Face amount/benefit	New plan name
☐ Base plan	$ _____	$ _____	_____
☐ Additional rider/coverage	$ _____	$ _____	_____

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
a) If the above indicated face amount/benefit to be converted is less than the current face amount/benefit, is the amount remaining under the current policy to be terminated?	○	○	○	○
If ***"yes,"*** balance will be terminated on the date the new policy becomes effective. If ***"no,"*** what amount will remain in force under the current policy? $ _____ (Must meet current plan minimum)				
b) If you are less than 55 years of age, do you wish to carry over any of the following riders to the new policy (if applicable):				
Accidental Death & Dismemberment (AD&D)	○	○	○	○
Waiver of Premium	○	○	○	○
If ***"yes,"*** are you able to perform all the duties of your normal occupation?	○	○	○	○
(**Note:** Accidental Death Benefit (ADB) riders cannot be carried over).				
c) If you are less than 65 years of age, do you wish to carry over the Children's Insurance Rider to the new policy (if applicable)?	○	○	○	○

Premium quoted: $ _____ Initial premium/deposit: $ _____

Mode of premium/deposit details:

○ Annually ○ Semi-annually ○ Quarterly ○ Monthly PAD ○ Quarterly PAD ○ Semi-annual PAD ○ Annual PAD

Provide source of premium/deposit (where is the premium/deposit coming from?): _____

23 Replacement

Complete this section and questions 18 to 21 and 33 to 51 if the Insured is 16 years of age or greater. If the Insured is less than 16 years of age, complete this section as well as questions 18 to 21 and 37 to 51. All lives insured under a Joint Last-to-Die coverage must also complete these requirements. **Note:** For universal life policies, submit a signed Illustration and *Supplement to the Insurance Application*.

NOTE ON BENEFICIARY DESIGNATIONS: The beneficiary on your current policy will be carried over to the new policy unless a *Change of Beneficiary* form (PS367) is submitted.

NOTE ON CHANGE OF OWNERSHIP: If there is a change in ownership, you must submit a *Notice of Transfer of Ownership* form (PS371) signed by the original Owner(s) and the new Owner(s) otherwise the original Owner(s) will be carried over to the new policy.

Please attach a completed Life Insurance Replacement Declaration (LIRD) or Replacement/Comparison Disclosure form(s).

Current policy number: _____ New policy number: _____

INSURED 1

Current plan name being replaced: _____ New plan name: _____

Current face amount/benefit: $ _____ New face amount/benefit: $ _____

INSURED 2

Current plan name being replaced: _____ New plan name: _____

Current face amount/benefit: $ _____ New face amount/benefit: $ _____

Additional rider(s)/Coverage(s): _____ Amount: $ _____

MODE OF PAYMENT Initial premium/deposit of: $ _____

Pre-Authorized Debit: ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

If PAD is requested, please complete a new *Pre-Authorized Debit (PAD) for Insurance Products* form *(PS375)* and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction.

Preferred date of withdrawal (days 1-28 only) _____

Direct billing: ○ Quarterly ○ Semi-annually ○ Annually

For universal life policies: Provide source of premium/deposit (where is the premium coming from?): _____

24 Change to Non-smoker

Complete this section and questions 33 to 51. **Order a urine/HIV specimen.**
All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

○ **INSURED 1** ○ **INSURED 2**

Please indicate all policies you wish to change.

Policy number(s): _____ , _____ , _____ , _____

If universal life plan: Will the planned periodic premium/deposit change? . . . . . ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit* $ _____ *Note: Must meet plan minimum premium.

Policy number(s): _____ , _____ , _____ , _____

25 Reduce or remove rating or change in risk classification

○ For Lifestyle (avocation and travel) ratings reconsideration on ***Life coverages***, complete this section and submit the appropriate avocation or travel questionnaire.

○ For all other ratings reconsideration or change in risk classification, complete this section and questions 33 to 51.
All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

○ **INSURED 1** ○ **INSURED 2**

Please indicate all policies you wish to change.

Policy number(s): _____ , _____ , _____ , _____

If universal life plan: Will the planned periodic premium/deposit change? . . . . . ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit* $ _____ *Note: Must meet plan minimum premium.

Policy number(s): _____ , _____ , _____ , _____

26 Reinstatement

Complete this section and questions 18 to 21 and 33 to 51 if the Insured is 16 years of age or greater. If the Insured is less than 16 years of age, complete questions 18 to 21 and 37 to 51. Reinstatement process cannot be started unless ALL questions are answered.

Lapsed policy number: _____

Reinstate the policy in accordance with its provisions. Back premiums to current date of $ _____ to be paid by:

○ Cheque made payable to *ivari* attached

or

○ Withdrawal from bank account upon approval of reinstatement (Complete *Pre-Authorized Debit (PAD) for Insurance Products* form (PS375), see below for additional instructions for pre-authorized debit)

Note: *ivari* may deposit any payment without prejudice to its right to decline to reinstate the policy.

MODE OF PAYMENT

Pre-Authorized Debit: ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

If PAD is requested, please complete a new *Pre-Authorized Debit (PAD) for Insurance Products* form (PS375) and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction.

Preferred date of withdrawal (days 1-28 only) _____

Direct billing: ○ Quarterly ○ Semi-annually ○ Annually

For universal life policies: Provide source of premium/deposit (where is the premium coming from?): _____

27 Change of Cost of Insurance

Underwriting is required if the Net Amount At Risk increases as a result of a change in the Cost of Insurance. If underwriting is required, **please submit the applicable administration fee** and complete: questions 33 to 51 if the Insured is 16 years of age or greater; or questions 37 to 51 if the Insured is less than 16 years of age. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Current policy number: _____

Please specify Cost of Insurance change: _____

_____

28 Change of Death Benefit Option

Underwriting is required if the Net Amount At Risk increases as a result of a change in the Death Benefit option. If underwriting is required, **please submit the applicable administration fee** and complete: questions 33 to 51 if the Insured is 16 years of age or greater; or questions 37 to 51 if the Insured is less than 16 years of age. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Current policy number: _____ ○ Increasing to level ○ Level to increasing

29 Addition of rider/Coverage on

Indicate only one answer – either existing or new:

◯ Existing Insured(s) or ◯ New Insured(s) for Term insurance and Critical Illness Protection Policies only

◯ Insured 1 ◯ Insured 2 ◯ Insured 1 ◯ Insured 2

Specify coverage/rider details by completing section 30 and/or section 31. If the Insured is 16 years of age or greater also complete questions 18 to 21 and 33 to 51. If the Insured is less than 16 years of age, complete questions 18 to 21 and 37 to 51. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

30 Insurance applied for Insured 1

☐ **UNIVERSAL LIFE COVERAGE** Current policy number: _____

Coverage amount (indicate additional coverage amount only): $ _____

For conversions and replacements to a universal life policy, submit a signed Illustration including the *Supplement to the Insurance Application*.

