APPLICATION FOR LIFE AND/OR CRITICAL ILLNESS INSURANCE

Equitable Life of Canada®

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 basic lives to be insured as well as children (under the Children's Protection Rider). If there are more than 2 basic 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 Life 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 Applicant/Owner.
   d) Verification of Identity must be completed to follow Anti-Money Laundering legislation.
   e) If applying for Critical Illness coverage please review the Pre-Qualifying questions in Form 347 to determine eligibility for coverage prior to completing the application.
   f) Questionnaires are available from Equinet.

4. STATEMENT OF HEALTH - NON-MEDICAL (Sections 18 & 19):
   a) CHILDREN'S STATEMENT OF HEALTH - NON-MEDICAL (Section 18)
      - used for all children under Exact Age 16 applying for Life and/or Critical Illness (includes children covered under Children's Protection Rider)
   b) STATEMENT OF HEALTH - NON-MEDICAL (Section 19)
      - to be used for all adults exact age 16 over and all children age 30 days to age 17 years applying for Juvenile Critical Illness.

5. SIGNATURES (Section 20)
   a) All basic 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 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 25)
   a) at least 1/12 of the annual premium is submitted with this Application, 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 28)
   Do not collect premium where the Critical Illness Insurance sum insured under all applications is in excess of $250,000 or if the Life 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, and
   b) all questions under the Temporary Critical Illness Insurance Request are answered "NO" by the life insured and
   c) the total sum insured under all Critical Illness applications does not exceed $250,000.

   Note: With COD Applications - the TIA Agreement is NOT to be given to the Applicant and is NOT effective.

8. DISCLOSURE NOTICE (Section 26 & 27)
   The notice regarding the MIB Section 26 and Confirmation of Advisor/Broker Disclosure Section 27 must always be given to the Applicant.

9. SALES ILLUSTRATION
   Attach a Sales Illustration signed by the Applicant/Owner with the Application.

10. PROOF OF AGE
    To prove age provide copy of Birth Certificate, passport or driver's license.

11. Stickers will expedite processing. Please refer to instructions on insert.

APPLICATION FOR LIFE AND CRITICAL ILLNESS INSURANCE - PART I (the Application includes this PART I and any PART II)

PLACE STICKER HERE

❏ New Application ❏ Term Conversion from policy #__________ (for partial conversions indicate in Section 13 direction regarding balance of term plan) ❏ Guaranteed Insurance Option from policy #__________ ❏ Group Conversion

SECTION 1- PERSON TO BE INSURED

LIFE 1

Surname ______

Former Last Name (if any) ______

Given Names ______

Social Ins. No. ______ ❏ Male ❏ Female

Expiry Date for numbers starting with 9 ______ dd/mm/yyyy

❏ Mr. ❏ Mrs. ❏ Miss ❏ Ms. Or ______

Marital Status	Date of Birth Day/Month/Year	Age (Nearest)	Place of Birth Province, State or Country

Residence Address (Street, City, Province) Postal Code

Employer's Name and Address Postal Code

Type of Business ______

Occupation and Duties ______

Mailing Address: ❏ Residence ❏ Employer ❏ Other (specify)

Postal Code

Telephone No.
Residence (_____) ______ Business (_____) ______

Email Address ______

LIFE 2

Surname ______

Former Last Name (if any) ______

Given Names ______

Social Ins. No. ______ ❏ Male ❏ Female

Expiry Date for numbers starting with 9 ______ dd/mm/yyyy

❏ Mr. ❏ Mrs. ❏ Miss ❏ Ms. Or ______

Marital Status	Date of Birth Day/Month/Year	Age (Nearest)	Place of Birth Province, State or Country

Residence Address (Street, City, Province) Postal Code

Employer's Name and Address Postal Code

Type of Business ______

Occupation and Duties ______

Mailing Address: ❏ Residence ❏ Employer ❏ Other (specify)

Postal Code

Telephone No.
Residence (_____) ______ Business (_____) ______

Email Address ______

VERIFICATION OF INSURED (required for all lives insured exact age 16 and over): 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 P.E.I. provincial health card).

Life 1

Identification Type: ______

Number: ______

Place of Issue: ______ Expiry Date: ______ dd/mm/yyyy

Verification of above: ______ (Advisor's/Broker's initials)

Life 2

Identification Type: ______

Number: ______

Place of Issue: ______ Expiry Date: ______ dd/mm/yyyy

Verification of above: ______ (Advisor's/Broker's initials)

SECTION 2 - SMOKING STATUS

	LIFE 1	LIFE 2
1) Are you applying as a Smoker or Non Smoker?	❏ Smoker ❏ Non Smoker	❏ Smoker ❏ Non Smoker

SECTION 3 - APPLICANT/OWNER for insurance is LIFE 1 unless otherwise indicated

1) INDIVIDUAL (IF OTHER) ❑ **LIFE 2** ❑ **LIFE 1 & 2** ❑ **OTHER (include address and verification Client ID)**

Surname: ______________ Given Names: ______________ Date of Birth: dd/mm/yyyy

Relationship: ______________ Occupation: ______________ Social Ins. No.: ______________

Address: ______________ Expiry Date for numbers starting with 9 ______________ dd/mm/yyyy

VERIFICATION OF OWNER - 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/mm/yyyy) Verification of above: ______________ (Advisor's/Broker's initials)

2) CORPORATION/NON-CORPORATE ENTITIES (IF OTHER)

For Corporations: refer to Articles of Incorporation or similar; For Non-Corporate Organizations: refer to Partnership Agreement, Declaration of Trust, Articles of Association or similar.

