

## APPLICATION FOR CHANGE

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): \_\_\_\_\_

Owners Address \_\_\_\_\_

Owners Phone # \_\_\_\_\_ Owners email \_\_\_\_\_

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 (refer to evidence of insurability schedule)
- 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)
- Excellerated Deposit Option (EDO)** – (Section A, B, C, D, F, G)

### Underwriting Rules

DO NOT complete Section B - Medical Questions if **any** of the following applies:

- a) this policy is less than one year old.
- b) there is One Year Term Insurance in force under the Enhanced Protection Option.
- c) the scheduled deposit is being reduced.

Complete Section B - Medical Questions (below) where:

- a) this policy is more than one year old; **and**
- b) there is **no** One Year Term Insurance in force under the Enhanced Protection Option; **and**
- c) when adding, increasing, making a Single Payment or reinstating Excellerator Deposit Option.

**Other** – \_\_\_\_\_

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

**Section A - Plan Specifications Once Change Completed:**

Plan Description	Amount	Premium
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
		<b>Total</b>

**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

**Equimax Only**

**Excelerated Deposit Option (EDO) Details**

Amount \$ \_\_\_\_\_ Scheduled deposit frequency       Annual       Monthly P.A.D.       Single Payment

**Dividend Option**

(Equimax and Equimax 20 - Pay only)

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

Payment method:       Annual\*       P.A.D.      \* If on annual billing, any addition or increase will require the difference in premium paid

**Section B (non-medical) - Personal & Medical Information**

**PERSON TO BE INSURED - LIFE 1**

Surname	Given Names	
Height	Weight	
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:	
Diagnosis:	Duration of Illness:	
Any follow-up advised? (e.g. tests, surgery, hospitalization) <input type="checkbox"/> Yes <input type="checkbox"/> No (IF NONE, SO STATE)		

**PERSON TO BE INSURED - LIFE 2**

Surname	Given Names	
Height	Weight	
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:	
Diagnosis:	Duration of Illness:	
Any follow-up advised? (e.g. tests, surgery, hospitalization) <input type="checkbox"/> Yes <input type="checkbox"/> No (IF NONE, SO STATE)		

## Section B (non-medical) - Personal & Medical Information con't

1. a) Do you drink alcoholic beverages? (If YES, specify type and weekly consumption.) \_\_\_\_\_  
 b) Have you ever received advice or treatment pertaining to your use of alcohol? (If YES, complete Drinking Habits Questionnaire)  
 c) Have you ever used marijuana, or any illegal or addictive drugs or received treatment for drug addiction? (If YES, complete Drug Use Questionnaire) \_\_\_\_\_
2. Have you been diagnosed, had any known indication of, or been treated for any mental or nervous disorder (e.g. depression, anxiety), epilepsy, fainting spells, MS or ALS? \_\_\_\_\_
3. Have you ever been treated for, or had any indication of heart, stroke or circulatory trouble, chest pains, high blood pressure, diabetes, kidney or liver disease, blood disorder, cancer or tumors of any kind? \_\_\_\_\_
4. 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? \_\_\_\_\_
5. Have you ever been treated for, or had any indication of a respiratory disorder, kidney or bladder disorder, hepatitis B, hepatitis C, hepatitis carrier or gastro-intestinal disorder, muscle or bone disorder? \_\_\_\_\_
6. Do you regularly take any medication (specify type and dosage.)? \_\_\_\_\_
7. Have you consulted any physician within the last 5 years for which details are not given above? \_\_\_\_\_
8. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician? \_\_\_\_\_
9. Have you been advised to have surgery, treatment or testing, which has not been completed? \_\_\_\_\_
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, 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? (If YES, provide relationship of family member, disease, age at diagnosis.) \_\_\_\_\_

Life 1		Life 2	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Section C - General Information

1. Do you have any Inforce/Pending Life or Critical Illness Insurance? (If YES, please indicate Company, Year Issued, Sum Insured, Personal/Business) \_\_\_\_\_
2. Will this contract, if issued, replace a Life insurance Contract currently in force? (If YES, complete Disclosure Statement(s).) \_\_\_\_\_
3. Have you ever had an application for Life, Disability, Critical Illness, or Group Insurance on your life postponed, declined, rated or modified in any way? \_\_\_\_\_
4. Do you expect to travel outside North America within the next 12 months? \_\_\_\_\_ (If YES, complete Foreign Travel Questionnaire)
5. Has your driver's license ever been suspended and/or have you had 2 or more moving violations within the past 3 years? (If YES, provide driver's license number, reason(s) and date(s).) \_\_\_\_\_
6. 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)
  - b) Engage in any hazardous sport or hobby? (e.g. scuba diving, hang gliding, skydiving, motor racing, mountain climbing) (If YES, complete appropriate Avocation Questionnaire) \_\_\_\_\_

Life 1		Life 2	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Details of all "YES" answers for Sections B, C

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Special Instructions

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**Section D - Smoking Declaration:** for "yes" answers, specify types and date last used

Have you smoked any cigarettes or marijuana within the last 12 months?

Have you used any other tobacco or nicotine based products within the last 12 months?

(If YES, specify types, frequency of use and date last used.) \_\_\_\_\_

Life 1

Yes  No

Yes  No

Life 2

Yes  No

Yes  No

Any misrepresentation or misstatement in the answers to these questions shall render any insurance issued in connection with this application voidable by Equitable Life of Canada®

**Section E - Proposed Life Insured:** If different than currently named on contract (life #2)

Name in Full (Last, First, Initial):

Date of Birth (Day, Month, Year):	Age (nearest):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Document to Verify I.D. :	Document # :	
Social Insurance Number:	Place of Birth:	
Occupation:	Annual Income:	
Residence Address (Street, City, Province, Postal Code):		
Residence Phone: (        )		Business Phone: (        )

**Section F - Producer Information**

Producer's Name: \_\_\_\_\_ # \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ email \_\_\_\_\_

MGA Name: \_\_\_\_\_ # \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ email \_\_\_\_\_

Signature of Producer: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.

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

### Notice Regarding The Medical Information Bureau

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](http://www.mib.com)

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