

SHORT FORM APPLICATION FOR SINGLE LIFE TERM INSURANCE



life & health



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

PLACE STICKER HERE

This short form single life term application is for amounts up to and including \$500,000. For all other applications our form #350 must be used. If the questions are asked by the Advisor they must be asked as is, word for word and not paraphrased.

To be kept with Application # _____

PROPOSED LIFE INSURED - FOR JOINT LIFE, MULTIPLE LIVES, SPOUSAL RIDER OR CPR COMPLETE APPLICATION FORM #350.

Mr Mrs Ms Miss Dr Or _____

Given Name: _____ Last Name: _____

Date of Birth (dd/mmm/yyyy): _____ Age (nearest): _____ Gender: Male Female

Social Insurance Number (SIN): _____ Place of Birth: _____

Occupation: _____ Annual Income: _____

Residence Address:

Number: _____ Street: _____ City: _____ Province: _____

Country: _____ Postal Code: _____ Email Address: _____

Residence Phone: _____ Business Phone: _____

Canadian Status:

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

Date of arrival in Canada: _____

Verification of Insured - Provide current/original Canadian government-issued photo ID (e.g. driver's licence, passport, citizenship card or permanent resident card) or if not available, two other identification documents (e.g. birth certificate and one of the following: foreign passport, employee ID card, SIN card, credit card or, except for ON, MB and PEI provincial health card).

Identification Type	Number	Place of Issue	Expiry Date (dd/mmm/yyyy)

OWNER - IF OTHER THAN PROPOSED LIFE INSURED.

If the Applicant/Owner is a Corporation or Non-Corporate Entity, Form 594 must be completed.

Is the Applicant/Owner acting on behalf of a third Party? (A third party is someone other than the Life Insured or Owner who is or will be paying the premiums, or has or will have an ownership interest in this policy.) No Yes - If "Yes", Form 31 must be completed.

Last Name: _____ First Name: _____

Date of Birth (dd/mmm/yyyy): _____ Relationship: _____

Social Insurance Number (SIN): _____ Occupation: _____

Residence Address:

Number: _____ Street: _____ City: _____ Province: _____

Country: _____ Postal Code: _____ Email Address: _____

Residence Phone: _____ Business Phone: _____



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

OWNER - IF OTHER THAN PROPOSED LIFE INSURED. (CONTINUED)

Verification of Insured - Provide current/original Canadian government-issued photo ID (e.g. driver's licence, passport, citizenship card or permanent resident card) or if not available, two other identification documents (e.g. birth certificate and one of the following: foreign passport, employee ID card, SIN card, credit card or, except for ON, MB and PEI provincial health card).

Table with 4 columns: Identification Type, Number, Place of Issue, Expiry Date (dd/mmm/yyyy)

BENEFICIARY

Applicant/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.

Table with 5 columns: Name, Date of Birth if minor (dd/mmm/yyyy), Trustee applies, Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies, Share %

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

Table with 5 columns: Name, Date of Birth if minor (dd/mmm/yyyy), Trustee applies, Relationship to Proposed Life Insured or Relationship to Owner where Quebec law applies, Share %

Trustee for all minor beneficiaries (not applicable in Quebec)

Name: _____ Given Last

PLAN DETAILS

PLAN: [] 10 Year Term [] 20 Year Term [] Other: (specify) _____

Amount: \$ _____

BENEFITS: [] Disability Waiver [] Additional Accidental Death Benefit Amount: \$ _____

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

SPECIAL INSTRUCTIONS



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

PREMIUM AND PAYMENT MODE

INITIAL PREMIUM OF \$ _____

PAID BY:

- 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)

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 (please check appropriate box) Note: 'Line of credit' accounts or credit cards are not acceptable payment options.

- Add to existing PAD for Equitable Policy Number: _____ (void cheque not required)
- 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)
- Change existing PAD, using:
 - The account shown on the attached VOID cheque or Bank Letter of Direction (payor name is required on the cheque)

General Information

Name of Payor(s): _____ (if different from Policy Owner(s) completed Third Party Information Form #31)

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.