Name of Company/Entity ______________ Address ______________ Registration number ______________ Jurisdiction (Fed/Prov) ______________

Insert Name(s) of Director(s)	Occupation

Insert names, address and occupation of all persons who directly or indirectly own or control 25% or more of the company shares or control 25% or more of the non-corporate entity:

Name	Address	Occupation

3) THIRD PARTY – In making application, is the Owner acting on behalf of a third Party? (Your answer should be "Yes" if someone other than the Life Insured or Owner is or will be paying the premiums, or has or will have an ownership interest in this policy.)
❑ No ❑ Yes If "Yes", answer the following questions:

INDIVIDUAL

❑ Mr. ❑ Mrs. ❑ Ms.

Name (first, middle, last) ______________ Date of Birth (dd/mm/yyyy)

Address (number, street and apartment) ______________ City or Town ______________ Province ______________ Postal code

❑ Retired or ❑ Occupation (specify) ______________ Relationship with third party ______________

CORPORATION OR NON-CORPORATE ENTITY

For Corporations: refer to Articles of Incorporation or similar; For Non-Corporate Organizations: refer to Partnership Agreement, Declaration of Trust, Articles of Association or similar.

Name of Company/Entity ______________ Address ______________ Registration number ______________ Jurisdiction (Fed/Prov) ______________

Insert Name(s) of Director(s)	Occupation

Insert names, addresses and occupation of all persons who directly or indirectly own or control 25% or more of the company shares or control 25% or more of the non-corporate entity:

Name	Address	Occupation

4) CONTINGENT OWNER (In the event of the death of the current Applicant/Owner)

Surname: ______________ Given Names: ______________

Relationship: ______________ Social Ins. No.: ______________

SECTION 4 - WHOLE LIFE PLAN INFORMATION - PLEASE ATTACH A SIGNED PLAN ILLUSTRATION

Plan Type: ❑ Equimax Estate Builder ❑ Equimax Wealth Accumulator

Premium Type: ❑ Life Pay ❑ 20 Pay

Coverage: ❑ Single Life ❑ Joint First to Die* ❑ Joint Last to Die* Face Amount: $______________

Dividend Option:

❑ Paid in Cash

❑ Premium Reduction

❑ On Deposit

❑ Paid-Up Additions

❑ Enhanced Protection: Basic Amount: $ __________________

❑ 10 Year Enhancement Guarantee Initial Enhancement Amount: $ __________________

❑ Lifetime Enhancement Guarantee Total Amount: $ __________________(Basic + Enhancement)

Riders and Additional Benefits:

❑ Disability Waiver of Premium

❑ Applicant/Payor Waiver of Premium**

❑ Excelerator Deposit Option (EDO) $ ______________________

❑ Term Rider **LIFE 1**: ❑ 10 YRCT ❑ 20 YRCT $ ___________________ **LIFE 2:** ❑ 10 YRCT ❑ 20 YRCT $ _________________

Risk Class: ____________________________ Risk Class: ___________________________

❑ Additional Life Term Rider* ❑ 10 YRCT ❑ 20 YRCT $ _______________________
(for Additional Life Term Rider please complete Application Information for Life 2)

Risk Class: ____________________________

❑ Applicant/Payor Death and Disability Waiver of Premium (juvenile plans only)*

❑ Additional Accidental Death Benefit $ _________________

❑ Children's Protection Rider $ _________________

❑ Guaranteed Insurability Option $ _________________

❑ 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

SECTION 5 - PLAN INFORMATION FOR EQUATION GENERATION® UNIVERSAL LIFE

Please attach a signed plan illustration

If applying for an Equation Generation® Universal Life plan please complete the following for Life 1 and Life 2 (where applicable).
For Investment Options please refer to Section 8
For Riders and Additional Benefits please refer to Section 7

Plan Option: ❑ With Bonus **OR** ❑ Low Fees (Please select one)

Coverage type:
❑ Single ❑ Joint First to Die* ❑ Joint Last to Die* ❑ Joint Last to Die Account Value Payout on First Death* ❑ Multiple Lives*

LIFE 1: ❑ **Face Amount: $** ______________________

LIFE 2: ❑ **Face Amount: $** ______________________(Multiple Lives Only)
*Must complete Application Information for Life 2

Death Benefit Options:	**Cost of Insurance Charges** (Check only one) **YRT**	**YRT to 85**	**Level**
❑ Account Value Protector	❑	❑	❑
❑ Level Protector	❑		❑
❑ Premium Protector	❑		
❑ Account Value with Calibrator®**	❑		
❑ Level Protector with Calibrator®**	❑		

*Life 2 Information must also be completed on this Application.
**Calibrator® is NOT available on Multiple Lives.
If Calibrator® is elected complete the CALIBRATOR® DEATH BENEFIT OPTION section below.
For Joint First to Die and Multiple Lives plans covering more than 2 basic lives please complete additional applications.

FOR JOINT LAST TO DIE ACCOUNT VALUE PAYOUT ON FIRST DEATH OPTION COMPLETE THE FOLLOWING:

Percentage of Account Value to be Paid ______% (25% – 100%)

Account Value Pay Out Beneficiary (LIFE 1):
❑ Beneficiary is the same as defined in Section 12.