Will the planned periodic premium/deposit change? ..... ◯ Yes ◯ No

If ***"yes,"*** new planned periodic premium/deposit***** $ _____ *****Note: Must meet plan minimum premium.

☐ **TERM LIFE COVERAGE**

Term riders	Face amount†	**Additional benefit**
☐ 10 Year Rider	$ _____	☐ Children's Insurance Rider
☐ 20 Year Rider	$ _____	If applying for a Children's Insurance rider complete questions 52 to 60 on page 23. For the base insured (parent) also complete questions 33 to 51.
☐ 30 Year Rider (Available only on a Term 30 policy)	$ _____	
☐ Other _____	$ _____	

Critical Illness Protection Rider***

	Benefit†		Benefit†
☐ Term 10 CI – 4 conditions	$ _____	☐ Term 10 CI – 25 conditions	$ _____
☐ Term 20 CI – 4 conditions	$ _____	☐ Term 20 CI – 25 conditions	$ _____
☐ Term to age 65 CI – 4 conditions	$ _____	☐ Term to age 65 CI – 25 conditions	$ _____

*****The Critical Illness Benefit applied for cannot exceed the total life insurance face amount applied for and may only be added to eligible products when applying for a life coverage.**

☐ **CRITICAL ILLNESS PROTECTION** Current policy number: _____

Additional coverage	Benefit†		Benefit†
☐ Term 10 CI – 4 conditions	$ _____	☐ Term 10 CI – 25 conditions	$ _____
☐ Term 20 CI – 4 conditions	$ _____	☐ Term 20 CI – 25 conditions	$ _____
☐ Term to age 65 CI – 4 conditions	$ _____	☐ Term to age 65 CI – 25 conditions	$ _____

Early Detection Benefit and Childhood Critical Illness Covered Conditions are only available with the 25 conditions critical illness protection products.

†Amount shown is the additional coverage/benefit being requested, not the total insured amount.

Note on beneficiary designations: For critical illness, the Critical Illness Benefit and Early Detection Benefit Beneficiary will be the Insured. If the Insured is a minor, the beneficiary will be the Owner, if living, or the Owner's estate, if deceased.

Return of Premium on Death proceeds will be payable to the Owner, if living, or the Owner's estate, if deceased. If you wish to designate other beneficiaries for critical illness, complete the *Change of Beneficiary* form (PS367).

31 Insurance applied for Insured 2

☐ **UNIVERSAL LIFE COVERAGE** Current policy number: _____

Coverage amount (indicate additional coverage amount only): $ _____

For conversions and replacements to a universal life policy, submit a signed Illustration including the *Supplement to the Insurance Application*.

Will the planned periodic premium/deposit change? ..... ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit***** $ _____ *****Note: Must meet plan minimum premium.

☐ **TERM LIFE COVERAGE**

Term riders	Face amount†	**Additional benefit**
☐ 10 Year Rider	$ _____	☐ Children's Insurance Rider
☐ 20 Year Rider	$ _____	If applying for a Children's Insurance rider complete questions 52 to 60 on page 23. For the base insured (parent) also complete questions 33 to 51.
☐ 30 Year Rider (Available only on a Term 30 policy)	$ _____	
☐ Other _____	$ _____	

Critical Illness Protection Rider***

	Benefit†		Benefit†
☐ Term 10 CI – 4 conditions	$ _____	☐ Term 10 CI – 25 conditions	$ _____
☐ Term 20 CI – 4 conditions	$ _____	☐ Term 20 CI – 25 conditions	$ _____
☐ Term to age 65 CI – 4 conditions	$ _____	☐ Term to age 65 CI – 25 conditions	$ _____

*****The Critical Illness Benefit applied for cannot exceed the total life insurance face amount applied for and may only be added to eligible products when applying for a Life Coverage.**

☐ **CRITICAL ILLNESS PROTECTION** Current policy number: _____

Additional coverage	Benefit†		Benefit†
☐ Term 10 CI – 4 conditions	$ _____	☐ Term 10 CI – 25 conditions	$ _____
☐ Term 20 CI – 4 conditions	$ _____	☐ Term 20 CI – 25 conditions	$ _____
☐ Term to age 65 CI – 4 conditions	$ _____	☐ Term to age 65 CI – 25 conditions	$ _____

Early Detection Benefit and Childhood Critical Illness Covered Conditions are only available with the 25 conditions critical illness protection products.

†Amount shown is the additional coverage/benefit being requested, not the total insured amount.

Note on Beneficiary Designations: For Critical Illness, the Critical Illness Benefit and Early Detection Benefit Beneficiary will be the Insured. If the Insured is a minor, the beneficiary will be the Owner, if living, or the Owner's estate, if deceased.

Return of Premium on Death proceeds will be payable to the Owner, if living, or the Owner's estate, if deceased. If you wish to designate other beneficiaries for Critical Illness, complete the *Change of Beneficiary* form (PS367).

32 Other changes or remarks

Current policy number: _____

Personal history

INSTRUCTIONS ***For Insureds 16 years of age or greater, complete questions 33 to 36 and proceed to next page.***

33 Have you smoked or used any of the products listed in the table below:

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
a) In the last 12 months?	○	○	○	○
b) In the last 24 months?	○	○	○	○

If ***"yes"*** to a) or b), complete the table below.

