

APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE



life & health

As an Equitable Life policyholder you will have instant access to your policy information through **Equitable Client Access!**

What is Equitable Client Access?

It is our secure online client site that allows you to access your policy information, right at your fingertips. With **Equitable Client Access** you can:

- **View policy details including:**
 - Total face amount or death benefit;
 - Beneficiaries;
 - Current cash surrender value (if applicable);
 - Investment holdings (for universal life policies);
 - Transaction history;
 - Premium amount, payment method and next payment due date.
- **Update your personal information including:**
 - Address and contact information;
 - Banking information and pre-authorized debit withdrawal date;
 - Beneficiary.
- **Access your statements and letters.**
- **And more!**

Register for Equitable Client Access one of two ways:

- 1) Include your email address on this application. Once your policy takes effect, Equitable Life will email you a link to Client Access.
- 2) Once you receive your policy, visit client.equitable.ca and click on "Create Account".

Do you have questions? Would you like some assistance registering your account? Our customer service team would be pleased to help.

You can reach them at 1.800.668.4095:

- Monday to Thursday between 8:30 a.m. – 6:00 p.m. EST
- Friday between 8:30 a.m. – 5:00 p.m. EST

INSTRUCTIONS TO ADVISORS

1. This form is to be used for:
 - a) Applications for new individual life or critical illness insurance policies
 - b) Attained Age Conversions (individual term and group)
 - c) Exercising a Guaranteed Insurability Option
 - d) Adding additional lives to an existing policy
2. This Application covers 2 lives to be insured as well as children (under the Children's Protection Rider). If there are more than 2 lives to be insured, additional Application(s) are to be completed.
3. COMPLETION OF THE APPLICATION
 - a) Make certain that all questions are answered clearly and completely in the white boxes provided. All Proposed Life insured 2 sections are clearly marked on the Application. If the questions are asked by the Advisor they must be asked as is, word for word and not paraphrased.
 - b) Do NOT use any type of white-out or liquid paper on the Application.
 - c) All changes or corrections must be initialed by the life or lives insured and the Owner.
 - d) Verification of Identity must be completed to comply with Anti-Money Laundering legislation.
 - e) If the policy is owned by an entity, please complete Business Information Form #594 for Universal Life and Whole Life policies.
 - f) If applying for Critical Illness coverage please review the Pre-Qualifying questions in Form #347 with the life insured(s) to determine eligibility prior to completing the Application.
 - g) Questionnaires, Business Information Form #594, Additional/Updated Customer Information Form #1027 and Third Party Form #31 are available from Equinet.
4. HEALTH INFORMATION (Sections 15 and 16):
 - a) CHILDREN'S STATEMENT OF HEALTH FOR CHILD PROTECTION RIDER (CPR) (Section 15)
 - used for all children covered under Children's Protection Rider
 - b) HEALTH INFORMATION (Section 16)
 - To be completed on all lives to be insured (except not required for children covered under Children's Protection Rider) for all adults exact age 16 and over and all children age 30 days to age 17 years applying for Juvenile Critical Illness.
5. SIGNATURES (Section 17)
 - a) All Life Insureds and children age 16, age 18 in Quebec, and over are to sign in the designated areas.
 - b) All Applicants/Owners are to sign in the designated area.
 - c) If the Owner is a Corporation or Non-Corporate Entity, the signature must include the Corporation or Non-Corporate Entity's exact name, Title, Signature of 1 Signing Officer, and Corporate Seal (if available).
6. TIA - TEMPORARY LIFE INSURANCE AGREEMENT (Section 21)

(see section 7 on this page for reference):

Do not collect premium if the life insured(s) does not qualify for the Temporary Life Insurance Agreement. The Life TIA may only be given if

 - a) at least 1/12 of the annual premium is submitted with this Application by way of cheque or PAD withdrawal authorization, and
 - b) all questions under the Temporary Life Insurance Request are answered "NO" by the Person to be insured or both Persons to be insured if a joint life application.
7. TIA - TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT (Section 22)

Do not collect premium if the person to be insured does not qualify for the Temporary Critical Illness Insurance Agreement. The Critical Illness TIA may only be given if:

 - a) at least 1/12 of the annual premium is submitted with this Application by way of cheque or PAD withdrawal authorization, and
 - b) all questions under the Temporary Critical Illness Insurance Request are answered "NO" by the person to be Insured.

Note: With COD Applications - the TIA Agreement is NOT to be given to the Applicant and is NOT effective.
8. DISCLOSURE NOTICE (Section 23 and 24)

The notice regarding the MIB Section 24 and Confirmation of Advisor/Broker Disclosure Section 23 must always be given to the Applicant.
9. SALES ILLUSTRATION
Attach a Sales Illustration signed by the Owner with the Application.
10. TRANSLATION AGREEMENT AND DECLARATION (Section 18)
Complete this section if the application was translated for any proposed life insured(s) and/or applicant(s) in a language other than English.
11. All pages 1 to 39 must be submitted to Head Office.



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☐ New Application ☐ Guaranteed Insurance Option from policy #

☐ **Term Conversion from policy #**

--	--	--	--	--	--	--	--	--

(for partial conversions indicate in Section 11 direction regarding balance of Term plan)

SECTION 1- PROPOSED LIFE INSURED – LIFE 1

[illegible]

Given Name

||

Middle Initial

[illegible]

Last Name

Former Last Name: _____

Gender: ☐ Male ☐ Female Date of Birth: (dd/mm/yyyy) _____

Marital Status: _____ Country of Birth: _____

Do you want to backdate to save age? ☐ YES ☐ NO

Are you applying as a Smoker or Non Smoker? ☐ Smoker ☐ Non Smoker

Important: For Universal Life and Whole Life, sections 2-6 and 2-7 (owner verification) must be completed even if the Life Insured is the Owner.

Mailing Address & Contact Information:

Number: _____ Street: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Is the residential address the same as the mailing? ☐ YES ☐ NO If "NO", provide residential address:

Home Telephone: _____ Business Telephone: _____

Email Address: _____

Your email address is important!

Once your policy is active we will send you a link to register for **Equitable Client Access**, our online client website where you can view and manage your policy information 24/7.

Canadian Status:

☐ Canadian Citizen ☐ Landed Immigrant/Permanent Resident
Date of arrival in Canada: _____

☐ Other: Type of Visa/ Work Permit _____
Date of arrival in Canada: _____
(provide copy of supporting documentation)

Employment Details:

Name of Employer: _____ Type of Business: _____

Occupation & Duties: _____
(if retired, indicate former occupation)

Employer's Address: _____



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SECTION 1- PROPOSED LIFE INSURED – LIFE 2

Given Name: _____ Middle Initial: _____

Last Name: _____

Former Last Name: _____

Gender: ☐ Male ☐ Female Date of Birth: (dd/mm/yyyy) _____

Marital Status: _____ Country of Birth: _____

Do you want to backdate to save age? ☐ YES ☐ NOAre you applying as a Smoker or Non Smoker? ☐ Smoker ☐ Non Smoker**Important: For Universal Life and Whole Life, sections 2-6 and 2-7 (owner verification) must be completed even if the Life Insured is the Owner.****Mailing Address & Contact Information:**

Number: _____ Street: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Is the residential address the same as the mailing? ☐ YES ☐ NO If "NO", provide residential address:

Home Telephone: _____ Business Telephone: _____

Email Address: _____

Your email address is important!Once your policy is active we will send you a link to register for **Equitable Client Access**, our online client website where you can view and manage your policy information 24/7.**Canadian Status:**☐ Canadian Citizen ☐ Landed Immigrant/Permanent Resident ☐ Other: Type of Visa/ Work Permit
Date of arrival in Canada: _____ Date of arrival in Canada: _____
(provide copy of supporting documentation)**Employment Details:**

Name of Employer: _____ Type of Business: _____

Occupation & Duties: _____
(if retired, indicate former occupation)

Employer's Address: _____



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SECTION 2 - OWNER

Reference to Owner(s) in this application means the parties who will own the policy if approved by Equitable Life, and also means the Applicant(s) for the policy.

Proposed Life Insured 1 unless otherwise indicated below

☐ **LIFE 2** ☐ **LIFE 1 & 2** ☐ **OTHER INDIVIDUAL** ☐ **OTHER JOINT** ☐ **BUSINESS**

2-1. OTHER INDIVIDUAL

Given Name: Sample Middle Initial: _____

Last Name: Sample

Relationship to Proposed Life Insured: _____ Occupation and Duties: _____
(If retired, indicate former occupation)

Gender: ☐ Male ☐ Female Date of Birth: (dd/mm/yyyy) _____ Country of Birth: _____

Important: For Universal Life and Whole Life, sections 2-6 and 2-7 (owner verification) must be completed even if the Life Insured is the Owner.

Mailing Address & Contact Information:

Number: _____ Street: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Telephone: _____ Email Address: _____

Your email address is important!

Once your policy is active we will send you a link to register for **Equitable Client Access**, our online client website where you can view and manage your policy information 24/7.

Canadian Status:

☐ Canadian Citizen ☐ Landed Immigrant/Permanent Resident ☐ Other: Type of Visa / Work Permit
Date of arrival in Canada: _____ Date of arrival in Canada: _____
(provide copy of supporting documentation)

2-2. OTHER JOINT

Given Name: _____ Middle Initial: _____

Last Name: _____

Relationship to Proposed Life Insured: _____ Occupation and Duties: _____
(If retired, indicate former occupation)

Gender: ☐ Male ☐ Female Date of Birth: (dd/mm/yyyy) _____ Country of Birth: _____

Important: For Universal Life and Whole Life, sections 2-6 and 2-7 (owner verification) must be completed even if the Life Insured is the Owner.



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SECTION 2 - OWNER**Mailing Address & Contact Information:**

Number: _____ Street: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Telephone: _____ Email Address: _____

Your email address is important!

Once your policy is active we will send you a link to register for **Equitable Client Access**, our online client website where you can view and manage your policy information 24/7.

Canadian Status:☐ Canadian Citizen☐ Landed Immigrant/Permanent Resident☐ Other: Type of Visa / Work Permit

Date of arrival in Canada: _____

Date of arrival in Canada: _____

(provide copy of supporting documentation)

2-3. OTHER BUSINESS OWNER - Must also complete Business Information Form #594 for Universal Life and Whole Life policies.

Full Legal name: _____

Incorporation number: _____ Place of incorporation: _____

Number: _____ Street: _____

City: _____ Province: _____

Country: _____ Postal Code: _____

Business/Quebec enterprise number: _____ Email Address: _____

Your email address is important!

Once your policy is active we will send you a link to register for **Equitable Client Access**, our online client website where you can view and manage your policy information 24/7.

2-4. CONTINGENT OWNER (In the event of the death of the current Owner)

Given Name: _____ Last Name: _____

Relationship to Proposed Life Insured: _____

2-5. MULTIPLE OWNERS

In all provinces, **except Quebec**, if a policy is to be owned by more than one owner, policy ownership will be joint tenants with right of survivorship, so a deceased owner's interest will automatically pass to the surviving owner(s) on their death. If you want policy ownership to be tenants in common instead of joint tenants with right of survivorship, select tenants in common by checking the box below.