❑ Other ________________________________
(Surname) (First names)

____
(Relationship)

Account Value Pay Out Beneficiary (LIFE 2):
❑ Beneficiary is the same as defined in Section 12

❑ Other ________________________________
(Surname) (First names)

____
(Relationship)

CALIBRATOR® DEATH BENEFIT

To start Calibrator face amount reductions written notification is required no later than 30 days prior to the applicable Policy Anniversary (no earlier than the 5th policy anniversary) and the applicable percentage of the maximum reduction available (0-100%) will be elected at that time.

Once Calibrator begins, prior to age 85 allow the Sum Insured to reduce to:

❑ Plan Minimum* **OR** ❑ $______________________ (Amount entered cannot be greater than the initial Sum Insured or less than the Plan Minimum)
*default if nothing is selected

❑ On or after age 85 allow the Sum Insured to reduce to zero (optional)

TAX EXEMPT HANDLING

My Death Benefit will be increased by up to 8% prior to transferring funds to the Shuttle Account ❑ Yes ❑ No
(If Calibrator has been elected the option selected must be Yes).

SECTION 6 – PLAN INFORMATION FOR EQUILIFE™ LIMITED PAY UNIVERSAL LIFE

Please attach a signed plan illustration

If applying for an EquiLife Universal Life plan please complete the following for Life 1 and Life 2 (where applicable).
For Riders and Additional Benefits please refer to Section 7. For Investment Options please refer to Section 8.

Coverage Type:

❑ Single ❑ Joint First to Die* ❑ Joint Last to Die*

Face Amount: $____________________

*Must complete Application Information for Life 2

Death Benefit: ☑ Account Value Protector

Cost of Insurance Options: (Check only one)

❑ Level for 10 Years ❑ Level for 20 Years

❑ Level for 15 Years ❑ Level to Age 65 (Equivalent Single Life Age 65 on Joint plans)

SECTION 7- 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 **AMOUNTS:**

❑ Term Rider ❑ 10 YRCT ❑ 20 YRCT $ ____________

Risk Class: ______________________________

❑ EquiLiving® Critical Illness*

❑ 10 Year Renewable $ ____________

❑ Level to 75

❑ Level to 100

❑ Disability Waiver of Monthly Charges

❑ Disability Waiver of Premium $ ____________

❑ Additional Accidental Death Benefit $ ____________

❑ Children's Protection Rider $ ____________

❑ Guaranteed Insurability Option $ ____________

❑ Additional Life Term Rider**

❑ 10 YRCT ❑ 20 YRCT $ ____________

Risk Class: ______________________________

ADDITIONAL RIDERS AVAILABLE WITH JOINT FIRST TO DIE PLANS:

❑ Disability Waiver of Monthly Charges - All Lives

❑ Disability Waiver of Premium - All Lives $____________

ADDITIONAL RIDERS AVAILABLE WITH MULTIPLE LIFE PLANS:

❑ Additional Accidental Death Benefit $ ____________

❑ Guaranteed Insurability Option $ ____________

❑ Respread Option (Multiple Lives with 3+ Lives Only)

❑ Other______________________________

For plans covering more than 2 basic lives please complete additional applications.

*To apply for the EquiLiving® Critical Illness Rider, please review Pre-Qualifying Questions in form 347.
**For Additional Life Term Rider please complete Life 2 Information.
***Life 2 Information must also be completed on this application.

LIFE 2 **AMOUNTS:**

❑ Term Rider ❑ 10 YRCT ❑ 20 YRCT $ ____________

Risk Class: ______________________________

❑ EquiLiving® Critical Illness*

❑ 10 Year Renewable $ ____________

❑ Level to 75

❑ Level to 100

❑ Disability Waiver of Monthly Charges

❑ Disability Waiver of Premium $ ____________

ADDITIONAL RIDERS AVAILABLE WITH JUVENILE PLANS:

❑ EquiLiving® Critical Illness*

❑ 10 Year Renewable $ ____________

❑ Level to 75

❑ Level to 100

❑ Applicant/Owner Waiver of Charges***

❑ Death & Disability ❑ Death Only

❑ Applicant/Owner Waiver of Premium*** $ ____________

❑ Death & Disability ❑ Death Only

❑ Flexible Guaranteed Insurability Option (to age 15)

Option Amount	Option Age
$	18
$	
$	
$	
$	

(Must complete age 18 amount if applicable, additional ages and amounts)

❑ Other ______________________________

SECTION 8 – UNIVERSAL LIFE – INVESTMENT AND SHUTTLE 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 (must total 100%).

Monthly Charges: My Monthly Charges will be deducted pro-rata from the Investment Interest Accounts selected under Premium Allocation unless indicated here ❑
(If indicated, monthly charges will be deducted as elected under Charges Allocation from the Interest Accounts specified under Premium Allocation (must total 100%))

Shuttle Account: Indicate below under Shuttle Account Allocation the percentage allocation of transfers to the Shuttle Account (must total 100%) **OR,** Funds transferred to the Shuttle Account will be allocated in the same proportion as defined under the Premium Allocation.

	Premium Allocation	Charges Allocation	Shuttle Account 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	_____%	_____%	_____%
❑ Global Growth	_____%	_____%	_____%
❑ Maximum Growth	_____%	_____%	_____%
❑ 1 Year Guaranteed Deposit Account	_____%	_____%	_____%
❑ 5 Year Guaranteed Deposit Account	_____%	_____%	_____%
❑ 10 Year 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

COMPLETE THE FOLLOWING IF THE SHUTTLE ACCOUNT BENEFICIARY IS DIFFERENT FROM THE BENEFICIARY DESIGNATED IN SECTION 12.