INSURED 1

PRODUCTS	QUANTITY	FREQUENCY
Cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts		○ day ○ week ○ month ○ year ○ single use
Traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe		○ day ○ week ○ month ○ year ○ single use
Pipe, chewing tobacco		○ day ○ week ○ month ○ year ○ single use
Any other smoking cessation products, or used tobacco in any other form		○ day ○ week ○ month ○ year ○ single use

INSURED 2

PRODUCTS	QUANTITY	FREQUENCY
Cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts		○ day ○ week ○ month ○ year ○ single use
Traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe		○ day ○ week ○ month ○ year ○ single use
Pipe, chewing tobacco		○ day ○ week ○ month ○ year ○ single use
Any other smoking cessation products, or used tobacco in any other form		○ day ○ week ○ month ○ year ○ single use

34 Do you use marijuana or cannabis/cannabinoids products?

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
	○	○	○	○

If ***"yes"***, on average, what is the quantity you typically consume (complete table below).

INSURED 1

FREQUENCY	GRAMS OR JOINTS		OTHER
○ Daily			
○ Weekly			
○ Monthly			
○ Average in 1 year			
○ Single used			
○ Never used			

Is marijuana or cannabis/cannabinoids use prescribed by a doctor? ○ Yes ○ No

If ***"yes"***, for which medical condition?

INSURED 2

FREQUENCY	GRAMS OR JOINTS		OTHER
○ Daily			
○ Weekly			
○ Monthly			
○ Average in 1 year			
○ Single used			
○ Never used			

Is marijuana or cannabis/cannabinoids use prescribed by a doctor? ○ Yes ○ No

If ***"yes"***, for which medical condition?

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
35 Have you ever used any drugs, other than cannabis (marijuana)? If ***"yes"*** complete the table below.	○	○	○	○

INSURED 1

TYPE	USED ON A REGULAR BASIS	USED ONCE OR MORE WITHIN LAST 2 YRS.	USED ONCE OR MORE WITHIN LAST 3-5 YRS.	USED ONCE OR MORE WITHIN LAST 5-10 YRS.	USED ONCE OR MORE OVER 10 YRS.
Amphetamines (ecstasy, speed)	○	○	○	○	○
Cocaine	○	○	○	○	○
Hallucinogens (acid, LSD)	○	○	○	○	○
Opiates (heroin, morphine)	○	○	○	○	○
Anabolic steroids	○	○	○	○	○
Other:	○	○	○	○	○

Did you receive treatment for this? ○ Yes ○ No If ***"yes"*** Date and Duration of treatment: _____

INSURED 2

TYPE	USED ON A REGULAR BASIS	USED ONCE OR MORE WITHIN LAST 2 YRS.	USED ONCE OR MORE WITHIN LAST 3-5 YRS.	USED ONCE OR MORE WITHIN LAST 5-10 YRS.	USED ONCE OR MORE OVER 10 YRS.
Amphetamines (ecstasy, speed)	○	○	○	○	○
Cocaine	○	○	○	○	○
Hallucinogens (acid, LSD)	○	○	○	○	○
Opiates (heroin, morphine)	○	○	○	○	○
Anabolic steroids	○	○	○	○	○
Other:					

Did you receive treatment for this? ○ Yes ○ No If ***"yes"*** Date and Duration of treatment: _____

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
36 Do you drink alcohol? If ***"yes"*** complete the table below.	○	○	○	○

INSURED 1

On average, how many alcoholic drinks do you typically consume per week?

TYPE	OVER 50	43–49	36–42	29–35	22–28	15–21	8–14	1–7
Beer	○	○	○	○	○	○	○	○
Wine	○	○	○	○	○	○	○	○
Liquor	○	○	○	○	○	○	○	○

How many units of alcohol do you typically consume per sitting: _____

Have you ever received or been advised to receive, counselling or treatment for alcohol? . . . . . ○ Yes ○ No

If ***"yes"*** select all that apply: ☐ Have been advised to reduce consumption or to seek counseling
☐ Sought advise / counseling ☐ Received treatment / counseling

INSURED 2

On average, how many alcoholic drinks do you typically consume per week?

TYPE	OVER 50	43–49	36–42	29–35	22–28	15–21	8–14	1–7
Beer	○	○	○	○	○	○	○	○
Wine	○	○	○	○	○	○	○	○
Liquor	○	○	○	○	○	○	○	○

How many units of alcohol do you typically consume per sitting: _____

Have you ever received or been advised to receive, counselling or treatment for alcohol? . . . . . ○ Yes ○ No

If ***"yes"*** select all that apply: ☐ Have been advised to reduce consumption or to seek counseling
☐ Sought advise / counseling ☐ Received treatment / counseling

Personal history

INSTRUCTIONS ***Complete questions 37 and 38 for Insureds of all ages.***
If a Child Rider Benefit is requested, complete the Children's Insurance Rider section questions 52 to 60.

TRAVEL

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
37 With the exception of travelling 6 months or less per year within North America, the Caribbean or European Union countries, do you have any plans to travel or reside outside of Canada in the next 12 months?	○	○	○	○

If ***"yes"***, provide details: countries, cities, purpose of travel, length of stay and expected number of trips per year.

If you require more space, please use the Remarks section or complete the *Foreign Travel Questionnaire* (UW-FTQ399).