☐ I/we stipulate tenants in common policy ownership.

In Quebec if a policy is to be owned by more than one owner and one of the owners die, that owner's interest will pass to their estate.



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SECTION 2 - OWNER**2-6. POLICY OWNER VERIFICATION** - To be completed for Universal Life and Whole Life only.

Verification of Identity: Your Canadian identification must be verified by your advisor. Choose one of the following: driver's license, provincial photo card (excluding provincial health cards), passport, citizenship card, permanent resident card, or certificate of Indian status card. If you do not have one of the pieces of identification indicated, please go to www.equitable.ca/go/alternative-identification for information on our alternative identification requirements.

Given Name: _____ Last Name: _____

Confirmation by advisor:

☐ I, the advisor, have held and viewed the original photo identification of the Owner. Provide details:

Identification Type	Identification Number	Issuing Jurisdiction/Country	Expiry Date (dd/mm/yyyy)	Date Advisor Verified (dd/mm/yyyy)

☐ I, the advisor, have followed the alternative identification instructions, including reviewing two original documents as set out in the instructions. Copies of the two documents are attached with this application.

Check all of the options that apply to you.☐ I am a tax resident of Canada: Provide Social Insurance Number (SIN): _____☐ I am a tax resident or citizen of the United States: Provide Taxpayer Identification Number (TIN): _____☐ I am a tax resident in a jurisdiction other than Canada or the United States:

Jurisdiction of residence: _____ Taxpayer Identification Number (TIN): _____

If you do not have a TIN for a specific jurisdiction, choose one of the following reasons:

☐ I will apply or have applied for a TIN but have not yet received it☐ My jurisdiction of residence does not issue TINs to its residents☐ Other reason _____



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SECTION 2 - OWNER**2-7. JOINT POLICY OWNER VERIFICATION** - To be completed for Universal Life and Whole Life only.

Verification of Identity: Your Canadian identification must be verified by your advisor. Choose one of the following: driver's license, provincial photo card (excluding provincial health cards), passport, citizenship card, permanent resident card, or certificate of Indian status card. If you do not have one of the pieces of identification indicated, please go to www.equitable.ca/go/alternative-identification for information on our alternative identification requirements.

Given Name: _____ Last Name: _____

Confirmation by advisor:

☐ I, the advisor, have held and viewed the original photo identification of the Owner. Provide details:

Identification Type	Identification Number	Issuing Jurisdiction/Country	Expiry Date (dd/mm/yyyy)	Date Advisor Verified (dd/mm/yyyy)

☐ I, the advisor, have followed the alternative identification instructions, including reviewing two original documents as set out in the instructions. Copies of the two documents are attached with this application.**Check all of the options that apply to you.**☐ I am a tax resident of Canada: Provide Social Insurance Number (SIN): _____☐ I am a tax resident or citizen of the United States: Provide Taxpayer Identification Number (TIN): _____☐ I am a tax resident in a jurisdiction other than Canada or the United States:

Jurisdiction of residence: _____ Taxpayer Identification Number (TIN): _____

If you do not have a TIN for a specific jurisdiction, choose one of the following reasons:

☐ I will apply or have applied for a TIN but have not yet received it☐ My jurisdiction of residence does not issue TINs to its residents☐ Other reason _____



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SECTION 3 - THIRD PARTY- TO BE COMPLETED FOR ALL APPLICATIONS.

In submitting this application, is the Owner acting on behalf of a Third Party?

☐ NO ☐ YES - complete either the "Individual Third Party" or "Business / Entity Third Party" section as applicable.

Your answer should be "Yes" if someone other than the Owner or Insured will be paying the premium or has/will have an ownership interest in this policy. Examples include a power of attorney signing on behalf of the owner, someone other than the owner or insured paying premiums, or a corporation having use or access to the policy values.

Individual Third Party

Name of Third Party (first, middle, last): _____

Date of birth (dd/mm/yyyy): _____ Relationship to Owner: _____

Address (number,street and apartment) _____

City or Town: _____ Province: _____ Postal code: _____

Country: _____ Occupation and Duties: _____
(If retired, indicate former occupation)

Type of Third Party (select one and attach any applicable legal documentation)

☐ Payor ☐ Trustee ☐ Executor ☐ Collateral/Assignee ☐ Attorney/Power of Attorney/Mandatar
☐ Other (please specify) _____

Business/Entity Third Party

Full legal name: _____

Relationship to Owner: _____

Address (number,street and apartment) _____

City or Town: _____ Province: _____ Postal Code: _____

Country: _____ Nature of principal business _____

Incorporation number (if applicable): _____ Place of Incorporation (if applicable): _____

Type of Third Party (select one and attach any applicable legal documentation)

☐ Payor ☐ Trustee ☐ Executor ☐ Collateral/Assignee ☐ Attorney/Power of Attorney/Mandatar
☐ Other (please specify) _____



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SECTION 4 - WHOLE LIFE PLAN INFORMATION - ATTACH A SIGNED PLAN ILLUSTRATION**PLAN TYPE:****LIFE 1**☐ Equimax Estate Builder ☐ Equimax Wealth Accumulator**PREMIUM TYPE:**☐ Life Pay ☐ 20 Pay**COVERAGE TYPE:**☐ Single Life ☐ Joint First to Die* ☐ Joint Last to Die***FACE AMOUNT: \$** _____**LIFE 2** (for additional single life policy)☐ Equimax Estate Builder ☐ Equimax Wealth Accumulator☐ Life Pay ☐ 20 Pay☐ Single Life ☐ Joint First to Die* ☐ Joint Last to Die***FACE AMOUNT: \$** _____**DIVIDEND OPTION:****LIFE 1**☐ Paid in Cash☐ Premium Reduction☐ On Deposit☐ Paid-Up Additions☐ Enhanced Protection:☐ 10 Year Enhancement Guarantee☐ Lifetime Enhancement Guarantee

Basic Amount: \$ _____

Initial Enhancement Amount: \$ _____

Total Amount: \$ _____ (Basic + Enhancement)

LIFE 2 (for additional single life policy)☐ Paid in Cash☐ Premium Reduction☐ On Deposit☐ Paid-Up Additions☐ Enhanced Protection:☐ 10 Year Enhancement Guarantee☐ Lifetime Enhancement Guarantee

Basic Amount: \$ _____

Initial Enhancement Amount: \$ _____

Total Amount: \$ _____ (Basic + Enhancement)



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SECTION 4 - WHOLE LIFE PLAN INFORMATION - ATTACH A SIGNED PLAN ILLUSTRATION**WHOLE LIFE RIDERS AND ADDITIONAL BENEFITS:****LIFE 1**

- ☐ Disability Waiver of Premium
- ☐ Applicant/Payor Waiver of Premium**
- ☐ Excelsior Deposit Option (EDO) \$ _____

- ☐ Term Rider ☐ 10 YRCT \$ _____
- ☐ 20 YRCT \$ _____
- ☐ T30/65 \$ _____

- ☐ EquiLiving® Critical Illness*** \$ _____
- ☐ 10 Year Renewable
- ☐ Level to 75
- ☐ Level to 100

- ☐ Applicant's Death and Disability Waiver of Premium (juvenile plans only)**
- ☐ Additional Accidental Death Benefit \$ _____
- ☐ Children's Protection Rider \$ _____
- ☐ Flexible Guaranteed Insurability Option (to age 17)

Option Amount	Option Age
\$	21
\$	
\$	
\$	
\$	

(Must complete age 21 amount and if applicable, additional ages and amounts)

- ☐ Other _____

*Life 2 information must also be completed on the Application.

** Must complete Application for Applicant/Payor

*** To apply for the EquiLiving Critical Illness Rider, please review Pre-Qualifying Questions in form # 347.

WHOLE LIFE RIDERS AND ADDITIONAL BENEFITS:**LIFE 2**

- ☐ Disability Waiver of Premium
- ☐ Applicant/Payor Waiver of Premium**
- ☐ Excelsior Deposit Option (EDO) \$ _____

- ☐ Term Rider ☐ 10 YRCT \$ _____
- ☐ 20 YRCT \$ _____
- ☐ T30/65 \$ _____

- ☐ EquiLiving® Critical Illness*** \$ _____
- ☐ 10 Year Renewable
- ☐ Level to 75
- ☐ Level to 100

- ☐ Applicant's Death and Disability Waiver of Premium (juvenile plans only)**
- ☐ Additional Accidental Death Benefit \$ _____
- ☐ Children's Protection Rider \$ _____
- ☐ Flexible Guaranteed Insurability Option (to age 17)

Option Amount	Option Age
\$	21
\$	
\$	
\$	
\$	

(Must complete age 21 amount and if applicable, additional ages and amounts)

- ☐ Other _____



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SECTION 5 - EQUATION GENERATION UNIVERSAL LIFE PLAN INFORMATION
ATTACH A SIGNED PLAN ILLUSTRATION

If applying for an Equation Generation® Universal Life plan complete the following for Life 1 and Life 2 (where applicable).
For Investment Options refer to Section 6.

	LIFE 1	LIFE 2 (for additional single life policy)
PLAN OPTION:	☐ With Bonus OR ☐ Low Fees (Select one)	☐ With Bonus OR ☐ Low Fees (Select one)
COVERAGE TYPE:	☐ Single ☐ Joint First to Die* ☐ Joint Last to Die*	☐ Single ☐ Joint First to Die* ☐ Joint Last to Die*
	FACE AMOUNT: \$ _____	FACE AMOUNT: \$ _____

DEATH BENEFIT OPTIONS:**COST OF INSURANCE CHARGES** (Check only one)

	LIFE 1		LIFE 2	
	YRT	Level	YRT	Level
Account Value Protector	☐	☐	☐	☐
Level Protector	☐	☐	☐	☐

*Life 2 Information must also be completed on this Application.



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SECTION 5 - EQUATION GENERATION UNIVERSAL LIFE PLAN INFORMATION**ATTACH A SIGNED PLAN ILLUSTRATION****UNIVERSAL LIFE RIDERS AND ADDITIONAL BENEFITS:**

NOTE: Availability of Riders and Additional Benefits will vary depending on the Universal Life plan and coverage option selected.

LIFE 1☐ Term

not available on Joint plans

☐ 10 YRCT☐ 20 YRCT**AMOUNTS:**

\$ _____

\$ _____

☐ EquiLiving® Critical Illness*☐ 10 Year Renewable☐ Level to 75☐ Level to 100☐ Disability Waiver of Monthly Charges☐ Additional Accidental Death Benefit

\$ _____

☐ Children's Protection Rider

\$ _____

LIFE 2☐ Term

not available on Joint plans

☐ 10 YRCT☐ 20 YRCT**AMOUNTS:**

\$ _____

\$ _____

☐ EquiLiving® Critical Illness*☐ 10 Year Renewable☐ Level to 75☐ Level to 100☐ Disability Waiver of Monthly Charges☐ Additional Accidental Death Benefit

\$ _____

☐ Children's Protection Rider

\$ _____

ADDITIONAL RIDERS AVAILABLE WITH JUVENILE PLANS:☐ Applicant/Owner Waiver of Charges**☐ Death & Disability☐ Death Only☐ Flexible Guaranteed Insurability Option (to age 15)

Option Amount	Option Age
\$	18
\$	
\$	
\$	
\$	

☐ Other _____

*To apply for the EquiLiving® Critical Illness Rider, please review Pre-Qualifying Questions in form # 347.