Shuttle Account Beneficiary:

❑ Other ________________________________
(Surname) (First names)

____
(Relationship)

Shuttle Account Contingent Beneficiary:

❑ Other ________________________________
(Surname) (First names)

____
(Relationship)

SECTION 9 - 10 AND 20 YEAR TERM PLAN INFORMATION - PLEASE ATTACH A PLAN ILLUSTRATION

If applying for a 10 or 20 Year Term plan please complete the following for Life 1 and Life 2 (where applicable):

Coverage type:

❏ Single Life ❏ Multiple Lives ❏ Joint First to Die

LIFE 1

Plan Information:

❏ 10 YRCT ❏ 20 YRCT

Face Amount: $____________________

Risk Class: ____

❏ Additional Term Coverage: ❏ 10 YRCT ❏ 20 YRCT

Face Amount: $____________________

Riders and Additional Benefits

❏ Disability Waiver of Premium

❏ Applicant/Payor Waiver of Premium**

❏ Additional Accidental Death Benefit $________________

❏ Children's Protection Rider $________________

❏ Guaranteed Insurability $________________

LIFE 2

Plan Information:

❏ 10 YRCT ❏ 20 YRCT

Face Amount: $____________________

Risk Class: ____

❏ Additional Term Coverage: ❏ 10 YRCT ❏ 20 YRCT

Face Amount: $____________________

SECTION 10 – Plan Information for EquiLiving Critical Illness

Prior to applying for EquiLiving Critical Illness review the Pre-Qualifying Questions in form 347 to determine eligibility for coverage.

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 on Surrender/Expiry
❏ Return of Premiums on Death
❏ Accidental Death Benefit Face Amount: $ ______________
❏ Term Rider: ❏ 10 YRCT ❏ 20 YRCT Face Amount: $______________

Risk Class: ____________________________

Additional Rider Available with Juvenile Plans:

❏ Applicants Death and Disability Waiver of premium*

*Life 2 information must also be completed on this application.
** Must complete Application for Applicant/Payor

SECTION 11 – PREMIUM AND PAYMENT MODE

a) INITIAL PREMIUM OF $_________________ PAID BY:

❏ cheque submitted with the Application
❏ cheque when the policy delivered (*TIA not available with this option*)
❏ Pre-Authorized Debit Plan when policy is issued. (*TIA not available with this option*)

For all Premiums and Deposits ≥ $100,000 Complete Form #345

b) SUBSEQUENT PREMIUMS PAID BY:

❏ Monthly Pre-Authorized debit plan – complete PAD

❏ Create New Pre-Authorized debit plan – complete PAD

❏ Add to existing Pre-Authorized debit plan – complete PAD

❏ Annual Premiums $ ____________________
(Includes EDO Amount)

c) 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:

i) General Information

Name of Payor(s) (if different from Policy Owner(s)) ____

ii) 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 Life Policy No: ______________________________
(void cheque not required)

❏ Establish new:

❏ 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)

iii) Withdrawal Information

Note: 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)

Preferred Withdrawal Date on _________ (1st – 28th of each month)

iv) 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

v) 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.

vi) 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).

vii) 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.

viii) 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

SECTION 12 – BENEFICIARY

Where Quebec law applies, designation of the owner's spouse (married or civil union) is irrevocable, unless the owner stipulates 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
LIFE 1

Surname ______________________

Given Name ______________________

Relationship ______________________
(to life insured, except in Quebec to the owner)

CONTINGENT BENEFICIARY - LIFE 1

Surname ______________________

Given Names ______________________

Relationship ______________________

TRUSTEE for minor beneficiaries (not applicable in Quebec)

Trustee's Name ______________________

CRITICAL ILLNESS BENEFICIARY
LIFE 1

❏ Insured

❏ Owner/Applicant

❏ Other ______________________
Surname Given Names Relationship

❏ On death of person to be insured, including Return of Premium on Death:
____
Surname Given Names Relationship

❏ Trustee for all minor beneficiaries named above (not applicable in Quebec)
____
Surname Given Names

Where Quebec law applies, designation of the owner's spouse (married or civil union) is irrevocable, unless the owner stipulates 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
LIFE 2

Surname ______________________

Given Names ______________________

Relationship ______________________
(to life insured, except in Quebec to the owner)

CONTINGENT BENEFICIARY - LIFE 2

Surname ______________________

Given Names ______________________

Relationship ______________________

TRUSTEE for minor beneficiaries (not applicable in Quebec)

Trustee's Name ______________________

CRITICAL ILLNESS BENEFICIARY
LIFE 2

❏ Insured

❏ Owner/Applicant

❏ Other ______________________
Surname Given Names Relationship

❏ On death of person to be insured, including Return of Premium on Death:
____
Surname Given Names Relationship

❏ Trustee for all minor beneficiaries named above (not applicable in Quebec)
____
Surname Given Names

SECTION 13 - SPECIAL INSTRUCTIONS FROM APPLICANT/OWNER

____

____

____

____

SECTION 14 - FINANCIAL INFORMATION

(Complete for all coverage amounts) Note: Applicant to complete Personal Section if insurance is for any child(ren)

