Equitable™

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OPTIONAL LIFE INSURANCE APPLICATION AND STATEMENT OF HEALTH

Please note:

- This form may be used for a Plan Member, Spousal, and/or Child Optional Life Insurance request.
- The amount applied for on this form cannot exceed the maximum stated in your Group Policy.
- Any misrepresentation or misstatement in the answers to these questions shall render any insurance issued in connection with this application voidable by The Equitable Life Insurance Company of Canada.
- Once completed this form can be mailed to the address above, faxed to 519.883.7403, or emailed to groupmeduw@equitable.ca.
  Please note: While using the internet and email is convenient, sending confidential and personal information through the internet is not secure. Email is vulnerable to interception. Equitable cannot ensure the privacy of information sent by email.

1. PLAN MEMBER OPTIONAL LIFE INSURANCE

Plan Member Information

Name of Policyholder	Policy Number	Division	Class	Certificate Number

Plan Member's Name (first, middle, last)	Date of Birth (mm/dd/yyyy)	Place of Birth (Province/State, Country)

Contact Information for Application

Address (number, street and apartment)	City	Province

Postal Code	Email Address	Telephone Number

Amount Requested (Enter in multiples of $10,000)

Current Amount (if any):	Additional Amount Requested:	Total Amount Requested:

If available under this Policy, do you want to apply for Optional Accidental Death and Dismemberment: ☐ Yes ☐ No
If Yes, the amount will be equal to your total amount of Optional Life Insurance.

Beneficiary Information

☐ Designate Beneficiary for Optional Life to be the same as Group Life Insurance provided under this Policy **OR** If you wish to designate a different beneficiary for Optional Life, complete the following. **Note: If no beneficiary is appointed, the proceeds shall be payable as required by provincial law.**

Full Name of Primary Beneficiary (first, middle, last)	Relationship to Plan Member	☐ Male ☐ Female

If the Primary Beneficiary pre-deceases me, proceeds of the policy shall be payable to the following Contingent Beneficiary:

Full Name of Contingent Beneficiary (first, middle, last)	Relationship to Plan Member	☐ Male ☐ Female

If the Beneficiary is under the age of majority at the time of my death, proceeds of the policy shall be payable to the following:

Full Name of Trustee (first, middle, last)	Relationship to Plan Member	☐ Male ☐ Female

For Quebec residents only: Designating your spouse as beneficiary is irrevocable unless you make the designation revocable by checking the box below. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.
I elect to make my spouse (married or civil union) designation: ☐ Revocable

1. PLAN MEMBER OPTIONAL LIFE INSURANCE (CONTINUED)

Plan Member Statement

Are you now actively at work on a full time basis? ☐ Yes ☐ No	If No, give details including the reason, last day worked and anticipated date of return:

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of Gain:	Amount of Loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months? ☐ Yes ☐ No

Products:	Frequency:	Date Last Used:

Name and address of your usual medical practitioner: (If none, state last physician contact – i.e. clinic, emergency room visit)

Date last consulted:	Reason:	Results/Diagnosis:

Treatment: (include check-up results)

Any follow-up advised: (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If yes, provide full details below)

2. SPOUSAL OPTIONAL LIFE INSURANCE

Applicant Spouse Information

Spouse's Name (first, middle, last)	Date of Birth (mm/dd/yyyy)	Place of Birth (Province/State, Country)

Contact Information for Application Same as above for Plan Member ☐ Yes ☐ No If Yes, proceed to Amount Requested.

Address (number, street and apartment)	City	Province

Postal Code	Email Address	Telephone Number

Amount Requested (Enter in multiples of $10,000)

Current Amount (if any):	Additional Amount Requested:	Total Amount Requested:

If available under this Policy, do you want to apply for Spousal Optional Accidental Death and Dismemberment: ☐ Yes ☐ No
If Yes, the amount will be equal to your total amount of Spousal Optional Life Insurance.