INSURED 1

CITY AND COUNTRY	PURPOSE OF TRAVEL	LENGTH OF STAY	# OF TIMES PER YEAR

INSURED 2

CITY AND COUNTRY	PURPOSE OF TRAVEL	LENGTH OF STAY	# OF TIMES PER YEAR

LIFESTYLE AND AVOCATION

	INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
38 a) Are you using a wearable fitness tracker to track calories burned, steps taken, heart rate measured, hours slept, etc.?	○	○	○	○
b) In the last 12 months, have you piloted an aircraft other than with a commercial/major airline carrier or do you intend to do so in the next 12 months? If ***"yes"***, complete the *Aviation Questionnaire* (UW-AVIQ312).	○	○	○	○
c) In the last 12 months, have you engaged in any hazardous or extreme sports (including, but not limited to, mixed martial arts, combat sports, ski jumping, bungee jumping, base jumping, motorized vehicle racing, cliff diving, scuba diving, sky diving, parachuting, sky surfing, hang-gliding and mountain climbing, out of bound snowmobiling, out of bound skiing), or do you intend to do so in the next 12 months? If ***"yes"***, complete the appropriate questionnaire	○	○	○	○

Questions 38 d) to g) are not applicable to a juvenile (Insureds less than 16 years of age).

d) In the last 10 years, have you had your driver's licence suspended or revoked?	○	○	○	○
e) In the last 2 years, have you refused to provide a breathalyzer sample, and/or have you had 2 or more highway traffic violations?	○	○	○	○

If ***"yes"***, to question d) & e) provide driver's licence number and provide reason(s), date(s), and type of offence.

_____

_____

f) In the last 10 years, have you been convicted of any criminal offence or fraudulent financial charges or do you have any charges pending? If ***"yes"***, provide reasons(s), date(s), type(s) of offence(s)	○	○	○	○

_____

_____

g) In the last 5 years, have you filed for bankruptcy and not received a discharge, or are you currently involved in a bankruptcy proceeding? If ***"yes"***, provide details	○	○	○	○

_____

_____

Health history INSUREDS OF ALL AGES

INSTRUCTIONS ***When answering the health questions on this form, DO NOT provide information about any genetic tests you have taken or plan to take. A genetic test is a type of medical test which analyses DNA, RNA or chromosomes. You must however, provide information about all other types of medical tests. ENSURE you answer all questions truthfully and as described in the Notice of Disclosures.***

INSURED 1

39 Name of the Insured: _____

Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Weight change in last 12 months:

☐ None, **or** Loss: _____ Gain: _____

Reason for weight change: _____

_____

40 Do you have a family doctor? . . . . . ○ Yes ○ No

If ***"yes"***, give the name of the doctor and the name of the clinic.

Name of Doctor/clinic: _____

Date of last visit: (DD/MM/YYYY) _____

Address: _____

Phone: _____

Reason for visit: _____

_____

INSURED 2

41 Name of the Insured: _____

Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Weight change in last 12 months:

☐ None, **or** Loss: _____ Gain: _____

Reason for weight change: _____

_____

42 Do you have a family doctor? . . . . . ○ Yes ○ No

If ***"yes"***, give the name of the doctor and the name of the clinic.

Name of Doctor/clinic: _____

Date of last visit: (DD/MM/YYYY) _____

Address: _____

Phone: _____

Reason for visit: _____

_____

Health history **INSUREDS OF ALL AGES**

INSTRUCTIONS ***For Insureds of all ages complete questions 43–51 except if a paramedical or telephone interview is required.***

○ **INSURED 1**

43 Have you ever had, or ever been told you had, or received treatment or advice for:

a) **Heart and circulatory system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Heart ☐ Blood vessels ☐ Chest pain ☐ Shortness of breath ☐ Transient Ischemic Attack (TIA) ☐ Irregular pulse
☐ Murmur ☐ High blood pressure ☐ Heart attack ☐ Stroke ☐ Peripheral vascular disease ☐ Rheumatic Fever
☐ Aneurysm ☐ Poor circulation ☐ Abnormal ECG ☐ Bypass ☐ Congenital heart disorder ☐ High cholesterol levels
☐ Angioplasty ☐ Arteriosclerosis ☐ Palpitations ☐ Blood clot ☐ Angina
☐ Any other disease or disorder of the blood vessels, the heart, congenital heart disorder or circulatory system

b) **Eyes, ears, nose, throat, lungs, respiratory system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Lungs ☐ Nose ☐ Throat ☐ Shortness of breath ☐ Persistent cough ☐ Hoarseness ☐ Blood spitting
☐ Chronic bronchitis ☐ Emphysema ☐ Asthma ☐ Tuberculosis ☐ Chronic obstructive pulmonary disease ☐ Sleep apnea ☐ Sarcoidosis
☐ Blindness ☐ Optic neuritis ☐ Other visual disturbance ☐ Deafness ☐ Persistent fever
☐ Any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system

c) **Gastrointestinal system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Digestive organs ☐ Ulcer ☐ Bleeding ☐ Recurrent indigestion ☐ Celiac disease
☐ Ulcerative colitis ☐ Colitis ☐ Crohn's disease ☐ Hepatitis ☐ Hepatitis carrier
☐ Jaundice ☐ Cirrhosis of the liver ☐ Gastrointestinal problem ☐ Persistent or chronic diarrhea ☐ Inflammatory bowel disease
☐ Any other disease or disorder of the mouth, esophagus, stomach, liver, pancreas, intestines or rectum

d) **Kidney, bladder and reproductive organs:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Kidney ☐ Bladder ☐ Prostate ☐ Genital organs ☐ Urinary organs
☐ Nephritis ☐ Abnormal pap ☐ Sexually transmitted disease ☐ Abnormal sugar level ☐ Abnormal protein levels
☐ Blood in the urine ☐ Abnormality in the urine ☐ Elevated Prostate Specific Antigen (PSA) ☐ Any other disease or disorder

e) **Nervous system and brain:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Chronic headaches ☐ Epilepsy ☐ Dizziness ☐ Chronic fatigue ☐ Motor neuron disease ☐ Muscular dystrophy
☐ Memory loss ☐ Alzheimer disease ☐ Paralysis ☐ Loss of sensation ☐ Loss of balance ☐ Hereditary disorder
☐ Weakness of the extremities ☐ Numbness or tingling ☐ Neuritis ☐ Neuropathy ☐ Multiple sclerosis ☐ Any congenital abnormality
☐ Parkinson's disease ☐ Meningitis ☐ Coma ☐ Cerebral palsy ☐ Down syndrome
☐ Head or brain injuries ☐ Loss of consciousness ☐ Loss of speech ☐ Seizure ☐ Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)
☐ Any other disease or disorder of the brain or nervous system