PERSONAL	**LIFE 1**	**LIFE 2**
1. Annual Earned Income		
2. Other Income – Amount		
– Source		
3. Net Worth		
4. Purpose of Insurance Coverage		
BUSINESS	**LIFE 1**	**LIFE 2**
5. Percentage of Ownership	%	%
6. Annual Sales	Current Year:	Current Year:
Previous Year:	Previous Year:	Previous Year:
7. Net Profit		
8. Fair Market Value		
9. Outstanding Loans/Liabilities		

To Follow: ❏ Financial Statement ❏ Letter of Explanation

HEALTH AND LIFE STYLE SECTIONS 15 TO 19 AND 21

SECTION 15 – INSURANCE HISTORY

LIFE 1

Do you have any other Insurance in force? ❑ YES ❑ NO
If "YES", please complete the following:

Name of Company	Year Issued	Sum Insured Personal	Sum Insured Business	Sum Insured Critical Illness
		$	$	$
		$	$	$
		$	$	$
		$	$	$

LIFE 2

Do you have any other Insurance in force? ❑ YES ❑ NO
If "YES", please complete the following:

Name of Company	Year Issued	Sum Insured Personal	Sum Insured Business	Sum Insured Critical Illness
		$	$	$
		$	$	$
		$	$	$
		$	$	$

SECTION 16 – GENERAL INFORMATION

(Questions A to M apply to all applicants exact age 16 and over. Questions E to L for all applicants under exact age 16)

IF "YES" ANSWER TO (A) OR (B) BELOW, COMPLETE SUPPLEMENTARY AVOCATION QUESTIONNAIRE

Question	LIFE 1 YES	LIFE 1 NO	LIFE 2 YES	LIFE 2 NO
A) Have you made any flights (within the last 2 years) or do you intend to make any flights other than as a fare-paying passenger on a scheduled airline? (If "YES", complete Aviation Questionnaire.)	❑	❑	❑	❑
B) Have you engaged (within the last 2 years) or do you intend to engage in any hazardous sport or hobby e.g. scuba diving, hang-gliding, skydiving, etc? (If "YES", complete Avocation Questionnaire.)	❑	❑	❑	❑
IF "YES" ANSWER TO ANY QUESTIONS BELOW IN C-M, COMPLETE "DETAILS" BELOW.				
C) Has your driver's license been suspended at any time, and/or have you had 2 or more highway traffic violations within the last 3 years? (If "YES", Driver's License No. ________ and provide reason(s), date(s), eg. kilometers over, in "Details" below.)	❑	❑	❑	❑
D) Have you ever been charged or convicted of a criminal offence?	❑	❑	❑	❑
E) Have you been a resident of Canada for less than 24 months? (If "YES", give previous country of residence, current immigration status and date of arrival)	❑	❑	❑	❑
F) Within the next 12 months, do you intend to change your Country of residence?	❑	❑	❑	❑
G) Have you traveled outside North America within the last 24 months? (If YES, complete Travel Questionnaire.)	❑	❑	❑	❑
H) Do you intend to travel outside North America within the next 12 months? (If YES, complete Travel Questionnaire.)	❑	❑	❑	❑
I) Have you ever had any application for LIFE, DISABILITY, GROUP or CRITICAL ILLNESS insurance on your life postponed, declined, rated or modified in any way?	❑	❑	❑	❑
J) Do you have an application for LIFE, DISABILITY, GROUP or CRITICAL ILLNESS insurance now pending with any other company?	❑	❑	❑	❑
K) Will this contract, if issued, replace a Life Contract now in force, with this or any other company? (If "YES", specify in "Details" below and forward completed Disclosure Statement(s)) **If replacing Equitable Life Policy, indicate policy number here** ________	❑	❑	❑	❑
L) Have you lapsed or cancelled a Life Contract within the past 6 months? (If "YES", specify in "Details" section and forward Completed Disclosure Statement(s))	❑	❑	❑	❑
M) Are you currently involved in bankruptcy proceedings, or have you ever been bankrupt and not received a discharge?	❑	❑	❑	❑

Details of "Yes" answers

Question #	Life #	Provide Details

SECTION 17 - SMOKING DECLARATION

	LIFE 1	LIFE 2
1) Have you smoked any cigarettes or marijuana within the last 12 months?	❑ YES ❑ NO	❑ YES ❑ NO
2) Have you used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months? (If yes, specify types and frequency):	❑ YES ❑ NO	❑ YES ❑ NO

LIFE 1 Types ______________________ **LIFE 2** Types ______________________

Frequency __________ Date last used __________ Frequency __________ Date last used __________

SECTION 18 - CHILDREN'S STATEMENT OF HEALTH - NON MEDICAL

CHILDREN TO BE INSURED NON-MEDICAL AND COVERAGE INFORMATION

Complete for: a) All children to be insured under Children's Protection Rider
b) Life 1 or Life 2 under the exact age 16.
Note: Section 19 also required on the lives of all children applying for Juvenile Critical Illness
Signature of all children who have attainted age 16, 18 in Quebec, is required in Section 20.

Print full name of each child to be insured	Sex	Date of Birth			Nearest Age	Current		Name and Address of usual medical advisor
		Day	Month	Year		Height	Weight	
1.								
2.								
3.								
4.								
5.								