**Must complete Application for Applicant/Owner.

ADDITIONAL RIDERS AVAILABLE WITH JUVENILE PLANS:☐ Applicant/Owner Waiver of Charges**☐ Death & Disability☐ Death Only☐ Flexible Guaranteed Insurability Option (to age 15)

Option Amount	Option Age
\$	18
\$	
\$	
\$	
\$	

☐ Other _____

*To apply for the EquiLiving® Critical Illness Rider, please review Pre-Qualifying Questions in form # 347.

**Must complete Application for Applicant/Owner.

**SECTION 6 – UNIVERSAL LIFE – INVESTMENT INTEREST ACCOUNTS MONTHLY CHARGES**

INVESTMENT INTEREST ACCOUNTS: Indicate below under Premium Allocation the percentage of the net premium to be allocated to the corresponding selected Interest Account. If your planned deposits are just sufficient to cover the minimum deposits, we recommend that you choose either the Daily Interest Account or one of the Guaranteed Deposit Accounts to avoid potential negative interest if markets go down.

MONTHLY CHARGES: My Monthly Charges will be deducted pro-rata from the Account and options selected under Premium Allocation unless indicated here ☐ (If indicated, monthly charges will be deducted as elected under Charges Allocation from the Account and options specified under Premium Allocation (must total 100%))

SHUTTLE ACCOUNT: Shuttle account allocation will be 100% to the Daily Interest Account.

	PREMIUM ALLOCATION	CHARGES ALLOCATION
INVESTMENT INTEREST ACCOUNT		
☐ Daily Interest Account	_____ %	_____ %
INDEX INTEREST OPTIONS:		
☐ American Equity	_____ %	_____ %
☐ European	_____ %	_____ %
☐ U.S. Technologies	_____ %	_____ %
☐ U.S. Blue Chip	_____ %	_____ %
☐ Canadian Equity	_____ %	_____ %
PERFORMANCE FUND INTEREST OPTIONS:		
☐ Global	_____ %	_____ %
☐ Canadian	_____ %	_____ %
☐ Canadian Bond	_____ %	_____ %
☐ Canadian Value Stock	_____ %	_____ %
☐ Large Cap Canadian Equity	_____ %	_____ %
☐ Global Fixed Income	_____ %	_____ %
☐ Global Balanced	_____ %	_____ %
PORTFOLIO INTEREST OPTIONS:		
☐ Diversified Income	_____ %	_____ %
☐ Balanced Income	_____ %	_____ %
☐ Balanced Growth	_____ %	_____ %
☐ Growth	_____ %	_____ %
☐ Diversified Equity	_____ %	_____ %
GUARANTEED DEPOSIT OPTIONS:		
☐ Guaranteed Deposit Account	_____ %	_____ %

I hereby elect that when sufficient funds (as stated in the contract) have accumulated in the Daily Interest Account, such amount will be transferred automatically as of the next policy month to a Guaranteed Deposit Account for a term of (choose one):

☐ 1 year ☐ 5 years ☐ 10 years



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SECTION 7 - TERM PLAN INFORMATION - ATTACH A PLAN ILLUSTRATION

If applying for a Term plan complete the following for Life 1 and Life 2 (where applicable):

COVERAGE TYPE:

☐ Single Life ☐ Joint First to Die* (10 YRCT/20 YRCT only) ☐ Multiple Lives* (not available for business-owned plans)

LIFE 1

☐ 10 YRCT ☐ 20 YRCT ☐ Term 30/65

FACE AMOUNT: \$ _____

☐ Additional Term Coverage: (not available for Joint plans)

☐ 10 YRCT \$ _____

☐ 20 YRCT \$ _____

☐ Term 30/65 \$ _____

RIDERS AND ADDITIONAL BENEFITS

☐ EquiLiving® Critical Illness** \$ _____

☐ 10 Year Renewable

☐ Level to 75

☐ Level to 100

☐ Disability Waiver of Premium

☐ Applicant/Payor Waiver of Premium***

☐ Additional Accidental Death Benefit \$ _____

☐ Children's Protection Rider \$ _____

☐ Guaranteed Insurability \$ _____

☐ If approved at Preferred Term Class, increase the face amount to maintain the agreed upon premium.

*Life 2 information must also be completed on this application.

**To apply for the EquiLiving Critical Illness Rider, please review Pre-Qualifying Questions in form # 347.

***Must complete Application for Applicant/Payor

LIFE 2

☐ 10 YRCT ☐ 20 YRCT ☐ Term 30/65

FACE AMOUNT: \$ _____

☐ Additional Term Coverage: (not available for Joint plans)

☐ 10 YRCT \$ _____

☐ 20 YRCT \$ _____

☐ Term 30/65 \$ _____

RIDERS AND ADDITIONAL BENEFITS

☐ EquiLiving® Critical Illness** \$ _____

☐ 10 Year Renewable

☐ Level to 75

☐ Level to 100

☐ Disability Waiver of Premium

SECTION 8 – EQUILIVING® CRITICAL ILLNESS PLAN INFORMATION

Prior to applying for EquiLiving Critical Illness review the Pre-Qualifying Questions in form # 347 to determine eligibility prior to completing this Section.

COVERAGE TYPE:

☒ Single Life

PLAN TYPE:

☐ 10 Year Renewable to Age 75

☐ Level to Age 75

☐ Level to Age 100

SUM INSURED: \$ _____

RIDERS:

☐ Disability Waiver of Premium

☐ Applicant/Payor Waiver of Premium*

☐ Return of Premiums at Surrender/Expiry

☐ Return of Premiums on Death

☐ Accidental Death Benefit \$ _____

☐ Term Rider: ☐ 10 YRCT ☐ 20 YRCT \$ _____

ADDITIONAL RIDER AVAILABLE WITH JUVENILE PLANS:

☐ Applicant's Death and Disability Waiver of Premium*

*Life 2 information must also be completed on this application.



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SECTION 9 - BENEFICIARY LIFE 1

Owner residing in Quebec: Quebec law stipulates that designation of the owner's spouse (married or civil union) is irrevocable, unless the owner indicates the designation to be revocable by checking the following box:

☐ I stipulate that any beneficiary designation of my spouse (married or civil union) is revocable.

LIFE BENEFICIARY: Primary Beneficiary - If there are more than 4 primary beneficiaries, name these in the Special Instructions Section.

Given name	Last name	Date of Birth if minor (dd/mm/yyyy)	Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies	Trustee applies	Benefit shared equally unless % specified
				☐	
				☐	
				☐	
				☐	

Contingent Beneficiary - If there are more than 4 contingent beneficiaries, name these in the Special Instructions Section.

Given name	Last name	Date of Birth if minor (dd/mm/yyyy)	Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies	Trustee applies	Benefit shared equally unless % specified
				☐	
				☐	
				☐	
				☐	

Trustee for all minor beneficiaries (not applicable in Quebec)

Name: _____
Given Last

CRITICAL ILLNESS BENEFICIARY:

☐ Owner ☐ Proposed Person to be Insured ☐ Other

If other: _____
Given Last Date of Birth if minor(dd/mm/yyyy)

Relationship to Proposed Life Insured or
Relationship to Owner where Quebec law applies

☐ Trustee applies

Return of Premium on Death Beneficiary (if applicable):

☐ Owner ☐ Estate of Owner ☐ Other

If other: _____
Given Last Date of Birth if minor(dd/mm/yyyy)

Relationship to Proposed Life Insured or
Relationship to Owner where Quebec law applies

☐ Trustee applies

Trustee for all minor beneficiaries (not applicable in Quebec)

Name: _____
Given Last



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 9 - BENEFICIARY LIFE 2

Owner residing in Quebec: Quebec law stipulates that designation of the owner's spouse (married or civil union) is irrevocable, unless the owner indicates the designation to be revocable by checking the following box:

☐ I stipulate that any beneficiary designation of my spouse (married or civil union) is revocable.

LIFE BENEFICIARY: Primary Beneficiary - If there are more than 4 primary beneficiaries, name these in the Special Instructions Section.

Given name	Last name	Date of Birth if minor (dd/mm/yyyy)	Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies	Trustee applies	Benefit shared equally unless % specified
				☐	
				☐	
				☐	
				☐	

Contingent Beneficiary - If there are more than 4 contingent beneficiaries, name these in the Special Instructions Section.

Given name	Last name	Date of Birth if minor (dd/mm/yyyy)	Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies	Trustee applies	Benefit shared equally unless % specified
				☐	
				☐	
				☐	
				☐	

Trustee for all minor beneficiaries (not applicable in Quebec)

Name:

Given

Last

CRITICAL ILLNESS BENEFICIARY:

☐ Owner ☐ Proposed Person to be Insured ☐ Other

If other:

Given

Last

Date of Birth if minor (dd/mm/yyyy)

Relationship to Proposed Life Insured or
Relationship to Owner where Quebec law applies

☐ Trustee applies

Return of Premium on Death Beneficiary (if applicable):

☐ Owner ☐ Estate ☐ Other

If other:

Given

Last

Date of Birth if minor (dd/mm/yyyy)

Relationship to Proposed Life Insured or
Relationship to Owner where Quebec law applies

☐ Trustee applies

Trustee for all minor beneficiaries (not applicable in Quebec)

Name:

Given

Last



APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

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SECTION 10 – PREMIUM AND PAYMENT MODE**INITIAL PREMIUM OF \$ _____****PAID BY:** For all Premiums and Deposits $\geq$ \$100,000 Complete Section 12-1

- ☐ Cheque payment submitted with the Application (TIA IS AVAILABLE WITH THIS OPTION)
☐ Withdrawal from Pre-Authorized Debit Plan when application is received (TIA IS AVAILABLE WITH THIS OPTION)
☐ Cheque when the policy delivered (TIA NOT AVAILABLE WITH THIS OPTION)
☐ Withdrawal from Pre-Authorized Debit Plan when policy is issued (TIA NOT AVAILABLE WITH THIS OPTION)

SUBSEQUENT PREMIUMS PAID BY:

- ☐ Monthly Pre-Authorized Debit Plan (Complete PAD section)
☐ Annual Premiums \$ _____ (collected by cheque on delivery)
(Includes EDO Amount)

PRE-AUTHORIZED DEBIT PLAN ("PAD"):

The Equitable Life Insurance Company of Canada ("Equitable Life") and my/our financial institution are directed and authorized to process withdrawals from my/our account on a monthly basis, subject to the conditions below, for the purpose of collecting premiums as follows:

Banking Information (check appropriate box) Note: "line of credit" accounts or credit cards are not acceptable payment options.