f) **Blood, glandular and endocrine system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Anemia ☐ Enlarged glands ☐ Diabetes ☐ Abnormal blood sugar ☐ Hormone disorders
☐ Thyroid ☐ Adrenal disorder ☐ Pituitary gland disorder ☐ Tumour ☐ Breast disorder
☐ Abnormal mammogram ☐ Abnormal ultrasound ☐ Biopsy of the breast ☐ Persistent anemia ☐ Hemophilia
☐ Disorder of the endocrine system ☐ Any other disease or disorder of the glands or the blood

g) **Nervous, mental or mood disorder:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Anxiety ☐ Stress ☐ Burnout ☐ Depression ☐ Bipolar disorder
☐ Schizophrenia ☐ Suicide attempt ☐ Suicide ideation disorder ☐ Behavioural disorder ☐ Eating disorder
☐ Emotional disorder ☐ Cognitive impairment ☐ Developmental handicap ☐ Attention deficit disorder (ADD) ☐ Autism
☐ Any other psychological, psychiatric disease or disorder

h) **Back, muscles and bones:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Arthritis ☐ Fibromyalgia ☐ Repetitive strain injury ☐ Osteoarthritis
☐ Paralysis ☐ Deformity ☐ Rheumatoid arthritis ☐ Other conditions causing limited motion
☐ Any other disease or disorder of the back, muscles, bones, joints, limbs, spine, other conditions causing limited motion or requiring adaptive devices

i) **Immune system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ An immune deficiency syndrome ☐ AIDS ☐ Test results indicating exposure to the virus causing AIDS (HIV)
☐ Lupus ☐ Scleroderma ☐ Any other disease or disorder of the immune system

j) **Tumours and growths:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Cancer ☐ Cyst ☐ Tumour ☐ Melanoma ☐ Lymphoma ☐ Leukemia ☐ Polyp
☐ Any any other form of malignant disease, any growth, lump, polyp or any other symptoms, treatment related to any tumour, lump, cyst, growth or cancer

k) **Skin disorders:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Psoriasis ☐ Skin sores ☐ Ulcer ☐ Mole ☐ Dysplastic nevus syndrome ☐ Any other disease or disorder of the skin

○ **INSURED 2**

44 Have you ever had, or ever been told you had, or received treatment or advice for:

a) **Heart and circulatory system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Heart ☐ Blood vessels ☐ Chest pain ☐ Shortness of breath ☐ Transient Ischemic Attack (TIA) ☐ Irregular pulse
☐ Murmur ☐ High blood pressure ☐ Heart attack ☐ Stroke ☐ Peripheral vascular disease ☐ Rheumatic Fever
☐ Aneurysm ☐ Poor circulation ☐ Abnormal ECG ☐ Bypass ☐ Congenital heart disorder ☐ High cholesterol levels
☐ Angioplasty ☐ Arteriosclerosis ☐ Palpitations ☐ Blood clot ☐ Angina
☐ Any other disease or disorder of the blood vessels, the heart, congenital heart disorder or circulatory system

b) **Eyes, ears, nose, throat, lungs, respiratory system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Lungs ☐ Nose ☐ Throat ☐ Shortness of breath ☐ Persistent cough ☐ Hoarseness ☐ Blood spitting
☐ Chronic bronchitis ☐ Emphysema ☐ Asthma ☐ Tuberculosis ☐ Chronic obstructive pulmonary disease ☐ Sleep apnea ☐ Sarcoidosis
☐ Blindness ☐ Optic neuritis ☐ Other visual disturbance ☐ Deafness ☐ Persistent fever
☐ Any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system

c) **Gastrointestinal system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section.**

☐ Digestive organs ☐ Ulcer ☐ Bleeding ☐ Recurrent indigestion ☐ Celiac disease
☐ Ulcerative colitis ☐ Colitis ☐ Crohn's disease ☐ Hepatitis ☐ Hepatitis carrier
☐ Jaundice ☐ Cirrhosis of the liver ☐ Gastrointestinal problem ☐ Persistent or chronic diarrhea ☐ Inflammatory bowel disease
☐ Any other disease or disorder of the mouth, esophagus, stomach, liver, pancreas, intestines or rectum

d) **Kidney, bladder and reproductive organs:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Kidney ☐ Bladder ☐ Prostate ☐ Genital organs ☐ Urinary organs
☐ Nephritis ☐ Abnormal pap ☐ Sexually transmitted disease ☐ Abnormal sugar level ☐ Abnormal protein levels
☐ Blood in the urine ☐ Abnormality in the urine ☐ Elevated Prostate Specific Antigen (PSA) ☐ Any other disease or disorder

e) **Nervous system and brain:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Chronic headaches ☐ Epilepsy ☐ Dizziness ☐ Chronic fatigue ☐ Motor neuron disease ☐ Muscular dystrophy
☐ Memory loss ☐ Alzheimer disease ☐ Paralysis ☐ Loss of sensation ☐ Loss of balance ☐ Hereditary disorder
☐ Weakness of the extremities ☐ Numbness or tingling ☐ Neuritis ☐ Neuropathy ☐ Multiple sclerosis ☐ Any congenital abnormality
☐ Parkinson's disease ☐ Meningitis ☐ Coma ☐ Cerebral palsy ☐ Down syndrome
☐ Head or brain injuries ☐ Loss of consciousness ☐ Loss of speech ☐ Seizure ☐ Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)
☐ Any other disease or disorder of the brain or nervous system

f) **Blood, glandular and endocrine system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Anemia ☐ Enlarged glands ☐ Diabetes ☐ Abnormal blood sugar ☐ Hormone disorders
☐ Thyroid ☐ Adrenal disorder ☐ Pituitary gland disorder ☐ Tumour ☐ Breast disorder
☐ Abnormal mammogram ☐ Abnormal ultrasound ☐ Biopsy of the breast ☐ Persistent anemia ☐ Hemophilia
☐ Disorder of the endocrine system ☐ Any other disease or disorder of the glands or the blood