	Yes	No
1. Has any application for Insurance on any child been declined, postponed or modified in any way?	❑	❑
2. If the child is less than 2 years of age, was the birth premature by more than 4 weeks or is there any indication of failure to thrive or gain weight? (If Yes, provide details).	❑	❑
3. Do any of the children have any physical or mental impairment or have they had any illness, impairment or injury that has required treatment, surgery, and/or hospitalization?	❑	❑
4. Are any of the children on medication or has any treatment or diagnostic test been advised that has not been completed?	❑	❑
5. Is there any Family History of Huntington's Chorea, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease? If yes provide relationship of family member, disease and age at diagnosis	❑	❑
6. Do any of the children to be insured NOT live with the applicant? Please state below the relationship to the children, date last seen and frequency of visits.	❑	❑
7. Are there any existing Life or Critical Illness Insurance policies or pending applications, on the lives of the parents of the child? (If Yes, provide type of insurance and amounts. If No, provide reason.)	❑	❑
8. Are there any existing Life or Critical Illness Insurance policies or pending applications on the lives of all siblings of the child? (if Yes, provide type of insurance and amounts. If No, provide reason.)	❑	❑

Details of all "Yes" answers and "No" answers to #7 and #8.

Question#	Life#	Date	Provide Details

SECTION 19 - STATEMENT OF HEALTH - NON MEDICAL

QUESTIONS TO BE ANSWERED BY THE PERSON(S) TO BE INSURED, EXACT AGE 16 AND OVER OR PARENT OR LEGAL GUARDIAN OF CHILDREN UNDER EXACT AGE 16.
(completion of this form is not required if a paramedical or medical Part II is required.)

PERSON TO BE INSURED - LIFE 1

Surname	Given Names	
Height ❏ ft/in ❏ cm	Weight ❏ lbs ❏ kg	
Weight changes past year?	Gain	Loss
Reason for weight change:		
Name & address of your usual medical advisor: (IF NONE, STATE LAST CONSULT)		
Date last consulted:	Reason/Symptoms:	
Any Diagnosis and Treatment? ❏ Yes ❏ No (If "YES" provide details)	Duration of Illness:	
Any follow-up advised? (e.g. tests, surgery, hospitalization) ❏ Yes ❏ No (If "Yes", provide details)		

PERSON TO BE INSURED - LIFE 2

Surname	Given Names	
Height ❏ ft/in ❏ cm	Weight ❏ lbs ❏ kg	
Weight changes past year?	Gain	Loss
Reason for weight change:		
Name & address of your usual medical advisor: (IF NONE, STATE LAST CONSULT)		
Date last consulted:	Reason/Symptoms:	
Any Diagnosis and Treatment? ❏ Yes ❏ No (If "YES" provide details)	Duration of Illness:	
Any follow-up advised? (e.g. tests, surgery, hospitalization) ❏ Yes ❏ No (If "Yes", provide details)		

FAMILY HISTORY (Family history is required on the Insured's grandparents if either of the Insured's parents are under age 40)

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, Mental Illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease?

LIFE1 ❏ Yes ❏ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age if Alive	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparent(s)					

LIFE 2 ❏ Yes ❏ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age if Alive	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparent(s)					

PERSONAL HISTORY

Have you ever had symptoms of, been treated for, or been advised to receive treatment for, or had or been advised to have any investigations or examinations with respect to questions 1 to 9 below?:

Question	LIFE 1 YES	LIFE 1 NO	LIFE 2 YES	LIFE 2 NO
1. Heart attack, angina, chest pain, rheumatic fever, stroke, TIA, elevated blood pressure (last reading and date), or cholesterol, murmur, or other heart or blood vessel disease or disorder?	❏	❏	❏	❏
2. Asthma, respiratory, sleep apnea or other lung disorder? (If "YES", complete respiratory questionnaire.)	❏	❏	❏	❏
3. Hearing or visual impairments?	❏	❏	❏	❏
4. Diabetes, colitis, bowel disorder, hepatitis, or hepatitis carrier state, kidney, bladder, prostate, gout, or urinary disorder, blood or endocrine abnormality?	❏	❏	❏	❏
5. Thyroid or glandular disorder, lupus, MS, ALS, epilepsy, muscle or bone disorder?	❏	❏	❏	❏
6. Cancer, tumour, cyst, polyp, mole, lump or other growth, breast disorder or abnormal mammogram or ultrasound?	❏	❏	❏	❏
7. Anxiety, depression, fatigue, stress, attempted suicide, nervous breakdown, eating disorder, or other nervous system disorder? (If "YES", complete nervous disorder questionnaire)	❏	❏	❏	❏
8. Optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?	❏	❏	❏	❏
9. The skin, muscles, bones and joints, e.g. arthritis, back or neck pain, paralysis, deformity, unusual skin lesions, unexplained infections, or major organ transplantation?	❏	❏	❏	❏
10. a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	❏	❏	❏	❏
b) Have you ever had a positive test result indicating exposure to the AIDS virus?	❏	❏	❏	❏
c) Within the past 5 years, have you had any indication of a sexually transmitted disease?	❏	❏	❏	❏
11. Have you ever had any:				
a) Electrocardiograms	❏	❏	❏	❏
b) X-Rays	❏	❏	❏	❏
c) Other Diagnostic Tests	❏	❏	❏	❏
(If "YES", advise type(s), date(s), reason(s), result(s).)				
12. Have you ever had:				
a) symptoms, illness, injury, surgery, treatment, examination or investigation;	❏	❏	❏	❏
b) or been advised to receive surgery, treatment, examination or investigation;	❏	❏	❏	❏
c) surgery, treatment, examination or investigation for which results are not yet known to you; which have not been disclosed in questions 1 to 11 above?	❏	❏	❏	❏
13. Do you regularly take any medication? (If "YES", specify type, dosage, when and by whom prescribed.)	❏	❏	❏	❏
14. Have you been absent from work as a result of illness or injury for 5 or more consecutive days within the past 5 years?	❏	❏	❏	❏
15. Have you consulted any physician within the past 5 years for anything not covered in the above questions or in this Application? (If "YES", give particulars)	❏	❏	❏	❏
16. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	❏	❏	❏	❏
17. Have you been advised to have surgery, treatment or testing, which has not been completed?	❏	❏	❏	❏
18. a) Do you drink alcoholic beverages? (If "YES", specify type and ounces per week.)	❏	❏	❏	❏
b) Have you ever received advice, treatment or counselling pertaining to your use of alcohol?	❏	❏	❏	❏
c) Have you ever used marijuana, cocaine or any illegal or addictive drugs?	❏	❏	❏	❏
d) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs?	❏	❏	❏	❏

