



I/We, the undersigned, hereby apply to The Equitable Life Insurance Company of Canada (the "Company") to amend the policy contract described below, in the following manner:

Change Request for Policy # _____ Owner(s): _____ Insured(s): _____

Verification of Insured - Provide current/original Canadian government-issued photo I.D. (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 and MB, provincial health card) or Certificate of Corporate Status.

Identification Type: _____ Number: _____

Place of Issue: _____ Expiry Date: _____

Verification of above _____

(Advisor's/Broker's initials)

Requested Change

(the following will require a specific form: Addition of Children's Protection Rider-Form 381, Revival/Reinstatement-Form 370)

- Addition - riders, benefits, lives: Form 374 (Section A, B, C, D, E, F, G), underwriting requirements based on current age and total insurance within a 6 month period
Increase - face amounts: Form 374 (Section A, B, C, D, F, G), underwriting requirements based on current age & total insurance within a 6 month period
Deletion - riders, benefits, lives: Form 374 (Section A, F, G)
Decrease - face amounts: Form 374 (Section A, F, G)
Smoker to Non Smoker Status - Critical Illness: Form 374 (Section A, B, C, D, F, G), Urine Other Plans: Form 374 (Section A, B, C, D, F, G), Saliva
Exchange Option - for 10 year Term plans issued after July 15, 2008 (Section A, F, G) see online Administration Guide for additional details.
Rating Reconsideration - removal or reduction: Form 374 (Section A, B, C, D, F, G)
Other - _____

Note: requirements may vary, based on actual change requested.

Section A - Plan Specifications Once Change Completed:

Table with 3 columns: Plan Description, Amount, Premium. Includes a Total row.

If applicable:

Universal Life (excluding EquiLife)

- DBO Level, Account Value Protector, Premium Protector, Inflation Protector
Calibrator (Equation Generation only): Level or Account Value Protector
Start Calibrator as soon as possible or in year (minimum 5)
Apply maximum reduction available to Sum Insured or limit reduction to % of maximum
Prior to age 85 allow the sum insured to reduce to: plan minimum, \$, zero

- COI Level, YRT, YRT 85

EquiLife Only

- COI Type 10 year, 15 year, 20 year, to age 65

Dividend Option

(Equimax and Equimax 20 - Pay only)

- paid in cash (cheque)
- applied towards premium and/or loan
- purchase fully paid-up additional insurance
- accumulate on deposit
- (at issue only) enhanced dividend

Payment method: Annual* P.A.P.

* If on annual billing, any addition or increase will require the difference in premium paid

Special Instructions:

Head Office Endorsements:

Section G - Legal Information

THE APPLICANT/OWNER AND THE PERSON(S) TO BE INSURED DECLARE AND AGREE THAT:

- The personal information willingly provided by me/us to the independent broker and/or the Company and collected on this Application and held in their files will be used by the Company for the purposes of underwriting, servicing, administration, and claims processing and adjudication related to this Application, the policy and any supplementary documents. The information on file is accessible for the above purposes to authorized employees and reinsurer(s) of the Company, as well as third parties retained by the Company, and any other person or party whom I/we authorize.
- The statements and answers in all parts of this Application are true, complete and correctly recorded.
- The insurance being applied for in this Application or such insurance as approved and issued by The Equitable Life Insurance Company of Canada (Hereinafter the "Company") shall not take effect until:
 - this Application is approved by the Company; and
 - a policy change is issued by the Company and the policy change is delivered by the Company's authorized representative to the Person(s) to be Insured; and
 - the first policy change premium is paid; and
 - there is no change in the insurability of the Person(s) to be Insured since the date this Application was signed by the Person(s) to be Insured and the date of delivery of the policy change.
- Knowledge of or notice to any person shall not constitute knowledge of or notice to the Company. No person, other than an Authorized Officer of the Company, shall have authority to place the Company under any risk or obligation, or pass on insurability.
- Acceptance of any policy change 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.
- If the Application is made by an Applicant/Owner (other than the Person to be Insured):
 - and if a policy (policies) change(s) is (are) issued under this Application, such policy (policies) change(s), including all rights thereunder, shall be under the full control of said Applicant/Owner, subject to the provisions of such policy (policies).
 - the person(s) on whose life (lives) this insurance is applied for consents to the insurance being placed on his/her (their) life (lives).
- They know of nothing not disclosed herein affecting the insurability of the Person(s) to be Insured.

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

- Acknowledge receiving the Notice regarding the MIB and authorize the Company to obtain information from the MIB, and.
- Consent to the obtaining of a consumer report containing personal and/or credit information, and.
- 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.
- Authorize the Motor Vehicle Division in any province requiring such authorization to permit the Company or an investigative agency acting on behalf of the Company, to be given a copy of all driving record information relevant to this Application. A photostatic copy of this authorization shall be as valid as the original, and
- Authorize any physician, practitioner, hospital, clinic or other medical or medically-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. A photostatic copy of this authorization shall be as valid as the original.
- If the pre-authorized method of payment is chosen, I/We authorize the company to make monthly withdrawals from the Owner/Payor's account designated to pay premiums (including those overdue). If premiums change for the insurance policy issued from this Application, the Company is authorized to amend the amount of the pre-authorized monthly withdrawals. The pre-authorized monthly payment plan may terminate if a cheque is not honoured by the financial institution because of a stopped payment or payment refused. When terminated the premiums for the policy will become payable on a monthly basis unless an alternative payment method is elected in writing. The pre-authorized monthly method of payment may be cancelled or changed by providing 10 days written notice to the Company. This authorization shall continue to have effect so long as I/We maintain the insurance coverage with the Company.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT/OWNER, PERSONS(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, SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

Signed at: (City) _____ (Province) _____ this _____ of _____ in the year _____

Signature of Life Insured(s)

Signature of Witness to all signatures

Signature of Owner(s) (if other than Life Insured)

Signature of Present Owner(s) (if Transfer of Ownership)

Owner(s) S.I.N. #

Previous Owner(s) S.I.N. #

Assignee required if the policy is assigned

Signature of Beneficiary (if preferred or irrevocable)

Underwriting Requirements Ordered

Urine (HIV) Saliva (HIV) MD Medical Paramedical ECG Blood Profile PSA (males only): Other:

Please provide bar code for urine or saliva.

MIB Pre-Notice
(To be given to Proposed Life Insured)