- ☐ Add to existing PAD for Equitable Policy Number: _____
☐ Establish new: **Void cheque required. Cheque must have account holder name pre-printed.**
☐ The same account shown on the first cheque provided with application
☐ The account shown on the attached VOID cheque or Bank Letter of Direction (payor name is required on the cheque)
☐ Cheque or Bank Letter of Direction will be provided upon policy delivery

General Information

Name of Payor(s): _____

(if different from Policy Owner(s) or Life Insured complete Section 3 - Third Party)

Withdrawal Information

In the event of non-payment due to insufficient funds, an attempt to re-draw your payment will automatically occur within 2 – 10 business days from the Withdrawal Date. The Payor is responsible for any NSF charges incurred by their Financial Institution.

Amount: \$ _____

(This amount is considered 'Fixed' and
Includes EDO Amount)

- ☐ Match Issue Date
☐ *Preferred Withdrawal Date on _____ (1st – 28th of each month)

*This option is not available for Universal Life Policies

Type of Service

For the purposes of this agreement, all PAD withdrawals from my/our bank account will be treated as personal withdrawals of insurance premiums, as defined by the Canadian Payments Association in Rule H1 at www.payments.ca.

Waivers

I/we waive the right to receive pre-notification of the first withdrawal, any increases in the fixed amount of the automatic withdrawal or a change in the date of the withdrawal.

Cancellation

Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.payments.ca). I/we have the right to cancel this PAD at any time. This PAD shall remain in effect until I/we notify Equitable Life of cancellation.

Note: To ensure cancellation of the next withdrawal, notice by way of telephone, letter, email or fax must be received at the Head Office of Equitable Life, 10 business days prior to your next withdrawal. Any cancellation of this PAD will not affect the policy contract(s) between you and Equitable Life so long as payment is provided by an alternate method within the period specified in your policy contract(s).

Recourse & Reimbursement

To obtain more information on recourse rights, please contact your financial institution or visit www.payments.ca. I/we have certain recourse rights if any withdrawal does not comply with this PAD. I/we have the right to receive reimbursement for any withdrawal that is not authorized or is not consistent with this PAD.

Contact Information

Equitable Life of Canada. One Westmount Road North, P.O. Box 1603 Stn Waterloo, Waterloo ON, N2J 4C7
T.F. 1.800.668.4095 • F. 519.883.7404 • Email: customer-service@equitable.ca



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 11 – SPECIAL INSTRUCTIONS FROM OWNER**SECTION 12 – FINANCIAL INFORMATION****12-1. POLITICAL POSITIONS** (For Universal Life and Whole Life and only when deposit is equal to or greater than \$100,000)

For the purposes of this question:

- "Payor" means the person who is making the payment(s) on the policy.
- "Close relative" means the Payor's spouse, sibling, parent, spouse's parent, child, or child's spouse.
- "Close associate" means an individual who is closely connected to the Payor for personal or business reasons.

a) Does the Payor, any of the Payor's close relatives or any of the Payor's close associates hold, or have they ever held, any of the positions listed below:

☐ Yes - indicate the position held below ☐ No - go to section 12.2**Position in Canada or in another country**

Note: For positions in Canada, list only the positions held in the past 5 years. For all other countries, list all such positions that have ever been held.

- ☐ Head of state or head of government (including Governor General and Lieutenant Governor)
- ☐ Deputy Minister (or equivalent)
- ☐ President of a state-owned company or bank (including a corporation that is wholly owned by a federal or provincial government)
- ☐ Leader or President of a political party in a legislature
- ☐ Member of the executive council of government or member of a legislature (including the Senate, House of Commons or a provincial legislature)
- ☐ Ambassador or ambassador's attaché or counsellor
- ☐ Head of a government agency
- ☐ Military General (or higher rank)
- ☐ Judge (in Canada only, must be a judge of an appeal court)
- ☐ Mayor of a Canadian municipality (does not include mayors in countries other than Canada)
- ☐ Head of an international organization that is established by the governments of countries or the head of an institution of any such organization

b) If you answered "Yes" to the question above, complete the following information:

What is the name of the person who holds or held the position? _____

What is the title of the position held? _____

Position held from: _____ to _____ In what country was the position held? _____
(starting year) (ending year)

With what organization, government or institution was the position held? _____

How is this person related to the Payor? ☐ The person is the Payor ☐ Close relative (relationship): _____☐ Close associate (relationship): _____

Note: If more than one person has held a position, complete section 1 and 2 of the "Additional / Updated Customer Information Form # 1027" for each additional person.



APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

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SECTION 12 – FINANCIAL INFORMATION**12-2. SOURCE OF FUNDS** (completion is mandatory for all plan types)

Check all that apply:

- | | | | |
|--|---|---|---|
| ☐ Salary or Earned Income | ☐ Business Income | ☐ Sale of Property | ☐ Borrowed Funds |
| ☐ Gifted Funds | ☐ Proceeds From Death Benefits or Estate | ☐ Owner Savings | ☐ Family Member |
| ☐ Foreign Funds (real estate, income) | ☐ Other _____ | | |

12-3. Have you ever declared bankruptcy, personal or business or had any major financial difficulties such as pay garnished, consumer proposal or a pending bankruptcy petition, whether discharged or not?

(Complete for all Proposed Lives Insured exact age 16 and over) If "YES" complete:

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

LIFE 1			
Reason	Date declared (mm/yyyy)	Date discharged (mm/yyyy)	Is the Trustee aware of this application for insurance?
☐ Personal			☐ YES
☐ Business			☐ NO

LIFE 2			
Reason	Date declared (mm/yyyy)	Date discharged (mm/yyyy)	Is the Trustee aware of this application for insurance?
☐ Personal			☐ YES
☐ Business			☐ NO

12-4. What is the reason for purchasing this policy? (Completion mandatory for all plan types. Not all policies are suitable for all purposes.)**LIFE 1 - What is the intended use of the insurance?** (Check all that apply)

- | | |
|--|--|
| ☐ Short Term Savings | ☐ Education Purposes |
| ☐ Retirement/Long Term Savings | ☐ Income Creation/Investment |
| ☐ Mortgage/Debt Insurance | ☐ Income/Family Protection |
| ☐ Inheritance/Estate Protection | ☐ Buy Sell Agreement |
| ☐ Business | ☐ Key Person Protection |
| ☐ Gift | ☐ Other sales concepts: _____ |

LIFE 2 - What is the intended use of the insurance? (Check all that apply)

- | | |
|--|--|
| ☐ Short Term Savings | ☐ Education Purposes |
| ☐ Retirement/Long Term Savings | ☐ Income Creation/Investment |
| ☐ Mortgage/Debt Insurance | ☐ Income/Family Protection |
| ☐ Inheritance/Estate Protection | ☐ Buy Sell Agreement |
| ☐ Business | ☐ Key Person Protection |
| ☐ Gift | ☐ Other sales concepts: _____ |

12-5. Personal and Business purposes: (Complete for all Personal / Business purposes for all Proposed Lives Insured exact age 16 and over)

LIFE 1	
Annual earned income	\$
Other income: including pensions, dividends, interest, rental income, bonuses, government benefits	\$
Assets: including cash, real estate, stocks, bonds	\$
Liabilities: including mortgages, loans	\$
Total Canadian net worth	\$
Total Foreign net worth	\$

LIFE 2	
Annual earned income	\$
Other income: including pensions, dividends, interest, rental income, bonuses, government benefits	\$
Assets: including cash, real estate, stocks, bonds	\$
Liabilities: including mortgages, loans	\$
Total Canadian net worth	\$
Total Foreign net worth	\$

12-6. Business purposes: (Complete for all Business purposes)

Nature of business			
Assets: current, fixed	\$		
Liabilities: current, long term	\$		
Fair market value	\$		
Net profit: last year	\$		
Net profit: previous year	\$		
Owner's name and title	% of Business ownership	Insurance in force	Insurance applied for
		\$	\$
		\$	\$
		\$	\$



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 13 – INSURANCE HISTORY - To be completed by all Lives Insured**13-1. Do you have any other insurance in force?**

If "YES" complete

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	Company name	Policy number	Date issued (mm/yyyy)	Plan type	Amount	Personal or business	Replacing
				☐ Life ☐ CI ☐ DI ☐ LTC	\$		☐ YES ☐ NO
				☐ Life ☐ CI ☐ DI ☐ LTC	\$		☐ YES ☐ NO
				☐ Life ☐ CI ☐ DI ☐ LTC	\$		☐ YES ☐ NO
				☐ Life ☐ CI ☐ DI ☐ LTC	\$		☐ YES ☐ NO

13-2. Have you ever had any application for life, disability, critical illness or long term care insurance declined, rated, postponed, offered with restrictions, cancelled or modified in any way?

If "YES" complete

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	Date (mm/yyyy)	Details: indicate which company and why

13-3. Do you have an application for life, disability, critical illness or long term care insurance currently pending or contemplated with any other insurance company?

If "YES" complete

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	Company name	Plan type	Amount applied for	Total amount of new insurance to be placed with all companies
		☐ Life ☐ CI ☐ DI ☐ LTC	\$	\$
		☐ Life ☐ CI ☐ DI ☐ LTC	\$	\$

**SECTION 14 – GENERAL INFORMATION****14-1. To be completed by all lives to be insured:**

Do you intend to travel outside of North America for longer than a total of 2 months, or change your Country of residence, in the next 12 months? If "YES" complete

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	City and Country	Purpose of travel (business, tourist, visit family)	Date of departure (mm/yyyy)	Length of stay

14-2. To be completed by all lives to be insured exact age 16 and over:

A. In the last 2 years have you flown in an aircraft as a pilot, student pilot or crew member, or do you intend to do so in the next 12 months? (If "YES", complete Aviation Questionnaire, Form # 1322)

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

B. In the last 2 years have you engaged in, or do you intend to engage in any hazardous activities including but not limited to: motorized racing, underwater diving (scuba), sky diving, bungee-jumping, base jumping, sky surfing, hang-gliding, ultra-light flying, mountain climbing, back country/out of bounds skiing/snowmobiling or snowboarding or Heli/Cat skiing. (If "YES", complete the applicable Questionnaire)

YES	NO	YES	NO
☐	☐	☐	☐

Life #	Dates (mm/yyyy)	Details of Activities

C. Have you been charged with, or convicted of driving under the influence of alcohol and/or drugs, or refused to provide a breathalyzer sample, in the last 10 years?

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

D. Within the last 3 years have you been charged or convicted of any other driving offences (excluding parking tickets) or have you had your driver's license suspended or revoked?

YES	NO	YES	NO
☐	☐	☐	☐

If "YES" to questions 14-2(C) and (D) provide drivers license # Life 1 _____ Life 2 _____

Life #	Dates (mm/yyyy)	Details of Violation

E. In the last 10 years have you been charged with or convicted of or pleaded guilty to any criminal offence or financial services regulatory offence (including securities regulators), or are any such charges pending?

If "YES", complete:

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	Nature of the offence	Date charged (mm/yyyy)	Sentence details: including imprisonment, fine, suspended sentence, conditional discharge, probation	Date Sentence and any Probation completed (mm/yyyy)



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 14 – GENERAL INFORMATION

14-3. Have you smoked any cigarettes or used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months?