(If "YES", to 18(b), (c), or (d) complete Alcohol or Drug Use questionnaire.)

Details of "YES" answers

Question #	Life #	Date	Provide Details

SECTION 20 - LEGAL INFORMATION

THE APPLICANT/OWNER 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 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. The policy is delivered or accepted in the manner specified in 3c i), ii) or iii); 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 Applicant/Owners; or, ii) the date of delivery of the life policy to the Applicant/Owners resident in Provinces and Territories other than Quebec; or, iii) the date the Application for a life policy is accepted by the Company with out 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(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.

THE APPLICANT/OWNER, AND THE PERSON(S) 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 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. 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(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.
6) I 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(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 THIS APPLICATION, INCLUDING ANY PART II SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

A. Equitable Life 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. I/we acknowledge receipt of the Confirmation of Advisor/Broker Disclosure ❑ Yes

C. I/we request all future correspondence from the Company in ❑ English ❑ French

D. All signatures for withdrawals from the account are present in this Application, and all terms and conditions set out in the "PAD" in section 11 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 (city) (province) this (day) of (month) 20 .

Signature(s) of Applicant/Owner(s)

(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)

LIFE 1		LIFE 2	
*** Signature of Person to be Insured**		*** Signature of Person to be Insured**	
Other		ADVISOR	
*** Signature of Person to be Insured**		**Witness to all Signatures**	

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

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

Signature of Payor(s) under P.A.D. in Section 11, if different from Applicant/Owner:

*If other than Life 1 or Life 2

SECTION 21 - TEMPORARY LIFE AND/OR TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST

Temporary Life Insurance Request

The Applicant/Owner and Person to be insured, or the Persons to be insured if a joint life application, in the Application for Life Insurance Part I (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:

(a) 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
(b) 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, or
(c) any cheque or draft given for payment has not been honored upon first presentation for payment, or

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 Applicant/Owner 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:

(a) the Person to be insured answers YES or fails to provide an answer to any of the Critical Illness Insurance questions below, or
(b) 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, or
(c) any cheque or draft given for payment has not been honored upon first presentation for payment, or
(d) the total amount of Critical Illness Coverage applied for under all Critical Illness applications with the Company exceeds $250,000.

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

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

Has (have) the Person(s) to be insured:	LIFE TIA		CI TIA		LIFE TIA		CI TIA	
	LIFE 1		LIFE 1		LIFE 2		LIFE 2	
	YES	NO	YES	NO	YES	NO	YES	NO
1. Ever been treated for or had any known 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	❑	❑	❑	❑	❑	❑	❑	❑
2. 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)?	❑	❑	❑	❑	❑	❑	❑	❑
3. 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?	❑	❑	❑	❑	❑	❑	❑	❑
4. 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?	❑	❑	❑	❑	❑	❑	❑	❑
5. Passed their 65th birthday, or not reached at least 15 days of age for Life applications or 30 days for Critical Illness applications?	❑	❑	❑	❑	❑	❑	❑	❑
6. Ever been treated for or had any known indication of: (only answer if applying for Life TIA insurance)								
- heart or blood vessel disease, not including high blood pressure	❑	❑			❑	❑		
7. Ever been treated for or had any known indication of: (only answer if applying for Critical Illness TIA insurance)								
- heart or blood vessel disease, including high blood pressure			❑	❑			❑	❑

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

The Applicant/Owner 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 ______ (city) ______ (province) this ______ (day) of ______ (month) 20 ____ .

Signature(s) of Applicant/Owner(s)

(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)

LIFE 1 ______
*** Signature of Person to be Insured**

LIFE 2 ______
*** Signature of Person to be Insured**

OTHER ______
*** Signature of Person to be Insured (parent or guardian for children under attained age 16 or under attained age 18 in Quebec)**

ADVISOR ______
Witness to all Signatures

*Signature required for each Person to be Insured who has attained their **16th, 18th in Quebec, birthday, at the date hereof**