Withdrawal Arrangements

Amount: \$ _____
(This amount is considered 'Fixed')

Timing of Withdrawal(s)

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

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.cdnpay.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.cdnpay.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.cdnpay.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



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

HEALTH AND LIFE STYLE SECTIONS PAGES 4 AND 5

SMOKING DECLARATION

Have you smoked any cigarettes or used any form of marijuana or hashish within the last 12 months? Yes No

Have you used any other tobacco or nicotine based products within the last 12 months? Yes No

Types: _____ Frequency: _____

PERSONAL AND MEDICAL INFORMATION

Name and Address of your usual medical advisor. (If none, state "None"): _____

Date and Reason last consulted: _____

Results/Diagnosis and treatment/follow up advised: _____

Height: _____ ft/in cm Weight: _____ lbs kg Have you had any weight change in the past year? YES NO
Gain: _____ lbs kg Loss: _____ lbs kg Reason for weight change? _____

PERSONAL AND MEDICAL INFORMATION - PLEASE PROVIDE DETAILS FOR "YES" ANSWERS IN SPACE PROVIDED BELOW.

Table with 11 rows of questions and 2 columns labeled YES and NO. Questions include: 1. Do you have any Inforce/Pending Insurance? 2. Will this contract, if issued, replace a Life Insurance Contract now in force? 3. Have you ever had an application for Life, Disability, Critical Illness, or Group Insurance on your life postponed, declined, rated or modified in any way? 4. In the last 10 years have you been charged with or convicted of or pleaded guilty to any criminal offence, or are any criminal charges pending? 5. Have you been a resident of Canada for less than 24 months? 6. Do you intend to travel outside of North America for longer than a total of 6 weeks, or change your Country of residence, in the next 12 months? 7. Have you been convicted of, have pending charges for, or pleaded guilty to driving under the influence of alcohol and/or drugs, or refused to provide a breathalyzer sample, in the last 10 years? 8. Have you been convicted of, have pending charges for, or pleaded guilty to any other driving offences (excluding parking tickets), or had your driver's license suspended or revoked in the last 3 years? 9. In the last 2 years have you or do you intend to: a) Make any flights other than as a fare-paying passenger? b) Engage in any hazardous sport or hobby? 10. Has any family member (whether living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer (specify type), Diabetes, Kidney Disease, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) or any other hereditary disease? 11. Have you ever declared bankruptcy, personal or business, whether discharged or not?



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

PERSONAL AND MEDICAL INFORMATION - PLEASE PROVIDE DETAILS FOR "YES" ANSWERS IN SPACE PROVIDED BELOW.

Have you ever had symptoms of, been treated for, or been advised to receive treatment or have any investigations for any of the following?

Table with 2 columns: YES, NO. Rows 12-25 containing medical questions such as heart attack, asthma, diabetes, thyroid, cancer, anxiety, skin conditions, AIDS, and alcohol/drug use.

DETAILS OF ALL "YES" ANSWERS - FOR ABOVE QUESTIONS 1-25; INDICATE QUESTION NUMBER, DATES, DIAGNOSIS, DOCTORS/HOSPITALS, TREATMENT ETC.

Large empty rectangular box for providing details of "YES" answers.



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

LEGAL INFORMATION

A. THE APPLICANT(S) / OWNER(S) AND THE PERSON 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 Company, collected on this Application and held in their files, will be used by the Company for the purposes of underwriting, servicing, administration, 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, its sales distribution network, participating reinsurer(s), other companies, and any other person or party whom I/we authorize.
- 2) The statements and answers in all parts of this Application are true, complete and correctly recorded.
- 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) A policy is issued by the Company; and b) The first policy premium is paid; and c) There is no change in the insurability of the Person to be insured between the date this Application was signed by the Person to be insured and: i) the date of delivery of the policy to the Applicant/Owners resident in Provinces and Territories other than Quebec; or, ii) the date the Application is accepted by the Company without modification for Applicant/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 Head Office Endorsements Section.
- 6) If the Application is made by an Applicant/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 Applicant/Owner, subject to the provisions of such policy (policies). b) The person on whose life this insurance is applied for consents to the insurance being placed on his/her life.
- 7) They know of nothing not disclosed in the Application affecting the insurability of the Person to be insured.

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

- 1) Acknowledge receiving the Notice regarding the MIB and authorize the Company to obtain information from the MIB.
- 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 under write 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. Your personal information collected by the testing facility may be processed and stored by such facility in Canada and or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
- 4) Authorize the Motor Vehicle Division in any province requiring such authorization to permit 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.
- 5) 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 on whose life this insurance is applied for, or his/her health, to give full particulars of such information, including any prior medical history, to the Company or its reinsurers.
- 6) Agree that this Application may be transmitted to the Company electronically and received by the Company as the Applicant/Owner's original application for insurance.
- 7) A photostatic copy of these authorizations shall be as valid as the original.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT/OWNER AND PERSON TO BE INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY OF THE PERSON TO BE INSURED, OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION, INCLUDING ANY PART II SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