g) **Nervous, mental or mood disorder:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Anxiety ☐ Stress ☐ Burnout ☐ Depression ☐ Bipolar disorder
☐ Schizophrenia ☐ Suicide attempt ☐ Suicide ideation disorder ☐ Behavioural disorder ☐ Eating disorder
☐ Emotional disorder ☐ Cognitive impairment ☐ Developmental handicap ☐ Attention deficit disorder (ADD) ☐ Autism
☐ Any other psychological, psychiatric disease or disorder

h) **Back, muscles and bones:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Arthritis ☐ Fibromyalgia ☐ Repetitive strain injury ☐ Osteoarthritis
☐ Paralysis ☐ Deformity ☐ Rheumatoid arthritis ☐ Other conditions causing limited motion
☐ Any other disease or disorder of the back, muscles, bones, joints, limbs, spine, other conditions causing limited motion or requiring adaptive devices

i) **Immune system:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ An immune deficiency syndrome ☐ AIDS ☐ Test results indicating exposure to the virus causing AIDS (HIV)
☐ Lupus ☐ Scleroderma ☐ Any other disease or disorder of the immune system

j) **Tumours and growths:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Cancer ☐ Cyst ☐ Tumour ☐ Melanoma ☐ Lymphoma ☐ Leukemia ☐ Polyp
☐ Any any other form of malignant disease, any growth, lump, polyp or any other symptoms, treatment related to any tumour, lump, cyst, growth or cancer

k) **Skin disorders:** ○ Yes ○ No If ***"yes"***, select appropriate box(es) and provide details in **remarks section**.

☐ Psoriasis ☐ Skin sores ☐ Ulcer ☐ Mole ☐ Dysplastic nevus syndrome ☐ Any other disease or disorder of the skin

Health history **INSUREDS OF ALL AGES**

INSTRUCTIONS ***Details of any "yes" answers must be provided in the remarks section.***

		INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
45	In the last 5 years, have you ever had or been recommended to have any tests listed below? If ***"yes"***, select appropriate box(es) and provide details in the **remarks section.** ☐ Computer Tomography Scan (CT Scan) ☐ Coronary calcium scan ☐ Magnetic Resonance Imaging (MRI) ☐ Electrocardiogram ☐ X-ray ☐ Any other diagnostic test	○	○	○	○
46	In the last 5 years, have you consulted any medical advisors other than as identified in questions 40 to 44? If ***"yes"***, provide name and address in the **remarks section.**	○	○	○	○
47	a) Are you being treated or followed by any medical advisor, **other than** as identified in questions 40 to 44?	○	○	○	○
	b) Are you taking herbal, holistic or prescribed medication **other than** as identified in questions 40 to 44? If ***"yes"***, provide name, dosage and reason in the **remarks section.**	○	○	○	○
48	Have you been absent from work or school for more than 7 days in the last 6 months because of sickness or injury or disability? If ***"yes"***, provide details in **remarks section.**	○	○	○	○
49	Have you ever had, or ever been told you had, any disease, condition, abnormality or hereditary disorder not already mentioned? If ***"yes"***, provide details in **remarks section.**	○	○	○	○
50	a) Are you or have you experienced any symptoms, abnormalities or undiagnosed pain, for which you have not yet sought treatment or consultation? If ***"yes"***, provide details in **remarks section.**	○	○	○	○
	b) Have you been advised to have treatment, consultation, or medical testing which has not yet been completed or for which you have not yet received the results?	○	○	○	○

REMARKS – Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

QUESTION #	INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Family history INSUREDS OF ALL AGES

		INSURED 1 YES	INSURED 1 NO	INSURED 2 YES	INSURED 2 NO
51	a) Has any family member (whether living or deceased) ever suffered from, or currently has: polycystic kidney disease, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)? ..... If ***"yes"***, complete the table below.	○	○	○	○
	b) Has 2 or more family members (whether living or deceased) ever suffered from, or currently suffering from: heart disease, stroke, cancer (specify type), diabetes, kidney disease, heart attack, multiple sclerosis, Alzheimer's Disease or Parkinson's disease? ..... If ***"yes"***, complete the table below.	○	○	○	○

INSURED 1

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

INSURED 2

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

REMARKS – Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

QUESTION #	INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Addition of the Children's Insurance Rider

INSTRUCTIONS

Complete this section on behalf of a child applying for a Children's Insurance Rider who is between 15 days and up to and including age 18. In addition, for base Insured (the parent), complete questions 33 to 51. All lives insured under the base joint coverage must also complete these requirements.

Face amount $ _____ minimum $5,000 to a maximum of $30,000 (must be in units of $5,000)

52 a) Child name (First, last): _____ Gender: ○ Male ○ Female
Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg
Name and address of family doctor: _____

b) Child name (First, last): _____ Gender: ○ Male ○ Female
Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg
Name and address of family doctor: _____

c) Child name (First, last): _____ Gender: ○ Male ○ Female
Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg
Name and address of family doctor: _____

d) Child name (First, last): _____ Gender: ○ Male ○ Female
Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg
Name and address of family doctor: _____

Refer to children named in question 52

If ***"yes"*** to any question(s), identify the child and provide additional information in the Remarks section.	A YES	A NO	B YES	B NO	C YES	C NO	D YES	D NO
53 Has there ever been an application for Life or Critical Illness Insurance on any of these children that was declined, postponed, offered with restrictions or modified with a rating in any way?	○	○	○	○	○	○	○	○
54 Has any child to be insured ever had any illness, impairment or injury that required treatment, surgery or hospitalization?	○	○	○	○	○	○	○	○
55 Was any child to be insured born prematurely? If ***"yes"*** provide birth weight in the Remarks section	○	○	○	○	○	○	○	○
56 Has any child to be insured consulted, or been treated by, any physician or other practitioner for any known or suspected heart problem, cancer, mental impairment or acquired immunodeficiency syndrome or ever tested positive for HIV or exhibited any delay in physical or mental development?	○	○	○	○	○	○	○	○
57 Has any child to be insured been prescribed any medication or had or been advised to have any treatment or diagnostic test, whether or not completed?	○	○	○	○	○	○	○	○
58 Is any child to be insured not a legal child or a child of the Insured(s) whose legal adoption has not yet been made final?	○	○	○	○	○	○	○	○
59 Are there any other health issues not described above?	○	○	○	○	○	○	○	○

60 Are there any children on whom coverage is not being requested? ○ Yes ○ No
If ***"yes"*** provide details in the Remarks section.

