

Term

SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE



Equitable Life
of Canada[®]

Head Office

One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Ontario N2J 4C7
TF 1.800.722.6615 **T** 519.886.5210 **F** 519.883.7422
Website: www.equitable.ca

SHORT FORM SINGLE LIFE APPLICATION FOR TERM INSURANCE

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.

PLACE STICKER HERE

If the questions are asked by the Advisor they must be asked as is, word for word and not paraphrased.

Proposed Life Insured For Joint Life, Multiple lives, Spousal rider or CPR complete application form #350.

Name in Full: _____
(Last) (First)

Mr. Mrs. Miss Ms.
 Or

Date of Birth: D _____ M _____ Y _____ Age (nearest): _____ Sex: M F

Social Insurance Number: _____ Place of Birth: _____

Occupation: _____ Annual Income: _____

Residence Address: _____
Street City Province Postal Code

Residence Phone: () _____ Business Phone: () _____

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: _____ Verification of above: _____
(Advisor's/Broker's Initials)

Owner If other than Proposed Life Insured

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 345 must be completed.

Name in Full: _____ Date of Birth: _____ Relationship: _____
Last First

Social Insurance Number: _____ Occupation: _____

Residence Address: _____
Street City Province Postal Code

Residence Phone: () _____ Business Phone: () _____

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: _____ Verification of above: _____
(Advisor's/Broker's Initials)

If the Applicant/Owner is a Corporation or Non-Corporate Entity, Form 345 must be completed.

Beneficiary All beneficiaries are revocable unless otherwise stated to be irrevocable.

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

Primary Beneficiary: _____ Relationship: _____
(to life insured, except in Quebec to the owner)

Contingent Beneficiary: _____ Relationship: _____
(to life insured, except in Quebec to the owner)

Trustee for minor beneficiaries (not applicable in Quebec)

Trustee's Name _____

Plan Details

Plan: 10 Year Term 20 Year Term Amount: \$ _____

Risk Class _____

Benefits: Disability Waiver Additional Accidental Death Benefit Amount: \$ _____

Special Instructions

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)

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 _____

Timing of Withdrawal(s) _____

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

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: customerservice@equitable.ca

HEALTH AND LIFE STYLE SECTIONS PAGES 4 AND 5

Smoking Declaration For "YES" answers specify types and date last used.

Have you smoked any cigarettes or marijuana within the last 12 months? Yes No

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

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: _____ Weight: _____ Any weight change in the last year? _____

Gain: _____ Loss: _____ Reason for weight change? _____

Personal and Medical Information - Please provide details for "YES" answers in space provided below.

1. Do you have any Inforce/Pending Insurance? Yes No
(If "YES", please indicate Company, Year Issued, Plan Type, Sum Insured, Personal/Business.)
2. Will this contract, if issued, replace a Life Insurance Contract now in force? (If "YES", complete Disclosure Statement(s). If Equitable Life, provide Policy Number.) Yes No
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? Yes No
4. Have you ever been charged or convicted of any criminal offense? Yes No
5. Have you been a resident of Canada for less than 24 months? (If "YES", give previous country of residence and current immigration status, and date of arrival). Yes No
6. Within the next year, do you intend to change your COUNTRY OF RESIDENCE? Yes No
7. Have you traveled outside of North America within the last 24 months or do you intend to travel outside North America within the next 12 months? (If "YES", complete Travel Questionnaire..) Yes No
8. Has your driver's license ever been suspended and/or have you had 2 or more highway traffic violations within the last 3 years?
(If "YES", provide driver's license number, reason(s) and date(s), kilometers over) Yes No
9. In the last 2 years have you or do you intend to:
a) Make any flights other than as a fare-paying passenger? (If "YES", complete Aviation questionnaire) Yes No
b) Engage in any hazardous sport or hobby? (e.g. scuba diving, hang gliding, skydiving, motor racing, mountain climbing) (If "YES", complete Avocation questionnaire) Yes No
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?
(Indicate age diagnosed, family member and condition) Yes No
11. Are you currently involved in bankruptcy procedures, or have you ever been bankrupt and not received a discharge Yes No

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?

- 12. 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? Yes No
- 13. Asthma, respiratory, sleep apnea or other lung disorder? (If "YES", complete respiratory questionnaire.) . . . Yes No
- 14. Diabetes, colitis, bowel disorder, hepatitis, or hepatitis carrier state, kidney, bladder, prostate, gout, or urinary disorder, blood or endocrine abnormality Yes No
- 15. Thyroid, or glandular disorder, lupus, multiple sclerosis, amyotrophic lateral sclerosis, epilepsy, muscle or bone disorder? Yes No
- 16. Cancer, tumour, cyst, polyp, mole, lump or other growth, breast disorder or abnormal mammogram or ultrasound? Yes No
- 17. Anxiety, depression, fatigue, stress, attempted suicide, nervous breakdown, eating disorder or other nervous system disorder? (If "YES", complete nervous disorder questionnaire) Yes No
- 18. The skin, muscles, bones and joints, e.g. arthritis, back or neck pain, paralysis, deformity, unusual skin lesions or unexplained infections? Yes No
- 19. 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? Yes No
b) Have you ever had a positive test result indicating exposure to the AIDS virus? Yes No
c) Within the past 5 years, have you had any indication of a sexually transmitted disease? Yes No
- 20. Have you had any illness, injury, operation, or medical examination not mentioned above? Yes No
- 21. Do you regularly take any medication? (If "YES", specify type, dosage, when and by whom prescribed.) . . Yes No
- 22. Have you consulted any physician within the past 5 years of which details are not given? (If "YES", give particulars.) Yes No
- 23. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician? Yes No
- 24. Have you been advised to have surgery, treatment or testing, which has not been completed? Yes No
- 25. a) Do you drink alcoholic beverages? (If "YES", specify type and weekly consumption.) Yes No
b) Have you ever received advice or treatment pertaining to your use of alcohol? Yes No
c) Have you ever used marijuana, cocaine or any illegal or addictive drugs? Yes No
d) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs? Yes No
(If "YES", to (b), (c) or (d), complete Alcohol or Drug Use questionnaire.)

Details Of All "YES" Answers; For above Questions 1-25; indicate question number, dates, diagnosis, doctors/hospitals, treatment etc.

THE APPLICANT/OWNER 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 subject to 3) c. ii), the policy is delivered to the Applicant/Owners; 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.

THE APPLICANT/OWNER, 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. 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" 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.

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

* 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:
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P.O. Box 1603 Stn. Waterloo, Ontario N2J 4C7
TF 1.800.722.6615 **T** 519.886.5210 **F** 519.883.7422
Website: www.equitable.ca

Advisor Information

Advisor's Name: _____ Advisor's # _____
Advisor's Phone # _____ Advisor's Fax # _____
Advisor's Email: _____
MGA Name: _____ MGA # _____
MGA Phone # _____ MGA Fax # _____
MGA Email: _____

Do you know of: Any criticism of the insured's character, habits, mode of living, or business reputation, past or present? . . . Yes No
Any additional information which would assist in underwriting this application? Yes No

Does the Applicant/owner and Person to be insured speak and read the English or French language? Yes No
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

Signature of Producer: _____ Date: _____

Requirements

Name of Service Provider: _____

Underwriting Requirements ordered: Non Medical Urine (HIV) Saliva (HIV) MD Medical Paramedical ECG
 Blood Profile Other: _____ Affix Bar Code Label

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; 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

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

Terms of the Temporary Insurance Agreement

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:
 - 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.

351(2010/03/01)

Confirmation of Advisor/Broker Disclosure

The Life 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 or 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 _____