- A. 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, unless I/we specify. No
- B. 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. Yes No
- C. I/we acknowledge 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.
- D. I/we request all future correspondence from the Company in English French
- E. All signatures for withdrawals from the account are present in this Application, and all terms and conditions set out in the "PAD" on page 3 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 of Applicant/Owner(s)

Signature of Person to be Insured

Signature of Advisor(Witness to all Signatures)

Signature of Payor(s) under P.A.D., if different from Applicant/Owner

(If Applicant/Owner is a corporation, affix Corporate Seal if available and have Authorizing Office(s) sign and indicate title(s) - if other than Person to be Insured)



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

ADVISOR INFORMATION

MGA Name: _____ MGA No: _____

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

Advisor's Name	Advisor's No	Servicing	Commission %	Advisor's Phone	Advisor's Fax
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

All correspondence to Advisor in English French

Advisor's Email Address: _____

Supervisor's Email Address: _____

Advisor's Signature _____

Supervising Advisor's Signature _____

Date (dd/mmm/yyyy)

Date (dd/mmm/yyyy)

Do you know of: Any criticism of the insured's character, habits, mode of living, or business reputation, past or present?

Any additional information which would assist in underwriting this application?

Does the Applicant/owner and Person to be insured speak and read the English or French language?

If "No", how was the application completed? Please provide details in Special Instructions Section.

I confirm that the Advisor/Broker disclosure form was provided and explained to the client

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Signature of Producer: _____ Date: _____

TEMPORARY INSURANCE AGREEMENT

This agreement with The Equitable Life Insurance Company of Canada (the "Company") provides a LIMITED AMOUNT of life insurance protection, for a LIMITED PERIOD of time, subject to the Conditions listed below and Terms (see reverse) of this Agreement.

Conditions of the Temporary Insurance Agreement

Temporary Life Insurance under this Agreement, commences on the date this application is signed by the Owner and Proposed Life Insured only if:

- a) Questions 3, 12, 16, 19, 23, and 24 in the Personal and Medical Information section have been answered "NO"; and
- b) Payment of at least one-twelfth of the yearly premium for the insurance applied for has been submitted with this application by way of cheque or PAD withdrawal authorization; and
- c) Any cheque or draft given for payment has been honoured upon first presentation for payment; and
- d) The Proposed Life Insured has not passed his/her 65th birthday; and
- e) The amount of Insurance applied for does not exceed \$500,000.

ANY MISREPRESENTATION OR MISSTATEMENT IN THE ANSWERS GIVEN IN THIS APPLICATION, INCLUDING ANY PART II SHALL RENDER ANY TEMPORARY LIFE INSURANCE AND THIS TEMPORARY LIFE INSURANCE AGREEMENT VOIDABLE BY THE COMPANY.

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



SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

REQUIREMENTS	AFFIX BAR CODE LABEL
<p>Name of Service Provider: _____</p> <p>Underwriting Requirements ordered:</p> <p> <input type="checkbox"/> Non Medical <input type="checkbox"/> Urine (HIV) <input type="checkbox"/> MD Medical <input type="checkbox"/> Paramedical <input type="checkbox"/> ECG <input type="checkbox"/> Blood Profile <input type="checkbox"/> Order shared evidence from: _____ <input type="checkbox"/> Other: _____ </p>	

Please note: Equitable Life® cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.722.6615.

TERMS OF THE TEMPORARY INSURANCE AGREEMENT
<ol style="list-style-type: none"> 1. If the Proposed Life Insured 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 (including any Additional Accidental Death Benefit provided death occurs as a result of an accident under the terms of the policy to be issued), and \$500,000. Regardless of the total amount of Temporary Life Insurance in effect 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 shall not exceed \$500,000. 2. If the death of the Proposed Life Insured is as a result of suicide, while sane or insane, the liability of the Company under this Agreement is limited to the return of the premium paid. 3. Insurance coverage under this Agreement terminates on the earlier of: <ol style="list-style-type: none"> a) The date the Life insurance policy applied for under the Application becomes effective; b) The date the Company mails written notice to the Applicant/Owner cancelling this Agreement. If the Company issues a life insurance policy, the payment 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 Applicant/Owner informing that the Application for a life insurance policy has been declined or cancelled; or e) The date insurance under this Agreement becomes payable. the terms of the Policy applied for will govern and will be paid to the beneficiary named in the Application.

CONFIRMATION OF ADVISOR/BROKER DISCLOSURE
<p>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.</p>

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
Visit our website: www.equitable.ca

® denotes a trademark of The Equitable Life Insurance Company of Canada.