2. SPOUSAL OPTIONAL LIFE INSURANCE (CONTINUED)

Beneficiary Information **Note: If no beneficiary is appointed, the proceeds shall be payable as required by provincial law.**

Full Name of Primary Beneficiary (first, middle, last)	Relationship to Applicant	☐ Male ☐ Female

If the Primary Beneficiary pre-deceases me, proceeds of the policy shall be payable to the following Contingent Beneficiary:

Full Name of Contingent Beneficiary (first, middle, last)	Relationship to Applicant	☐ Male ☐ Female

If the Beneficiary is under the age of majority at the time of my death, proceeds of the policy shall be payable to the following:

Full Name of Trustee (first, middle, last)	Relationship to Applicant	☐ Male ☐ Female

For Quebec residents only: Designating your spouse as beneficiary is irrevocable unless you make the designation revocable by checking the box below. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.
I elect to make my spouse (married or civil union) designation: ☐ Revocable

Applicant Spouse Statement

Are you now actively at work on a full time basis? ☐ Yes ☐ No (30 hours per week)	If No, give details including the reason, last day worked and anticipated date of return:

Height: ☐ ft/in ☐ cm	Weight: ☐ lbs ☐ kg	Weight changes in the past year? ☐ Yes ☐ No
Amount of Gain:	Amount of Loss:	Reason for weight changes:

Have you smoked any cigarettes or used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months? ☐ Yes ☐ No

Products:	Frequency:	Date Last Used:

Name and address of your usual medical practitioner: (If none, state last physician contact – i.e. clinic, emergency room visit)

Date last consulted:	Reason:	Results/Diagnosis:

Treatment: (include check-up results)

Any follow-up advised: (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If yes, provide full details below)

3. CHILD OPTIONAL LIFE INSURANCE (IF AVAILABLE UNDER THIS POLICY)

Note: You will be the beneficiary of your child(ren)'s Optional Life insurance. If you are not living at the time of a claim, the proceeds shall be payable as required by provincial law.

Amount Requested Per Child (Enter in multiples of $5,000)

Current Amount (if any):	Additional Amount Requested:	Total Amount Requested:

If available under this Policy, do you want to apply for Child Optional Accidental Death and Dismemberment: ☐ Yes ☐ No
If Yes, the amount will be equal to your total amount of Child Optional Life Insurance.

4. STATEMENT OF HEALTH FOR PLAN MEMBER AND SPOUSAL OPTIONAL LIFE

Note: You must complete ALL questions below. For any "Yes" answers, provide all details, including diagnosis, treatment dates, duration etc., and complete names and addresses of ALL physicians and/or medical facilities in the space provided in Section 5.

	Plan Member	Spouse
4.1 Have you: (If yes to any of these questions, provide details including current driver's license number)		
a) Been convicted of, have pending charges for, or pleaded guilty to any other driving offences (excluding parking tickets) in the last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No
b) Had your driver's license been suspended or revoked in the last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No
c) Been convicted of, have pending charges for, or pleaded guilty to driving under the influence of alcohol and/or drugs, or refused to provide a breathalyzer sample in the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
4.2 In the last 2 years have you or do you intend to:		
a) Make any flights as a pilot or in any flying capacity (other than as a fare-paying passenger)?	☐ Yes ☐ No	☐ Yes ☐ No
b) Engage in a hazardous sport or hobby, such as underwater diving, hang gliding or ultra-light flying, sky diving, motorized racing, mountain climbing, etc.). (If so, specify sport/hobby)	☐ Yes ☐ No	☐ Yes ☐ No
4.3 Has any family member, related by blood, (whether living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Mental Illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease? (If yes, indicate family member, age at diagnosis and condition)	☐ Yes ☐ No	☐ Yes ☐ No
4.4 Within the past 5 years, have you received disability benefits from any source or missed 5 or more consecutive days from work due to illness or injury or had any company decline, modify, cancel or rescind any life, disability income or critical illness insurance? (If yes, please provide full details)	☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been treated for or had any symptoms, complaints or indication of any of the following: (Applies to questions 4.5 to 4.16)

	Plan Member	Spouse
4.5 Heart Attack, Angina, Chest pain, Rheumatic Fever, Stroke, TIA, Elevated Blood Pressure (include most recent Blood Pressure reading and date), Elevated Cholesterol (include most recent levels), Heart Murmur or other Heart or Blood Vessel disease or disorder? (If yes, please provide full details)	☐ Yes ☐ No	☐ Yes ☐ No
4.6 Asthma, Respiratory, Sleep Apnea or other Lung disorder? (If yes, complete part a)	☐ Yes ☐ No	☐ Yes ☐ No

