Equitable Life of Canada®

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GROUP LIFE INSURANCE WAIVER OF PREMIUM

ONGOING ELIGIBILITY REVIEW

Last Name: _____ First Name: _____

Group Policy No.: _____ Certificate No: _____ Date of Birth: _____

Street Address: _____ City _____ Province _____

Postal Code _____ Telephone Number _____

1. Are you still receiving disability benefits from your Long Term Disability provider? ☐Yes ☐No (If "No" please enclose a copy of their termination letter as well as any documentation you may have received.) _____

2. If you answered "No" to question (1.) are you or will you be appealing the decision to terminate your Long Term Disability benefits? Please comment on when this appeal took place and whether you have received a response to date.

3. Have you experienced any changes in your condition since our last correspondence? ☐Yes ☐No (If "Yes", please explain)

4. Has there or will there be any changes in your address or telephone contact information? (If "Yes", please advise)

5. Do you expect to return to work at your own or any occupation in the future? ☐Yes ☐No (If "Yes", please explain)

6. Are you currently involved in any type of rehabilitation? (e.g. volunteer work, trial return to work, etc.) ☐Yes ☐No (If "Yes", please describe below) _____

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.

Signature _____ Date _____

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