If "YES", complete:

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

LIFE 1		
Product	Amount	Frequency
Cigars/ cigarillos ☐ YES ☐ NO		☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time
Cigarettes, pipe, chewing tobacco, nicotine gum/ patch, betel nuts/leaves, smoking cessation aids, snuff, shisha/hookah, e-cigarettes or vaping other _____ ☐ YES ☐ NO		☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time

LIFE 2		
Product	Amount	Frequency
Cigars/ cigarillos ☐ YES ☐ NO		☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time
Cigarettes, pipe, chewing tobacco, nicotine gum/ patch, betel nuts/leaves, smoking cessation aids, snuff, shisha/hookah, e-cigarettes or vaping other _____ ☐ YES ☐ NO		☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time

14-4. a) Have you used any form of marijuana or hashish within the last 5 years?**b) Was it prescribed by your physician?**

If "YES", complete:

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐
☐	☐	☐	☐

LIFE 1		
Amount	Frequency	Date last used
	☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time	☐ Within 0-12 months ☐ Within last 13-24 months ☐ Within last 25-60 months

LIFE 2		
Amount	Frequency	Date last used
	☐ Per day ☐ Per week ☐ Per month ☐ Per year ☐ Single time	☐ Within 0-12 months ☐ Within last 13-24 months ☐ Within last 25-60 months

14-5. Have you ever used unprescribed drugs or experimented with drugs or narcotics such as ecstasy, cocaine, LSD, heroin, amphetamines, barbiturates, anabolic steroids or similar agents?

If "YES", complete Drug Use Questionnaire, Form # 1326.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

14-6. Do you drink alcohol?

If "YES", complete:

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

LIFE 1		
Product	Amount consumed	Frequency
Beer	# bottles _____	☐ Daily ☐ Weekly ☐ Monthly
Wine	# of glasses _____	☐ Daily ☐ Weekly ☐ Monthly
Liquor	# of _____ ☐ oz ☐ ml	☐ Daily ☐ Weekly ☐ Monthly

LIFE 2		
Product	Amount consumed	Frequency
Beer	# bottles _____	☐ Daily ☐ Weekly ☐ Monthly
Wine	# of glasses _____	☐ Daily ☐ Weekly ☐ Monthly
Liquor	# of _____ ☐ oz ☐ ml	☐ Daily ☐ Weekly ☐ Monthly

14-7. Have you ever been treated or counselled for alcohol consumption or abuse, or has someone ever recommended that you seek treatment or counselling for alcohol consumption or abuse or to reduce your alcohol consumption?

If "YES", complete Drinking Habits Questionnaire, Form # 1325.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐



APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

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SECTION 14 – GENERAL INFORMATION**14-8. To be completed for all lives insured under exact age 16:****A. Are all other children in the family insured?**

If "YES", indicate the amount of life insurance:

Sibling #1	\$	Sibling #4	\$
Sibling #2	\$	Sibling #5	\$
Sibling #3	\$	Sibling #6	\$

If "NO", explain:

B. What is the total amount of life insurance in effect on each of the child's parents?

Parent #1	\$	Parent #2	\$
-----------	----	-----------	----

C. What is the gross earned income of each of the child's parents?

Parent #1	\$	Parent #2	\$
-----------	----	-----------	----

SECTION 15 – CHILDREN'S STATEMENT OF HEALTH FOR CHILDRENS PROTECTION RIDER (CPR)

Complete this section only if you are applying for a childrens Protection Rider.

CHILDREN'S PROTECTION RIDER					
Child's name (Given, Last)	Gender	Date of birth (dd/mm/yyyy)	Height	Weight	Relationship to Insured
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____
	☐ Male ☐ Female		☐ ft/in ☐ cm	☐ lbs ☐ kg	☐ Child ☐ Stepchild ☐ Legally adopted ☐ Other _____



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 15 – CHILDREN’S STATEMENT OF HEALTH FOR CHILD PROTECTION RIDER (CPR)

15-1. Has there ever been an application for life or critical illness insurance on any of these children that was declined, rated, postponed, offered with restrictions, cancelled or modified in any way?

If “YES”, identify the child and provide details below.

YES	NO
☐	☐

15-2. If any of the children is less than 2 years of age, was the birth premature by less than 36 weeks gestation or is there any indication of failure to thrive or gain weight or have you been told the child is not meeting developmental or growth milestones?

If “YES”, identify the child and provide details and birth weight below.

YES	NO
☐	☐

15-3. Do any of the children have any physical or mental health impairment or have they had any illness, impairment or injury that has required treatment, surgery, or hospitalization?

If “YES”, identify the child and provide details below.

YES	NO
☐	☐

15-4. Are any of the children on medication or has any treatment or diagnostic test been advised that has not been completed?

If “YES”, identify the child and provide details below.

YES	NO
☐	☐

15-5. Have any of the children been treated, tested for or had a symptom or indication of autism, cancer, cerebral palsy, congenital heart disease, cystic fibrosis, Down’s syndrome, developmental delay or muscular dystrophy?

If “YES”, identify the child and provide details below.

YES	NO
☐	☐

15-6. Do any of the children reside at a different address from the Proposed Lives Insured or Owner?

If “YES”, identify the child and provide details below.

YES	NO
☐	☐

Question	Name of Child	Details (including dates, doctor name, medications, dosage etc.)

**SECTION 16 – HEALTH INFORMATION**

Note: Signatures of all children who have attained age 16, (18 in Quebec) are required in Section 17.

To be completed for all lives insured applying for Life Insurance and Critical Illness Insurance. Questions to be answered by all Person(s) exact age 16 and over or Parent or Legal Guardian on behalf of Children under exact age 16. Completion of this section is not required if a paramedical or medical Part II is required.

IMPORTANT - when completing your application:

Do not provide any information about genetic tests. A "genetic test" is a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, monitoring, diagnosis or prognosis.

Do include information about treatment for or symptoms, complaints or indication of a genetic condition. When asked about family history, include any genetic conditions in your response.

LIFE 1

Given name: _____

Last name: _____

16-1.Height: ☐ ft/in ☐ cm Weight: ☐ lbs ☐ kgHave you had any weight change in the past year? ☐ YES ☐ NOGain: ☐ lbs ☐ kg Loss: ☐ lbs ☐ kg

Reasons for weight change: _____

Are you pregnant ☐ YES ☐ NO ☐ lbsIf yes, Pre-pregnancy weight _____ ☐ kg

Due date _____

16-2. Name and address of medical or health care advisor or medical clinic:

Date last consulted (dd/mm/yyyy): _____

Reason for last medical consultation: _____

At the last medical consultation was: (i) a diagnosis made; (ii) treatment or medication prescribed; (iii) test results obtained or provided; or (iv) follow-up advised? ☐ YES ☐ NO If "YES" provide details:

LIFE 2

Given name: _____

Last name: _____

16-1.Height: ☐ ft/in ☐ cm Weight: ☐ lbs ☐ kgHave you had any weight change in the past year? ☐ YES ☐ NOGain: ☐ lbs ☐ kg Loss: ☐ lbs ☐ kg

Reasons for weight change: _____

Are you pregnant ☐ YES ☐ NO ☐ lbsIf yes, Pre-pregnancy weight _____ ☐ kg

Due date _____

16-2. Name and address of medical or health care advisor or medical clinic:

Date last consulted (dd/mm/yyyy): _____

Reason for last medical consultation: _____

At the last medical consultation was: (i) a diagnosis made; (ii) treatment or medication prescribed; (iii) test results obtained or provided; or (iv) follow-up advised? ☐ YES ☐ NO If "YES" provide details:

16-3. If the child is less than 2 years of age, was the birth premature by less than 36 weeks gestation or is there any indication of failure to thrive or gain weight or have you been told the child is not meeting developmental or growth milestones?

YES	NO
☐	☐

If "YES", identify the child and provide details and birth weight below.

Name of Child	Details (including dates, doctor name, medications, dosage etc.)



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 16 – HEALTH INFORMATION

16-4. Family History: Has any family (father, mother, brother or sister) member ever been diagnosed with:

- Alzheimer's disease
- heart disease
- multiple sclerosis
- retinitis pigmentosa
- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Parkinson's disease
- any other hereditary disease or disorder
- cancer (include type)
- hepatitis
- stroke
- diabetes (include type)
- Huntington's chorea
- polycystic kidney disease
- any other motor neuron disease

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

If "YES", complete:

Life #	Family member: Father, Mother, Sisters and Brothers	Condition	Age at onset	Age if living	Age at death

16-5. Heart and circulatory system: Have you ever been treated for or had any symptoms, complaints or indication of:

- aneurysm
- chest pain or shortness of breath
- heart murmur
- high cholesterol (hyperlipidemia)
- stroke or cerebrovascular accident (CVA)
- pacemaker
- angina
- coronary artery disease (CAD) including Bypass/angioplasty
- heart attack (myocardial infarction)
- irregular heart beat, pulse
- transient ischemic attack (TIA)
- blood clot
- high blood pressure (hypertension)
- peripheral vascular disease (poor circulation)
- any other disease or disorder of the heart or blood vessels

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

If "YES", provide details in section 16-22.

16-6. Abnormal growths or malignancy: Have you ever been treated for or had any symptoms, complaints or indication of:

- abnormal mammogram
- polyp
- any other growths or malignancies
- cancer
- tumour
- leukemia
- basal cell carcinoma
- lump/cyst
- melanoma
- lymphoma

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

If "YES", provide details in section 16-22.

16-7. Blood, glandular and endocrine system: Have you ever been treated for or had any symptoms, complaints or indication of:

- abnormal blood sugar
- goiter
- a bleeding disorder
- any other thyroid or endocrine disease or disorder
- diabetes
- hyperthyroidism/hypothyroidism
- anemia
- gestational diabetes
- lymph, adrenal or pituitary gland disease or disorder
- hemophilia
- any other blood disease or disorder

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

If "YES", provide details in section 16-22.

16-8. Gastrointestinal system: Have you ever been treated for or had any symptoms, complaints or indication of:

- cirrhosis
- hepatitis (including carrier state)
- pancreatitis
- ulcer (peptic or gastric)
- Crohn's disease
- irritable bowel syndrome
- persistent diarrhea
- ulcerative colitis
- diverticulitis
- jaundice
- rectal or intestinal bleeding
- any other disease or disorder of the esophagus, intestine, rectum, pancreas, stomach or liver

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

If "YES", provide details in section 16-22.