a) Respiratory Disorder

Plan Member	Spouse
Do you have a history of:	Do you have a history of:
☐ Asthma ☐ Recurrent Bronchitis	☐ Asthma ☐ Recurrent Bronchitis
☐ Emphysema ☐ Other _____	☐ Emphysema ☐ Other _____
Date of first episode: _____	Date of first episode: _____
Date of last episode: _____	Date of last episode: _____
Frequency of episodes: _____	Frequency of episodes: _____
Severity of episodes: ☐ Mild ☐ Moderate ☐ Severe	Severity of episodes: ☐ Mild ☐ Moderate ☐ Severe
Have you ever been hospitalized or been seen in Emergency? ☐ Yes ☐ No (If yes, provide details)	Have you ever been hospitalized or been seen in Emergency? ☐ Yes ☐ No (If yes, provide details)
Have you ever undergone tests (Pulmonary Function Tests, Chest X-rays, other)? ☐ Yes ☐ No (If yes, provide details)	Have you ever undergone tests (Pulmonary Function Tests, Chest X-rays, other)? ☐ Yes ☐ No (If yes, provide details)
Indicate all medications used (inhalers, oral, other)	Indicate all medications used (inhalers, oral, other)
Type: _____ (At time of flare-up)	Type: _____ (At time of flare-up)
_____ (Maintenance Medications)	_____ (Maintenance Medications)
Dosage: _____ (At time of flare-up)	Dosage: _____ (At time of flare-up)
_____ (Maintenance Medications)	_____ (Maintenance Medications)
Frequency: _____ (At time of flare-up)	Frequency: _____ (At time of flare-up)
_____ (Maintenance Medications)	_____ (Maintenance Medications)

4. STATEMENT OF HEALTH FOR PLAN MEMBER AND SPOUSAL OPTIONAL LIFE (CONTINUED)

	Plan Member	Spouse
4.7 Diabetes (include age at diagnosis, date and last known Hemoglobin (A1C)), Digestive System (e.g. Gastric Ulcer), Colitis, Bowel Disorder, Liver Disorder, Hepatitis or Hepatitis carrier state, Kidney, Bladder or Prostate, Gout or Urinary disorder, Blood or Endocrine abnormality?	☐ Yes ☐ No	☐ Yes ☐ No
4.8 Any Eye or Ear Impairment including Visual or Hearing Impairment, Dizziness, Fainting, Convulsions, Stroke, Blurred Vision, Seizure Disorder, etc.?	☐ Yes ☐ No	☐ Yes ☐ No
4.9 Thyroid, or Glandular disorder, Lupus, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Epilepsy, Muscle or Bone disorder?	☐ Yes ☐ No	☐ Yes ☐ No
4.10 Cancer, Tumour, Cyst, Polyp, Mole, Lump or other growth, Breast disorder or abnormal Mammogram or Ultrasound? (If yes, include pathology results, malignant or benign)	☐ Yes ☐ No	☐ Yes ☐ No
4.11 Anxiety, Stress, Depression, Fatigue, Suicidal Thoughts/Attempts, Nervous Breakdown, Eating Disorder, ADD or ADHD, or other Nervous System disorder? (If yes, complete part a)	☐ Yes ☐ No	☐ Yes ☐ No

a) Nervous Disorder

Plan Member	Spouse
Have you ever had any indication of the following:	Have you ever had any indication of the following:
Depression: ☐ Yes ☐ No	Depression: ☐ Yes ☐ No
Eating Disorder: ☐ Yes ☐ No	Eating Disorder: ☐ Yes ☐ No
Weight Loss: ☐ Yes ☐ No	Weight Loss: ☐ Yes ☐ No
Insomnia: ☐ Yes ☐ No	Insomnia: ☐ Yes ☐ No
Suicidal Thoughts/Attempt: ☐ Yes ☐ No	Suicidal Thoughts/Attempt: ☐ Yes ☐ No
Other, e.g. anxiety, stress: ☐ Yes ☐ No	Other, e.g. anxiety, stress: ☐ Yes ☐ No
When did you first consult a doctor/therapist and what was the diagnosis? _____	When did you first consult a doctor/therapist and what was the diagnosis? _____
Name of medications, both prescription or non-prescription, with dates, dosage and frequency: _____	Name of medications, both prescription or non-prescription, with dates, dosage and frequency: _____
Are your symptoms: ☐ Resolved ☐ Unchanged ☐ Less Severe ☐ More Severe	Are your symptoms: ☐ Resolved ☐ Unchanged ☐ Less Severe ☐ More Severe
Any time off work? ☐ Yes ☐ No (If yes, provide details)	Any time off work? ☐ Yes ☐ No (If yes, provide details)
Describe any current symptoms: _____	Describe any current symptoms: _____