SECTION 22 - ADVISOR'S REPORT

	Yes	No
1. Does the Applicant/Owner and Person(s) 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 13.	❑	❑
2. Has there been prior contact with Head Office regarding the Insured(s)? ...... If "YES", give date(s), insured's name(s), and reference of last Head Office letter, and person or department contacted in Section 13.	❑	❑
3. Do you know of:		
a) Any criticism of the insured's character, habits, mode of living, or business reputation, past or present?	❑	❑
b) Any additional information which would assist in underwriting this application? ...... If "YES", please provide details in Section 13:	❑	❑
4. Was this sale derived from a financial needs analysis?	❑	❑
5. Was this sale based on needs that were: ❑ Business ❑ Personal ❑ Other ______		
6. I confirm that the Advisor/Broker disclosure form was provided and explained to the client	❑	❑

ADVISOR'S INFORMATION (PLEASE PRINT):

MGA Name:______ MGA No.: ______

MGA Phone No.______ MGA Fax No. ______ MGA E-Mail Address ______

	Advisor's Name	Servicing Agent	Advisor's No.	%	Advisor's Phone No.	Advisor's Fax No
1)	______	______	______	______	( )______	( )______
		OR				
2)	______	______	______	______	( )______	( )______

Advisor's Signature ______ Date ______

Advisor's E-Mail Address: ______

All correspondence to Advisor in ❑ English ❑ French

SECTION 23 - UNDERWRITING REQUIREMENTS

Affix Bar Code Labels [ ] [ ]

NAME OF SERVICE PROVIDER: ______

INDICATE REQUIREMENTS ARRANGED: ______

	LIFE 1	LIFE 2
Non Medical	❑	❑
M.D. Medical	❑	❑
Paramedical	❑	❑
Electrocardiogram......	❑	❑
Blood Profile	❑	❑
PSA	❑	❑
Urine (HIV)	❑	❑

	LIFE 1	LIFE 2
Saliva (HIV)	❑	❑
Inspection Report	❑	❑
Financial Statements	❑	❑
Avocation Questionnaire......	❑	❑
Health Questionnaire	❑	❑
Other (state)	❑	❑

SECTION 24 - 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 questions or any of the Temporary Critical Illness Insurance 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 of _______________________________________ .

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

Signature of Representative ____

SECTION 25 - TEMPORARY LIFE INSURANCE AGREEMENT

PLACE STICKER HERE

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 request is signed by the Applicant/Owner and the Person(s) to be Insured, 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 Part I (the "Application") has been submitted with this Application; and

c) Any cheques or draft given for 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 lessor 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 Applicant/Owner; and c) any Critical Illness Rider.
3. If death of any Person(s) to be 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.
4. If the Company issues a Life insurance policy, the amount acknowledged in the Receipt For Payment With 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 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.
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 this Application, including any Part II shall render any Temporary Life Insurance and this Temporary Life Insurance Agreement voidable by the Company.

SECTION 26 - 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.

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.

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 27 - Confirmation of Advisor/Broker Disclosure

The Life and/or Critical Illness policy purchased is underwritten and managed by Equitable Life of Canada, licenced to conduct business in all provinces of Canada. I am an independent broker/producer, representing Equitable Life of Canada through____ (agency/MGA name).

I hereby disclose that I have earned commissions for the policy that you have purchased and will continue receiving servicing/renewal commissions, if you continue to keep this policy inforce. 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, during a given time period. In my duty to disclose any conflict of interest with you as my client, I confirm there is no conflict of interest resulting this transaction.

Commission sharing arrangements(s) for this policy is:	
Advisor Name(s):	Percentage % :

For Independent Advisor/Brokers in British Columbia and Ontario:
"I am a licensed general agent, life agent, general insurance salesperson by the Insurance Council of British Columbia and Financial Services Commission of Ontario respectively."

Advisor's Name:__________________________ Advisor's Signature__________________________ Date__________________
Advisors/Brokers working in BC and Ontario are required to list the companies they represent:

____

____

Section 28 - TEMPORARY CRITICAL ILLNESS AGREEMENT

PLACE STICKER HERE

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 listed below.

CONDITIONS

Temporary Critical Illness Insurance under this Agreement commences on the date the Temporary Critical Illness Insurance Request is signed by Applicant/Owner and the Person(s) to be insured, 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 Part I ("Application"); and
c) any cheques or draft given for payment has been honoured upon first presentation for payment; and
d) the total amount of Critical Illness Insurance applied for by the Person to be insured under all applications with the Company does not exceed $250,000.

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 5; and
d) the Person(s) insured under this Agreement has satisfied the survival period described in paragraph 7; 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 by 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 applied for under the Application becomes effective;
   b) the date the Company mails written notice to the Applicant/Owner 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 Applicant/Owner cancelling this Agreement. If the Company issues a EquiLiving Critical Illness policy, the payment submitted with the Application will be credited toward the first premium due under the policy.
4. If the Company issues an EquiLiving Critical Illness Policy, the amount acknowledged in the Receipt for Payment with Application will be credited toward the first premium due under the policy.
5. 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.
Exclusion: 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.
Exclusion: 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."

6. 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 while sane or insane;
   - 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.
7. 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.
8. 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.
9. No representative of the Company is authorized to modify this Agreement.
10. ANY MISREPRESENTATION OR MISSTATEMENT IN THE ANSWERS GIVEN IN THE TEMPORARY CRITICAL ILLNESS INSURANCE REQUEST OR IN THIS APPLICATION, INCLUDING ANY PART II, SHALL RENDER ANY TEMPORARY CRITICAL ILLNESS INSURANCE AND THIS TEMPORARY CRITICAL ILLNESS INSURANCE AGREEMENT VOIDABLE BY THE COMPANY.