Equitable Life of Canada®

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GROUP LIFE INSURANCE WAIVER OF PREMIUM APPLICATION

EMPLOYEE INFORMATION

Last Name: | First Name: | ☐ Male ☐ Female | Date of Birth: Month / Day / Year

Address (Number, Street & City): | Telephone Number

Province | Postal Code

Group Policy No: | Certificate No:

Date you were first unable to work due to this disability: Month / Day / Year

If you have returned to work, provide the date of return: Month / Day / Year

Diagnosis (including all conditions affecting your inability to work):

Are you insured under any other policy for life insurance with Equitable Life of Canada?
☐ Yes ☐ No → If 'yes', provide Policy Number(s):

Name and Address(es) of other physicians consulted: | Dates Consulted:

If confined to Hospital for this disability, provide:
Name and Address of Hospital(s): | Dates of Confinement:

Has surgery been performed or is surgery planned? ☐ Yes ☐ No → If 'yes', (Proposed) Date(s) of Surgery:

Are you taking any Medication? If "yes": ☐ Yes ☐ No
Names | Dosage & Frequency

Are you now:
☐ Able to complete all activities of daily living
☐ Confined to hospital or other medical institution
☐ Unable to go outside
☐ Able to go outside only with help
☐ Confined to bed or wheelchair at home
☐ Able to go outside without help

Describe Symptoms, Limitations:

What is the highest level of education you have?
☐ Primary School
☐ Secondary School
☐ University: # of years _____ Degree _____
☐ Other Training: _____

JOB DESCRIPTION

Describe in detail what your job involves, including shift work, weekends, supervisory responsibilities and whether your job is dependent upon others or whether their job depends on you.

List all types of machines, tools, office equipment and other special equipment you use to do your job.

How might your condition prevent you from performing any of your job duties or using any of the above mentioned equipment?

Before you stopped working, did your disability cause you to change: ☐ Your job duties ☐ Your hours of work ☐ Your attendance

If yes, explain how your condition caused these changes and provide the dates the changes were made, if possible.

What are the physical activities required in this job with regard to: sight, hearing, speech, lower extremities and upper & lower back/neck?

Do you expect to return to work at your current/any job? ☐ Part-time ☐ Modified ☐ Regular Date Expected to Return: _____ (dd/mm/yyyy)
☐ Yes ☐ No (give details below)

Are you currently involved in any other type of employment? ☐ Yes ☐ No → If 'yes', please describe below.
i.e. part-time employment elsewhere, home based business or volunteer work.

Are you eligible for, have you applied for, or are you now receiving income benefits from:	Canada/Quebec Pension Plan	☐ Yes ☐ No
	Workers' Compensation Board/WSIB	☐ Yes ☐ No
	Employment Insurance	☐ Yes ☐ No
	Any Other Disability Income Benefits	☐ Yes ☐ No

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify that the information given on this form is true, correct and complete.

For the purposes of underwriting, administration, claims processing and adjudication with respect to the Group Policy and any supplementary forms/documents, I authorize The Equitable Life Insurance Company of Canada ("Equitable"), its employees, representatives and service providers to use my personal information, and exchange such personal information with reinsurers, insurers, investigative agencies, health care providers and facilities, and any other person or party whom I authorize.

For the above purposes, I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), WSIB/Workers Compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of my health, to give to Equitable full particulars of such information, including any prior medical history and benefits.

I transfer and assign to Equitable, and agree to pay and refund to Equitable those disability and income replacement benefits which I receive or are receivable from all other sources, in accordance with the provisions of the Group Policy, including without limitation, CPP, Worker's Compensation, and other insurance policies.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

Date: _____ Employee/Member Signature: _____

Please forward completed form promptly to:

Group Life & Disability Claims Department
The Equitable Life Insurance Company of Canada
One Westmount Road North, PO Box 1603 Stn Waterloo
Waterloo, Ontario N2J 4C7