4. STATEMENT OF HEALTH FOR PLAN MEMBER AND SPOUSAL OPTIONAL LIFE (CONTINUED)

	Plan Member	Spouse
4.12 The Skin, Muscles, Bones and Joints, e.g. Arthritis, Knee, Back, Neck, Shoulder, Elbow, Ankle, etc. pain, Paralysis, Deformity, unusual Skin Lesions, Migraines or Headaches, or unexplained Infections? (If yes, complete part a)	☐ Yes ☐ No	☐ Yes ☐ No

a) Pain Questionnaire

Plan Member	Spouse
☐ Headaches ☐ Back ☐ Neck ☐ Arthritis ☐ Other Pain Disorder	☐ Headaches ☐ Back ☐ Neck ☐ Arthritis ☐ Other Pain Disorder
Location of Pain: _____	Location of Pain: _____
Radiating to (if applicable): _____	Radiating to (if applicable): _____
Duration of Pain: _____	Duration of Pain: _____
First Episode: _____	First Episode: _____
Most recent Episode: _____	Most recent Episode: _____
How often does pain occur? _____	How often does pain occur? _____
Longest duration of discomfort: _____	Longest duration of discomfort: _____
If back or necked involved, check box: ☐ Neck (Cervical) ☐ Middle (Thoracic) ☐ Low (Lumbo sacral)	If back or necked involved, check box: ☐ Neck (Cervical) ☐ Middle (Thoracic) ☐ Low (Lumbo sacral)
Diagnosis/Cause:	Diagnosis/Cause:
i) History of medications? ☐ Yes ☐ No	i) History of medications? ☐ Yes ☐ No
ii) History of treatment (i.e. physiotherapy, massage)? ☐ Yes ☐ No	ii) History of treatment (i.e. physiotherapy, massage)? ☐ Yes ☐ No
iii) Have you been advised to undergo any tests, investigations or surgery? ☐ Yes ☐ No	iii) Have you been advised to undergo any tests, investigations or surgery? ☐ Yes ☐ No
iv) Have you ever been hospitalized, unable to work or restricted in any way? ☐ Yes ☐ No	iv) Have you ever been hospitalized, unable to work or restricted in any way? ☐ Yes ☐ No
v) Do you have associated symptoms or signs? ☐ Yes ☐ No	v) Do you have associated symptoms or signs? ☐ Yes ☐ No
If yes to any of the above, provide full details in section 5.	If yes to any of the above, provide full details in section 5.

	Plan Member	Spouse
4.13 a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you ever had a positive test result indicating exposure to the AIDS Virus (Positive HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
c) Within the past 5 years, have you had any indication of a sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No
4.14 Do you regularly take any medication? (If yes, specify type, dosage, when and by whom prescribed, if not previously indicated on this form)	☐ Yes ☐ No	☐ Yes ☐ No
4.15 Do you have any symptoms or are you aware of any problems for which you have not yet consulted a doctor or other health practitioner, or that has not already been listed above?	☐ Yes ☐ No	☐ Yes ☐ No

4. STATEMENT OF HEALTH FOR PLAN MEMBER AND SPOUSAL OPTIONAL LIFE (CONTINUED)

	Plan Member	Spouse
4.16 a) Do you drink alcoholic beverages and/or use marijuana, cocaine or any illegal or addictive drugs?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you ever received advice or treatment pertaining to your use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
c) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs?	☐ Yes ☐ No	☐ Yes ☐ No

If yes to a), b), or c), complete part d).

d) Alcohol and Drug Use	Plan Member	Spouse
i) Alcohol	☐ Yes ☐ No	☐ Yes ☐ No
ii) Cocaine (includes Crack)	☐ Yes ☐ No	☐ Yes ☐ No
iii) Marijuana and/or Hashish	☐ Yes ☐ No	☐ Yes ☐ No
iv) Amphetamines (Ecstasy, etc.)	☐ Yes ☐ No	☐ Yes ☐ No
v) Barbiturates type: _____	☐ Yes ☐ No	☐ Yes ☐ No
vi) Heroin, Morphine, Demerol, Methadone	☐ Yes ☐ No	☐ Yes ☐ No
vii) Hallucinogens (LSD)	☐ Yes ☐ No	☐ Yes ☐ No
viii) Pain Killers/Narcotics	☐ Yes ☐ No	☐ Yes ☐ No
ix) Other: _____	☐ Yes ☐ No	☐ Yes ☐ No

Give details regarding "Yes" answers: ("Type" refers to alcohol and/or drugs)