**SECTION 16 – HEALTH INFORMATION**

16-9. Ears, eyes, nose, throat and mouth: Have you ever been treated for or had any symptoms, complaints or indication of: (excluding routine check-ups, tonsillectomy, adenoidectomy, sinusitis, or other disorder requiring eye glasses, contact lenses or ear tubes):

- blindness
- blurred or double vision
- deafness
- glaucoma
- impaired hearing
- impaired sight
- labyrinthitis
- optic neuritis
- tinnitus
- any other disease or disorder of ears, eyes, nose, throat or mouth

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-10. Respiratory system: Have you ever been treated for or had any symptoms, complaints or indication of :

- asthma
- chronic obstructive pulmonary disease (COPD)
- chronic bronchitis
- cystic fibrosis
- emphysema
- persistent cough
- sarcoidosis
- sleep apnea
- tuberculosis
- any other respiratory disease or disorder

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-11. Mental Health: Have you ever been treated for or had any symptoms, complaints or indication of:

- attention deficit disorder
- burnout
- anxiety
- chronic fatigue
- depression
- eating disorder
- bipolar disorder
- schizophrenia
- suicide attempt or ideation
- any other psychological, developmental, emotional or behavioural disorder

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-12. Skin and connective tissue: Have you ever been treated for or had any symptoms, complaints or indication of (excluding poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema):

- dysplastic nevi or nevus
- lupus
- psoriasis
- scleroderma
- any other lesions, freckles or moles that have changed in size, colour or bleed
- any other skin disease or disorder

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-13. Kidney, bladder and reproductive system: Have you ever been treated for or had any symptoms, complaints or indication of:

- abnormal pap smear
- abnormal prostate specific antigen (PSA)
- hysterectomy
- kidney stone(s)
- nephritis
- uterine fibroid
- sexually transmitted infection
- sugar, blood or protein in the urine
- any other kidney or bladder disease or disorder
- any other reproductive, prostate or breast related disease or disorder

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 16 – HEALTH INFORMATION

16-14. Musculoskeletal system: Have you ever been treated for or had any symptoms, complaints or indication of:

- arthritis
- chronic fatigue
- chronic pain syndrome
- fibromyalgia
- muscular dystrophy
- numbness or weakness of any arm or leg
- paralysis
- any other disease or disorder of the muscles, joints, limbs, back or bones

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-15. Nervous system: Have you ever been treated for or had any symptoms, complaints or indication of:

- Alzheimer's disease
- amyotrophic lateral sclerosis (ALS)
- cerebral palsy
- cognitive impairment
- coma
- dementia
- developmental delay or Down's syndrome
- dizziness or vertigo
- epilepsy or seizures
- fainting or syncope
- loss of sensation, speech or balance
- multiple sclerosis (MS)
- Parkinson's disease
- any other motor neuron disease or disorder
- tremor
- severe headache
- post concussion syndrome
- Autism
- any other congenital neurological disease or disorder
- any other disease or disorder of the brain or nervous system

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-16. Immune system: Have you ever been treated for or had any symptoms, complaints or indication of:

- AIDS
- HIV
- any other immune system disease or disorder

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-17. In the last 5 years have you had any of the following medical or diagnostic tests:

- ECG
- X-ray
- CT scan
- MRI
- Colonoscopy
- ultrasound
- biopsy
- blood test
- any other medical or diagnostic tests

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-18. In the last 5 years have you had an illness or injury which prevented you from performing your usual activities or the regular duties of your occupation for a period exceeding 2 weeks?

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-19. Do you have any symptoms, complaints or indication, including persistent or undiagnosed pain, regarding your health for which you have not yet consulted a physician or received medical treatment?

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-20. Do you have any medical conditions, not addressed in the previous questions in this Section 16, for which you have been or are being investigated, under observation, tested or treated for, or for which you are currently awaiting investigation, observation, testing, test results or treatment?

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

16-21. Are you taking any prescribed or non-prescribed medication including herbal or holistic treatment (excluding vitamins), for any symptoms, complaints, indication or medical conditions not addressed in the previous questions in this Section 16?

If "YES", provide details in section 16-22.

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 17 - LEGAL INFORMATION (This Section 17 consists of two pages including paragraphs A to H)

A. THE OWNER(S) AND THE PERSON(S) TO BE INSURED DECLARE AND AGREE THAT:

- 1) The personal information willingly provided by me/us to the independent broker/sales advisor and/or The Equitable Life Insurance Company of Canada (the "Company"), collected on this Application and held in their files, will be used by the Company for the purposes of underwriting, servicing, administration, determining Canadian or foreign tax payor status, claims processing and adjudication related to this Application, any resulting insurance and any supplementary documents. I/We understand and authorize 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 the Company, MIB Inc. as provided for in the MIB Notice, the Company's sales distribution network, participating reinsurer(s), other companies, Canadian or foreign tax authorities and any other person or party whom I/we authorize.

See www.equitable.ca for further details about the Company's privacy practices and for information about how to contact the Company's Privacy Officer."

- 2) I/We certify that the information provided on this form is current, correct and complete. For Universal Life and Whole Life policies, I/We will notify Equitable Life within 30 days of any change to my/our tax residency, US citizenship status or tax identification numbers.
- 3) The insurance being applied for in this Application or such insurance approved by The Equitable Life Insurance Company of Canada (the "Company") shall not take effect unless:
- a) The policy is delivered or accepted in the manner specified in 3c; and
 - b) The first policy premium is paid; and
 - c) There is no change in the insurability of the Person(s) to be Insured between the date this Application was signed by the Person(s) to be Insured and: i) the date of delivery of the Critical Illness policy to the Owners; or, ii) the date of delivery of the life policy to the Owners resident in Provinces and Territories other than Quebec; or, iii) the date the Application for a life policy is accepted by the Company without modification for Owners resident in Quebec.
- 4) Knowledge of or notice to any person shall not constitute knowledge of or notice to the Company unless disclosed in this Application. No person, other than an Authorized Officer of the Company shall have authority to place the Company under any risk or obligation, or approve insurability.
- 5) Acceptance of any policy issued on this Application shall be a ratification of any changes or corrections in or additions to this Application which the Company may make in the Endorsements.
- 6) If the Application is made by an Owner (other than the Person to be Insured):
- a) And if a policy (policies) is (are) issued under this Application, such policy (policies), including all rights thereunder, shall be under the full control of the Owner, subject to the provisions of such policy (policies).
 - b) The person(s) on whose life (lives) this insurance is applied for consents to the insurance being placed on his/her (their) life (lives).
- 7) They know of nothing not disclosed in the Application affecting the insurability of the Person(s) to be Insured.

B. THE OWNER(S), AND THE PERSON(S) TO BE INSURED:

- 1) Acknowledge receiving the Notice Regarding MIB and authorize the Company to obtain information from the MIB, Inc.
- 2) Consent to the obtaining of a consumer report containing personal and/or credit information.
- 3) Authorize the Company to perform all tests, including, without limitation, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this Application for insurance. Such tests may include tests to determine the presence of various diseases including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS). The Company may disclose to its reinsurer(s), your attending physician(s), health service providers, and the MIB, 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.
- 4) Acknowledge that their personal information may be processed and stored by service providers in jurisdictions outside Canada and may therefore be subject to disclosure to governmental authorities in those jurisdictions.
- 5) Authorize the Motor Vehicle Division in any province requiring such authorization to permit the Company or any investigative agency on behalf of the Company, to be given a copy of all driving record information relevant to this Application.
- 6) Authorize any physician, practitioner, hospital, clinic, or other medical-related facility, insurance company, the MIB or any other organization, institution or person, that has any record or knowledge of the person(s) on whose life (lives) this insurance is applied for, or his/her (them or their) health, to give full particulars of such information, including any prior medical history, to the Company or its reinsurers, and authorize the Company disclosing such information to your attending physician(s).
- 7) Agree that this Application may be transmitted to the Company electronically and received by the Company as the Owner's original application for insurance.
- 8) A photostatic copy of these authorizations shall be as valid as the original.

**SECTION 17 - LEGAL INFORMATION** (This Section 17 consists of two pages including paragraphs A to H)

- C. FAILURE TO DISCLOSE EVERY FACT WITHIN THE OWNER(S) AND PERSON(S) TO BE INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY OF THE PERSON(S) TO BE INSURED, OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THE APPLICATION, INCLUDING ANY PART II AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THE APPLICATION VOIDABLE BY THE COMPANY.**
- D.** The Company is authorized to use the information in this Application and its existing files to provide information to me/us about its other products and services. ☐ YES ☐ NO
- E.** The Company is authorized to provide my health, medical and life style information obtained during its underwriting process, regardless of the source, to my advisor for the purposes of explaining to me any adverse assessment of my insurability.
- F.** I/we acknowledge:
- a) receiving from my/our Advisor, disclosure and an explanation of the companies the Advisor represents, licensing, commissions, additional compensation, conflicts of interest, the MIB Notice, and if applicable the Temporary Insurance Agreement or Agreements; and
 - b) reviewing the Sales Illustration with my Advisor and understanding the Sales Illustration.
- G.** I/we request all future correspondence from the Company in ☐ English ☐ French
- H.** All signatures for withdrawals from the account are present in this Application, and all terms and conditions set out in the "PAD" in SECTION 10 are understood and agreed upon. NOTE: if withdrawals are to be made from a joint account both account owners must sign if your bank or financial institution requires both signatures.

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

Signature(s) of Owner(s)

If Owner is a corporation, affix Corporate Seal if available and have Authorizing Officer(s) sign and indicate title(s)

LIFE 1

LIFE 2

***Signature of Person to be Insured if other than Owner**

***Signature of Person to be Insured if other than Owner**

Other

ADVISOR

***Signature of Person to be Insured if other than Owner**

****Witness to all Signatures**

*Signature required for each Person to be Insured who has attained age **16, (18 in Quebec)** at the date hereof.

*Signature of parent/legal guardian of children under attained age **16, (18 in Quebec)**

** Must be a disinterested third party who is not named as an insured, owner, payor, beneficiary or trustee on the Application.

Signature of Payor(s) under P.A.D. in Section 10,
if different from the Owner(s):



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 18 - TRANSLATION AGREEMENT AND DECLARATION

Was this application translated for any proposed life insured(s) and/or owner(s) in a language other than English? ☐ Yes ☐ No
if "Yes", you must complete the sub sections below.

Note: The translator must be 18 years of age or older and may not be:

- a beneficiary,
- a proposed owner. or
- any other person who has an interest in the policy (excluding the advisor).

18.1 Proposed insured(s) and/or proposed owner(s) agreement

In this section, you and your refer to the proposed insured(s) and/or proposed owner(s).

1. Who was this application translated for in a language other than English?

☐ Life 1 ☐ Life 2 ☐ Proposed owner 1 ☐ Proposed owner 2

2. Do you agree that your answers to the questions asked and translated for you are complete and true, and do you understand they form part of the application?

Life 1 ☐ Yes ☐ No Life 2 ☐ Yes ☐ No Proposed owner 1 ☐ Yes ☐ No Proposed owner 2 ☐ Yes ☐ No

Note: If "No", we are unable to continue with your application at this time. The application must not be submitted.

3. Do you also agree that this application was fully explained to you in your preferred language, and do you understand the content provided by the translator?

Life 1 ☐ Yes ☐ No Life 2 ☐ Yes ☐ No Proposed owner 1 ☐ Yes ☐ No Proposed owner 2 ☐ Yes ☐ No

Note: if "No", we are unable to continue with your application at this time. The application must not be submitted.