REMARKS – Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

QUESTION #	INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Acknowledgement and authorization

Acknowledgement of variability of UL policies

There are many variables that can affect an insurance policy's performance. Interest rates and the performance of the securities markets, in particular, can fluctuate significantly and can have a negative or a positive impact on the policy's non-guaranteed benefits and values.

The benefits and values outlined in the illustration are not guaranteed, as they are based on assumptions that are subject to change. They are neither an estimate nor a guarantee of future policy performance.

Exclusions and limitations for Critical Illness Protection

Any Critical Illness Benefit, if applied for, contains exclusions, a survival period and a moratorium period.
Refer to your policy wording for details.

Applicant's acknowledgement

I/We, the applicant(s) and Owner(s) stated in this *Policy Change Application*, have reviewed and discussed with my/our independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my/our satisfaction.

Authorization to disclose information to your independent insurance advisor

By agreeing to the authorization below, you are giving us permission to disclose your personal information to your independent insurance advisor, who may use it to help you with your insurance options.

This information could include:

- Your medical history
- Medical tests and laboratory results obtained from your physician, or performed for insurance purposes
- Employment history, personal finances, substance abuse history, driving record and criminal history
- Any other facts about your life that have affected the assessment of your insurance request

The information will be shared only with the independent insurance advisor indicated below. You may also cancel this authorization at any time by calling us at 1-800-846-5970. This authorization will remain in effect for 45 days after we issue a policy or send you a letter indicating that your insurance request has been declined.

Advisor's name: _____ Advisor's code: _____

Does **INSURED 1** agree to the disclosure of information? . . . . . ○ Yes ○ No

Does **INSURED 2** agree to the disclosure of information? . . . . . ○ Yes ○ No

Grouped policies

INSTRUCTIONS If you wish to have this policy issued on the same day as another policy or policies for families, partnership or other business reasons, please give the names of the other Insured(s) below (not applicable to any policy with a Critical Illness Protection Rider or any Critical Illness Protection policy). Group with:

_____ _____ or _____
(First name) *(Last name)* *(Policy number)*

_____ _____ or _____
(First name) *(Last name)* *(Policy number)*

Declaration

I/We have read all of the questions and answers in this application and I/we understand the meaning and importance of them. **The statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief.**

ACKNOWLEDGEMENT AND AGREEMENT

I/We acknowledge and agree that:

1. This application consists of pages i and 1–25, any supplement to it (if applicable) and any other declaration made in connection with this application. Together all of this information will form the basis for any policy/coverage issued.
2. This application does not include any "Temporary Insurance Agreement."
3. No information acquired by any representative of *ivari* will be binding on *ivari* unless set out in writing in this application.
4. Any policy issued on this application will not take effect unless all of the following conditions are satisfied:
   a) the full amount of the first premium is received by *ivari* during the lifetime of all Insured(s) under the policy;
   b) the policy is delivered to the Owner during the lifetime of the Insured(s) under the policy;
   c) all statements and answers given in this application continue to be true and complete on the date of delivery of the policy; and
   d) no change has taken place in the insurability of any Insured(s) between the time this application is completed and the time the policy is delivered to the Owner.
5. Only the president together with a vice-president or secretary of *ivari* has the authority to bind *ivari* or to make any change in this application or any policy issued. *ivari* will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend or modify any of the terms or provisions in this application or any policy issued. However, *ivari* may make certain changes to this application as provided for in your policy contract. The Owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements or amendments.
6. If the answer to any question(s) in this application is misstated or omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
7. All premium payments must be made payable to *ivari*.
8. I/We have received and fully understand the contents of the Disclosure of Compensation, where applicable.
9. Effective January 1, 2017 new tax rules for life insurance policies have taken effect. If your policy was issued prior to 2017, certain changes made to your existing policy may impact your policy's tax status. Ensure you talk to your advisor to fully understand how these changes may affect your policy.

PERSONAL INFORMATION AUTHORIZATION

I/We have read and fully understand the contents of the Notices regarding MIB, Inc., Investigative Consumer Reports and Collection, Use and Disclosure of Personal Information (collectively, the "Notices") and acknowledge and consent to the collection, use and disclosure of my/our personal information by *ivari* and its affiliates for the purposes identified in those Notices.

For the **purposes of evaluating my/our insurance application, servicing my/our policy, and investigation and claim analysis**, I/we, the Insured(s), hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the MIB, Inc. or any other organization, institution, association or person identified in the Notices that now has or may in future have any information concerning me/us or my/our health to disclose to *ivari*, its authorized representatives and its reinsurers, upon the request of *ivari*, any such information for the purposes identified in the Notices. I/We authorize *ivari*, or its reinsurers, to make a brief report of my/our personal health information to MIB, Inc.

I/We further authorize a representative of *ivari* to perform such tests, examinations, x-rays, electrocardiograms and blood or urine tests as may be required by *ivari*. I/We understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus and the presence of medications, drugs, nicotine or their metabolites. *ivari* may release the results of these tests and examinations to my personal physician(s).

I/We certify that the information given in this section is correct and complete. I/We agree to immediately notify *ivari* of any errors, omis- sions or changes in the information provided in this section. As the pol- icy owner(s), I/We acknowledge that I/we have an obligation under the *Income Tax Act* to notify *ivari* of any changes in my/our tax residency status. I/We acknowledge that the information contained in this sec- tion and information regarding my/our policy, contract and account may be reported to Canada Revenue Agency (CRA).

A photocopy of this authorization shall be as valid as the original.