Plan Member	Spouse
Use at present	**Use at present**
Type: _____ Daily Amount: _____	Type: _____ Daily Amount: _____
Type: _____ Weekly Amount: _____	Type: _____ Weekly Amount: _____
Type: _____ Monthly Amount: _____	Type: _____ Monthly Amount: _____
Previous 1-2 years	**Previous 1-2 years**
Type: _____ Daily Amount: _____	Type: _____ Daily Amount: _____
Type: _____ Weekly Amount: _____	Type: _____ Weekly Amount: _____
Type: _____ Monthly Amount: _____	Type: _____ Monthly Amount: _____

5. STATEMENT OF HEALTH ADDITIONAL DETAILS

If you answered "Yes" to any of the above questions in Section 4, provide full details here. If more space is needed, you can attach another page to this application.

Question #	Applicant	Details
	☐ Plan Member ☐ Spouse	
	☐ Plan Member ☐ Spouse	
	☐ Plan Member ☐ Spouse	
	☐ Plan Member ☐ Spouse	
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6. AUTHORIZATION

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER, DECLARE, AGREE AND CERTIFY THAT:

1. All the statements, information and answers provided in all sections of this Application are true, complete, accurate and correctly recorded.
2. The personal information willingly provided by the member to the member's employer, the independent broker/sales advisor and The Equitable Life Insurance Company of Canada (Equitable), collected on this Application and held in their files, will be used by Equitable for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Policy and all benefits under the Policy, and any supplementary documents. The member understands and authorizes that for the above purposes the personal information on file is accessible to and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable, any industry drug pooling entity, participating reinsurer(s), other insurance companies, investigative parties, health care providers, including, but not limited to pharmacies, physicians and dentists, and any other person or party whom the member authorizes. If applying for the member's spouse and/or dependents, the member confirms that the member is authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. The member understands that all claims made under the Policy are submitted through the member as insured plan member. The member therefore authorizes Equitable to exchange information about these claims with the member or any person acting on the member's behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing a claim.
3. I acknowledge that my/our personal information may be processed and stored outside of Canada and may therefore be subject to the laws of those jurisdictions. For residents of Quebec, any personal information collected will be stored outside Quebec.
4. See **www.equitable.ca/en/privacy** for further details about the Company's privacy practices and for information about how to contact the Company's Privacy Officer.

THE APPLICANT MEMBER AND ALL DEPENDENTS AGE 16 YEARS AND OLDER:

1. Agree that the insurance being applied for in this Application or such insurance as issued by Equitable shall not take effect unless the first premium for the insurance coverage has been paid.
2. Acknowledge receiving the Notice regarding the Medical Information Bureau and authorize Equitable to obtain information from the Medical Information Bureau;
3. Authorize Equitable to perform all tests, including, without limitation, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this Application. Such tests may include tests to determine the presence of various diseases including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS). Equitable may disclose to its reinsurer(s), their attending physician(s), health service providers, and the Medical Information Bureau, the results of all such tests and personal information necessary to fulfill any of the identified purposes in this Application. I/We understand and agree that any positive results for HIV, hepatitis, or any other communicable diseases will be reported to the appropriate Public Health Authority. Their personal information collected by the testing facility may be processed and stored by such facility in Canada and/or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
4. Authorize the Motor Vehicle Division in any province requiring such authorization to permit Equitable or any investigative agency on behalf of Equitable, to be given a copy of all driving record information relevant to this Application.
5. Authorize any physician, practitioner, hospital, clinic, or other medical-related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any record or knowledge of the person(s) this insurance is applied for, or their health, to give full particulars of such information, including any prior medical history, to Equitable or its reinsurers.
6. Agree that this Application may be transmitted to Equitable electronically and received by Equitable as the Applicant's original application for insurance.
7. A photostatic copy of these authorizations shall be as valid as the original.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT MEMBER'S KNOWLEDGE AND WITHIN THE KNOWLEDGE OF THE PERSON(S) AGED 16 YEARS OR OLDER, THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY AND HEALTH OF ALL PERSON(S) TO BE INSURED OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY EQUITABLE.

Signed at _____ (city) _____ (province) this _____ (day) of _____ (month) 20 _____.

Signature of Member (Employee)	Signature of Spouse of Member (when applicable)

Signature of Dependent Child(ren) (when applicable) age 16 or older

NOTICE REGARDING THE MIB, INC

Information regarding the insurability of the Person(s) to be Insured will be treated as confidential. We or our reinsurer may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590, or privacy@mib.com for privacy questions. We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured may apply for life, critical illness or health insurance or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com