4. Name of person who provided the translation:

Translator's first name	Middle initial	Last name
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5. Relationship to proposed insured(s) and/or proposed owner(s):

Life 1	☐ Advisor ☐ Other Indicate _____	Proposed owner 1	☐ Advisor ☐ Other Indicate _____
Life 2	☐ Advisor ☐ Other Indicate _____	Proposed owner 2	☐ Advisor ☐ Other Indicate _____

6. In what language were the questions translated?

Proposed Life Insured 1		Proposed owner 1	
Proposed Life Insured 2		Proposed owner 2	

18.2 Translator's declaration/signature

In this section, you and your refer to the translator.

By signing below, you declare that for any proposed insured(s) and/or proposed owner(s) indicated above in sub-section 18.1, you:

- faithfully and truly translated this application and the answers provided to you,
- read over the entire contents of this application and explained the nature and contents to be completed, and
- everyone appeared to understand the contents of this application and provided all requested information.

You also declare that you do not have any interest in this application and are age 18 or older.

Province signed	Date (dd/mm/yyyy)	Translator's signature (if other than advisor)
-----------------	-------------------	--

**SECTION 19 - TEMPORARY LIFE AND/OR TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST****TEMPORARY LIFE INSURANCE REQUEST**

The Owner(s) and Person to be Insured, or the Persons to be Insured if a joint life application, in the Application for Life Insurance (the "Application") (excluding the children to be insured under the Children's Protector Rider) request Temporary Life Insurance Coverage, but understand that the Temporary Life Insurance will NOT become effective if:

- the Person to be Insured, or any of the Persons to be Insured if a joint life application, answers YES or fails to provide an answer to any of the Life questions below, or
- payment of at least 1/12 of the annual premium for the Life insurance applied for in the Application is not submitted with the Application by way of cheque or PAD withdrawal authorization, or
- the payment has not been honored upon first presentation for payment.

If any of the above are applicable, then no Temporary Life Insurance is provided and the Temporary Life Insurance Agreement is VOID.

TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST

The Owner(s) and Person(s) to be Insured in the Application request Temporary Critical Illness Insurance Coverage, but understand that the Temporary Critical Illness Insurance will NOT become effective if:

- the Person to be Insured answers YES or fails to provide an answer to any of the Critical Illness Insurance questions below, or
- payment of at least 1/12 of the annual premium for the Critical Illness Insurance applied for in the Application is not submitted with the Application by way of cheque or PAD withdrawal authorization, or
- the payment has not been honored upon first presentation for payment.

If any of the above are applicable, then no Temporary Critical Illness Insurance is provided and the Temporary Critical Illness Insurance Agreement is VOID.

Eligibility for Temporary Life Insurance is subject to the Terms and Conditions of the Temporary Life Insurance Agreement. Eligibility for Temporary Critical Illness Insurance is subject to the Terms and Conditions of the Temporary Critical Illness Insurance Agreement.

Has (have) the Person(s) to be Insured:

- Ever been treated for or had any known symptoms, complaints or indication of:
 - stroke, chest pain, cancer, tumours, chronic kidney or liver disease
 - Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immunological disorder?
- Within the last 90 days, been admitted to a medical facility, been advised to be admitted to a medical facility, or had a diagnostic test and/or surgery recommended or performed (other than normal childbirth)?
- Ever had an application for Life or Critical Illness Insurance on their life (lives) declined, and/or received a Life or Critical Illness insurance policy that was postponed, rated or modified in any way?
- Within the last 12 months, been absent from work, regular occupation, or unable to perform regular daily activities for 15 or more consecutive days because of illness or injury?
- Passed their 65th birthday, or not reached at least 15 days of age for Life applications or 30 days for Critical Illness applications?
- Ever been treated for or had any known symptoms, complaints or indication of heart or blood vessel disease, not including high blood pressure? (Required for Life Requests only)
- Ever been treated for or had any known symptoms, complaints or indication of heart or blood vessel disease, including high blood pressure? (Required for Critical Illness Requests only)

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐

ANY MISREPRESENTATION OR MISSTATEMENT IN THE ANSWERS GIVEN ABOVE OR IN THE APPLICATION, INCLUDING ANY PART II AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY SHALL RENDER ANY TEMPORARY LIFE INSURANCE AND/OR ANY TEMPORARY CRITICAL ILLNESS INSURANCE VOIDABLE BY THE COMPANY.

The Owner(s) and the Person(s) to be Insured requesting temporary insurance coverage: acknowledge that they have read, understand and agree to the provisions of the Request(s) and to the terms and conditions contained in the Temporary Life Insurance Agreement and/or the Temporary Critical Illness Insurance Agreement.



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 19 - TEMPORARY LIFE AND/OR TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST

The Owner(s) and the Person(s) to be Insured requesting temporary insurance coverage: acknowledge that they have read, understand and agree to the provisions of the Request(s) and to the terms and conditions contained in the Temporary Life Insurance Agreement and/or the Temporary Critical Illness Insurance Agreement.

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

Signature(s) of Owner(s)

(If Owner is a corporation, affix Corporate Seal if available and have Authorizing Officer(s) sign and indicate title(s).)

LIFE 1

***Signature of Person to be Insured if other than Owner**

Other

***Signature of Person to be Insured if other than Owner**

LIFE 2

***Signature of Person to be Insured if other than Owner**

ADVISOR

****Witness to all Signatures**

*Signature required for each Person to be Insured who has attained age **16, (18 in Quebec)** at the date hereof.

*Signature of parent/legal guardian of children under attained age **16, (18 in Quebec)**

** Must be a disinterested third party who is not named as an insured, owner, payor, beneficiary or trustee on the Application.



APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

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SECTION 20 – ADVISOR’S REPORT**UNDERWRITING REQUIREMENTS**

Recent evidence (within the past 12 months) may be considered. Please contact head office for any additional requirements.

Name of Service Provider:					
Underwriting Requirements	Life 1	Ordered	Life 2	Ordered	Comments/order number(s)
M.D. Medical	☐	☐	☐	☐	
Paramedical	☐	☐	☐	☐	
Electrocardiogram	☐	☐	☐	☐	
Blood Profile	☐	☐	☐	☐	
PSA (request with blood profile)	☐	☐	☐	☐	
Urine (HIV)	☐	☐	☐	☐	
Inspection Report	☐	☐	☐	☐	
Treadmill Electrocardiogram	☐	☐	☐	☐	
Motor Vehicle Report	☐	☐	☐	☐	
Financial Statements	☐	☐	☐	☐	
Order Shared Evidence	☐	☐	☐	☐	
Other:					

1. Has there been prior contact with Head Office regarding the proposed Life Insured(s)?
If “YES” give dates and reference of last Head Office letter, and person or department contact in Advisor’s Notes below.
2. Are you or the servicing advisor the proposed Life Insured(s), payor or beneficiary on this policy?
3. Are you or the servicing advisor a related party to the proposed Life Insured(s) or Owner(s)?
A related party includes:
a) immediate family members such as a spouse, parent, grandparent, child, grandchild, or in-law
b) a corporation where the Advisor or an immediate family member, individually or together own 50% or more of any class of shares of the corporation
c) where the Advisor is incorporated, any director, officer, employee or agent of the Advisor, and any parent, subsidiary or affiliated corporation of the Advisor
If “YES” give details in Advisor’s Notes below.
4. Do you know of:
a) Any criticism of the proposed Life Insured(s) or Owner(s) character, habits, mode of living, or business reputation, past or present? (If “YES”, provide details in Advisor’s Notes below)
b) Any additional information which would assist in underwriting this application?
(If “YES”, provide details in Advisor’s Notes below)
5. Was this sale derived from a financial needs analysis?
6. I have made a reasonable effort to determine if the Owner(s) are acting on behalf of a third party.
7. I have reviewed and explained the Sales Illustration to the Owner(s)

YES	NO
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐



APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

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SECTION 20 – ADVISOR’S REPORT**8. I confirm that I have disclosed the following to the Owners:**.....

- a) the life or critical illness policy, if issued, is underwritten and managed by Equitable Life of Canada;
- b) the company or companies I represent;
- c) I am an independent broker/advisor representing Equitable Life of Canada;
- d) I am a life agent licensed by the Insurance Council of British Columbia and/or the Financial Services Commission of Ontario, if applicable;
- e) I receive compensation and will continue receiving servicing/renewal commissions, if a policy is issued and comes into effect, and if it remains in force;
- f) I may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business I place with Equitable Life of Canada;
- g) I have disclosed any conflicts of interest I may have regarding this Application.

9. I have reviewed the information provided in this Application with the proposed Owner(s) and to the best of my knowledge, it is complete and true

YES	NO
☐	☐
☐	☐

ADVISOR’S NOTES:**ADVISOR’S INFORMATION:**

MGA Name: _____ MGA No: _____

MGA Phone: _____ MGA Fax: _____ MGA Email: _____

List the advisors involved in this sale.

Advisor’s Name	Advisor’s No	Servicing	Commission %	Advisor’s Phone	Advisor’s Fax
		☐			
		☐			
		☐			

All correspondence to Advisor in ☐ English ☐ French

Advisor’s Email Address _____

Supervisor’s Email Address _____

Advisor’s Signature _____

Supervising Advisor’s Signature _____

Date (dd/mm/yyyy) _____

Date (dd/mm/yyyy) _____

**SECTION 21 – TEMPORARY LIFE INSURANCE AGREEMENT****Temporary Life Insurance Agreement**

This Temporary Life Insurance Agreement ("Agreement") with The Equitable Life Insurance Company of Canada ("Company") provides a LIMITED AMOUNT of life insurance coverage for a LIMITED PERIOD, subject to the Conditions and Terms of this Agreement, outlined below.

CONDITIONS

Temporary Life Insurance under this Agreement commences on the date the last of the Owner(s) and Person(s) to be Insured signed the Temporary Life Insurance Request, if:

- a) All questions in the Temporary Life Insurance Request have been answered "NO" by the Person to be Insured, or by both Persons to be Insured if a joint life application; and
- b) Payment of at least one-twelfth of the annual premium for the Life insurance applied for on the Application has been submitted with this Application by way of cheque or PAD withdrawal authorization; and
- c) The payment has been honoured upon first presentation for payment.