We may communicate with you about other insurance products and services. If we rely on a marketing service provider to communicate with you, we will disclose only your name, contact information, and your current insurance coverage, but not your health or financial information. *ivari* requires its service providers to safeguard the confidentiality of personal information consistent with *ivari's* privacy and security practices and in accordance with applicable laws.

If you do not wish your personal information to be used for this optional purpose, check here ☐ or write to us at: ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8, Attention: Privacy Office.

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

Sign here

Signature of **INSURED 1**
If Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **INSURED 2**
If Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **OWNER 1**, if not an Insured

Sign here

Signature of **OWNER 2**, if not an Insured

Print name of signing officer and title, if entity owned

Print name of signing officer and title, if entity owned

Sign here

Current Preferred/Irrevocable Beneficiary Signature (if applicable)

Sign here

Witness to signature(s)

Sign here

Assignee Signature (stamp required if Assignee is a financial institution)

If the Owner is an entity, the signature(s), name(s) and title(s) of the authorized signing officers thereof are required, as stated in the by-laws of the entity.

Independent Insurance Advisor's Report **MUST BE COMPLETED IN ALL CASES**

1. Third party determination must be completed for all applications. Every reasonable effort must be made by you to determine if the Owner(s) is/are acting on behalf of a third party. The ***Proceeds of Crime (Money Laundering) and Terrorist Financing Act*** requires each Insured's identity to be verified by referring to certain documents. The law also requires the existence of third parties, if any, to be determined and recorded.

   When asked whether the Owner(s) is/are acting on behalf of a third party, the individual submitting the application answered:
   ○ No
   ○ Yes, complete and submit the *Identity and Third Party Determination* form (IP-LP782)
   ○ Unable to determine; however, I have reasonable grounds to suspect there is a third party.
   Provide details (attach separate page if necessary):

   _____

   _____

2. Did you complete the application in person with all Insured(s)/Owner(s)? ..... ○ Yes ○ No
   If ***"no,"*** explain why: _____

   Reinstatement, Addition/Increase in coverage, COI/DBO changes with underwriting requires the application to be completed in person with all Insured(s)/Owner(s). Refer to Requested Change Page.

	ADVISOR 1	ADVISOR 2
3. Are you the Insured, Owner or beneficiary on this policy?	○ Yes ○ No	○ Yes ○ No
4. If you have a family relationship* with the Insured, Owner or Beneficiary, please specify with who:	_____	_____

   * A family member such as a spouse, parent, grandparent, sibling, child, grandchild or in-law.
   A corporation where you or a family member, individually or together own.

5. By signing below, I/we acknowledge that I/we have disclosed, where applicable, the following items to the Owner of the policy resulting from this application:
   a) The company or companies I/we represent;
   b) That I/we will receive compensation in the form of bonuses *(such as commissions or a salary)*; and
   c) That I/we have disclosed any conflicts of interest that I/we may have with respect to this transaction.
   d) I/We attest that I/we have followed the ivari Code of Ethical Market Conduct in all aspects of this sale of insurance.
   e) That I/we are licensed in the province in which this application was completed.
   f) That I/we have disclosed the nature of relationship with company(ies) represented
   g) That I/we have disclosed that the consumer has the right to ask for more information

Advisor's notes:

Future effective date: (DD/MM/YYYY) _____ If permitted, save age? ○ Yes _____ ○ No _____

NOTE: A replacement/conversion of a rider/coverage from a Universal Life policy will be effective on the closest monthly anniversary date of the policy. The new policy can not be backdated.

Do you have any knowledge of each Insured's personal habits, health, avocations, finances or reputation that might affect the underwriting risk? If so, give details below.

_____

Advisor's email address: _____

I/We hereby declare that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief, and that I am/we are not aware of additional information material to the Insured(s) except as stated in any advisor's notes. When applicable, I/we have verified the identity of the individuals who submitted the application by referring to the original, non-expired documents. I/We confirm that the information recorded was correctly copied from such document(s). Reasonable effort has also been exercised to determine if the Owner(s) is/are acting on behalf of a third party.

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

Sign here _____ _____
Signature of advisor | Name of advisor

Sign here _____ _____
Signature of advisor | Name of advisor

Sign here _____ _____
Signature of supervising advisor (where required) | Name of supervising advisor

To be completed by advisor and distributor **MUST BE COMPLETED IN ALL CASES**

The individual who wrote this application must be listed below as either Advisor 1, 2 or 3 and MUST have his/her own SA code.

1. Distributor contact name: _____ Distributor name and code: _____

   Distributor contact email: _____ Distributor contact phone number: _____

   Advisor name or managing broker (1): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

   Advisor name or managing broker (2): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

   Advisor name or managing broker (3): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

   If shared, who is the Servicing Advisor? ○ **Advisor 1** ○ **Advisor 2** ○ **Advisor 3**

2. Advisor/Distributor notes:

   _____

   _____

   _____

   _____

3. **Underwriting Requirements** ○ **Ordered by advisor** ○ **Ordered by distributor**

INSURED 1

ORDERED	ORDERED FROM	SUBMITTED
☐ Paramedical	_____	☐ Signed illustration
☐ Urine/HIV	_____	☐ Signed supplement to the insurance application
☐ Blood/Urine	_____	☐ Replacement/Disclosure forms
☐ ECG	_____	☐ Financial statements
☐ Stress ECG	_____	☐ Questionnaires: _____
☐ Inspection/BBR	_____	
☐ Telephone interview	_____	☐ Other: _____
Best time to contact	_____	

INSURED 2

ORDERED	ORDERED FROM	SUBMITTED
☐ Paramedical	_____	☐ Signed illustration
☐ Urine/HIV	_____	☐ Signed supplement to the insurance application
☐ Blood/Urine	_____	☐ Replacement/Disclosure forms
☐ ECG	_____	☐ Financial statements
☐ Stress ECG	_____	☐ Questionnaires: _____
☐ Inspection/BBR	_____	
☐ Telephone interview	_____	☐ Other: _____
Best time to contact	_____	

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