TERMS

1. If the Person to be Insured, or one or both of the Persons to be Insured if a joint life application, dies while insurance under this Agreement is in effect, the amount of insurance under this Agreement will be the lesser of the Amount of Insurance applied for on the Application (including any Additional Accidental Death Benefit provided death occurs as a result of any accident under the terms of the policy to be issued, any Term Rider (excluding any Critical Illness Rider), and any Initial Enhancement Amount on the Equimax Plan) and \$1,000,000. Regardless of the total amount of Temporary Life Insurance in effect for the Person to be Insured, or the Persons to be Insured if a joint life application, at the date of death under this Agreement and all other Temporary Life Insurance Agreements in effect with the Company, the aggregate amount to be paid under this Agreement and all other Temporary Life Insurance Agreements for the Person to be Insured, or both Persons to be Insured if a joint life application, shall not exceed \$1,000,000.
2. No benefits will be payable under this Agreement with respect to: a) children to be insured under the Children's Protection Rider; b) Applicant's Death Benefit on the Owner; and c) any Critical Illness Rider.
3. If death of any Person(s) to be Insured is as a result of suicide, regardless of their mental state, the liability of the Company under this agreement is limited to the return of the premium paid.
4. If the Company issues a Life insurance policy, the amount of the initial cheque or PAD withdrawal submitted with the Application will be credited toward the first premium due under the policy.
5. Insurance coverage under this Agreement terminates on the earliest of:
 - a) the date the Life insurance policy issued under the Application becomes effective;
 - b) the date the Company mails written notice to the Owner(s) cancelling this Agreement. If the Company issues a life insurance policy, the amount of the initial cheque or PAD withdrawal submitted with the Application will be credited toward the first premium due under the policy;
 - c) ninety days from the date insurance commences under this Agreement;
 - d) the date the Company mails written notice to the Owner(s) informing that the Application for a life insurance policy has been declined or cancelled; or
 - e) the date insurance under this Agreement becomes payable.
6. Any payment made under this Agreement will be governed by the terms of the policy applied for, and will be paid to the Beneficiary named in the Application.
7. No representative of the Company is authorized to modify this Agreement.
8. ANY MISREPRESENTATION OR MISSTATEMENT IN THE ANSWERS GIVEN IN THE TEMPORARY LIFE INSURANCE REQUEST OR IN THE APPLICATION, INCLUDING ANY PART II AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY SHALL RENDER ANY TEMPORARY LIFE INSURANCE AND THIS TEMPORARY LIFE INSURANCE AGREEMENT VOIDABLE BY THE COMPANY.

**SECTION 22 – TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT****Temporary Critical Illness Insurance Agreement**

This Temporary Critical Illness Insurance Agreement ("Agreement") with The Equitable Life Insurance Company of Canada (the "Company") provides a Limited Amount of Critical Illness Insurance for a Limited Period of time for 9 critical illness conditions, subject to the Terms and Conditions of this Agreement outlined below.

CONDITIONS

Temporary Critical Illness Insurance under this Agreement commences on the date the last of the Owner(s) and Person(s) to be Insured signed the Temporary Critical Life Insurance Request, if:

- a) all questions in the Temporary Critical Illness Insurance Request have been answered "NO" by the Person to be Insured; and
- b) payment of at least one-twelfth of the annual premium for the Critical Illness insurance applied for has been submitted with the Application by way of cheque or PAD withdrawal authorization; and
- c) the payment has been honoured upon first presentation for payment.

TERMS

1. If the Temporary Critical Illness Agreement is in effect when the Person(s) Insured under this Agreement is Diagnosed with one of the 9 Covered Critical Conditions under this Agreement, the Company will pay the lesser of the amount of Critical Illness Insurance applied for on the Application and \$250,000, provided that:
 - a) all of the above conditions for this Critical Illness Temporary Insurance Agreement have been satisfied, and
 - b) the Diagnosis of any Covered Critical Condition under this Agreement or the advice to undergo Surgery for any Covered Critical Condition under this Agreement requiring Surgery, must be made by a Licensed Specialist in Canada or the United States or other jurisdiction approved by the Company. The date of Diagnosis shall be the date the Licensed Specialist makes the Diagnosis of your condition. The Diagnosis must be supported by objective medical evidence; and
 - c) the Covered Critical Condition must meet all of the requirements specified in the Definition of Covered Critical Conditions in Paragraph 4; and
 - d) the Person(s) Insured under this Agreement has satisfied the survival period described in Paragraph 6; and
 - e) the Person(s) Insured under this Agreement has allowed the Company to undertake medical examinations of the Person(s) Insured under this Agreement when and as often as reasonably required by the Company while the claim under this Agreement is being reviewed.
2. Regardless of the total amount of Temporary Critical Illness Insurance in effect with the Company at the date of Diagnosis of a Covered Critical Condition under this Agreement, the aggregate amount to be paid under this Agreement and all other Temporary Critical Illness Insurance Agreements for the Person to be Insured shall not exceed \$250,000.
3. The Temporary EquiLiving Critical Illness Insurance Agreement terminates on the earlier of:
 - a) the date the EquiLiving Critical Illness Insurance policy issued under the Application becomes effective;
 - b) the date the Company mails written notice to the Owner(s) informing that the Application for an EquiLiving Critical Illness policy or Rider has been declined or cancelled;
 - c) the date insurance under this Agreement becomes payable;
 - d) ninety (90) days from the date insurance commences under this Agreement, unless the Person(s) Insured under the Agreement has been Diagnosed with a Covered Critical Condition under this Agreement and is in the Survival period for the Covered Critical Condition. In this case the Agreement will end on the date the Person(s) Insured under this Agreement is no longer satisfying the survival period for that Covered Critical Condition, or
 - e) the date the Company mails written notice to the Owner cancelling this Agreement. If the Company issues an EquiLiving Critical Illness policy, the amount of the initial cheque or PAD withdrawal submitted with the Application will be credited toward the first premium due under the policy.



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APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

SECTION 22 – TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT**4. Definition of Covered Critical Conditions:**

- Heart Attack:** is defined as “a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in: Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
- heart attack symptoms
 - new electrocardiogram (ECG) changes consistent with a heart attack
 - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty”;
- The diagnosis of Heart Attack must be made by a Specialist.
- Exclusions: No benefit will be payable under this condition for:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
 - ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.
- Stroke:**
(Cerebrovascular Accident) is defined as “a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms, and
 - new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.”
- These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of Stroke must be made by a Specialist. Exclusions: No benefit will be payable under this condition for:
- Transient Ischaemic Attacks; or,
 - Intracerebral vascular events due to trauma; or,
 - Lacunar infarcts which do not meet the definition of stroke as described above.”
- Blindness:** is defined as “a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:
- the corrected visual acuity being 20/200 or less in both eyes; or,
 - the field of vision being less than 20 degrees in both eyes.”
- The diagnosis of Blindness must be made by a Specialist.
- Deafness:** is defined as “a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.” The diagnosis of Deafness must be made by a Specialist.
- Loss of Speech:** is defined as “a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days” The diagnosis of Loss of Speech must be made by a Specialist. Exclusions: No benefit will be payable under this condition for all psychiatric related causes.
- Paralysis:** is defined as “a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.” The diagnosis of Paralysis must be made by a Specialist.
- Loss of Limbs:** is defined as “a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.” The diagnosis of Loss of Limbs must be made by a Specialist.
- Coma:** is defined as “a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.” The diagnosis of Coma must be made by a Specialist.
- Exclusions: No benefit will be payable under this condition for:
- a medically induced coma; or,
 - a coma which results directly from alcohol or drug use; or,
 - a diagnosis of brain death.
- Severe Burns:** is defined as “a definite diagnosis of third-degree burns over at least 20% of the body surface.” The diagnosis of Severe Burns must be made by a Specialist.

**SECTION 22 – TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT**

5. Exclusions and Limitations: If any of the above 9 conditions arise directly or indirectly from any of the following, they shall not be a Covered Critical Condition under this Agreement and no Temporary Critical Illness Insurance will apply:
- suicide attempt or self-inflicted injury, regardless of the mental state of the person to be insured;
 - misuse of medication or the use of illegal drugs or intoxicants;
 - the failure to seek or follow the medical advice of a physician who is licensed and practicing medicine;
 - war, or any act or incident of war, whether declared or not, or any conflict between the armed services of countries or international organizations;
 - terrorism;
 - committing or attempting to commit a criminal offence;
 - operating a motor vehicle while the concentration of alcohol in one-hundred (100) milliliters of blood exceeds eighty (80) milligrams;
 - taking a poisonous substance or inhaling toxic gases or fumes.
6. Survival Period: The Survival Period begins on the date of Diagnosis of, or Surgery for, a Covered Critical Condition under this Agreement, and ends thirty (30) days following the date of Diagnosis of, or Surgery for, a Covered Critical Condition under this Agreement, unless otherwise specified in the Definitions of Covered Critical Conditions. The Person(s) Insured must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all brain functions during the Survival Period.

If such irreversible cessation occurs, NO Temporary Critical Illness Insurance is payable. If artificial life support is used to sustain the Person(s) Insured during the Survival Period, the date the Person(s) Insured experiences irreversible cessation of all brain functions shall be deemed to be the date of death of the Person(s) Insured for the purposes of this Temporary Critical Illness Insurance Agreement. Determination of irreversible cessation of brain function shall be generally accepted medical criteria.

7. Any insurance payable under this Temporary Critical Illness Insurance Agreement will be payable once for only one Covered Critical Condition under this Agreement regardless of how many additional Covered Critical Conditions the Person(s) Insured may be diagnosed with, and NO Critical Illness Policy will be issued by the Company.
8. No representative of the Company is authorized to modify this Agreement.
9. ANY MISREPRESENTATION OR MISSTATEMENT IN THE ANSWERS GIVEN IN THE TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST OR IN THE APPLICATION, INCLUDING ANY PART II AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY SHALL RENDER ANY TEMPORARY CRITICAL ILLNESS INSURANCE AND THIS TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT VOIDABLE BY THE COMPANY.

SECTION 23 – CONFIRMATION OF ADVISOR/BROKER DISCLOSURE

The Insurance product you are applying for is underwritten and supplied by Equitable Life of Canada, licensed to conduct business in all provinces and territories of Canada. The advisor/broker soliciting this insurance application is a licensed independent broker representing Equitable Life of Canada through an independent agency, and will receive compensation from Equitable Life of Canada if a policy is issued and comes into effect, and will continue receiving ongoing compensation if you continue to keep the policy in force. The advisor/broker may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business the advisor/broker places with Equitable Life of Canada during a given time period. You are not obligated to transact any other business with Equitable Life of Canada, the advisor/broker or any other person or entity as a condition of the Application.

SECTION 24 – 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

SECTION 25 – RECEIPT FOR PAYMENT WITH APPLICATION

NO PAYMENT IS TO BE ACCEPTED WITH THIS APPLICATION IF:

- a) the amount of CRITICAL ILLNESS insurance applied for under all applications with the Company exceeds \$250,000; or,
- b) if any of the Temporary Life Insurance Request or Temporary Critical Illness request questions asked are answered "YES" or left blank by the Person to be insured, or any of the Persons to be insured if a joint life application;

THE APPLICATION MUST BE SUBMITTED ON A C.O.D. BASIS.

The Equitable Life Insurance Company of Canada acknowledges receipt of \$ _____ paid in connection with
an application for insurance on the life / lives and or health of _____.

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

Signature of Advisor _____

Works for me.®

Through personal service, superior products and an ongoing commitment to mutuality, Equitable Life can assist you in reaching your financial goals. Whether you're making your first investment, building your financial plan, or looking for ways to protect what is most important to you, we have the solutions you need. With customer-centred staff, and a prudent investment strategy focused on long-term stability, growth and profitability, we also have the focus and expertise you need. In all aspects of your life, we're committed to helping you achieve the financial future you're looking for, by putting you first.

While Equitable Life has made every effort to ensure the accuracy of the information presented here, the policy contract governs in all cases.



**Equitable Life
of Canada®**

One Westmount Road North,
Waterloo, Ontario N2J 4C7

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