

<b>Name of Life Insured:</b>	<b>Policy No.:</b>
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**If policy is Joint/Multi-Lives/ includes Spousal Term Rider, complete separate Declaration of Insurability on each Life Insured.**

**HEALTH**

1. HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ Change in the past 12 months: Gain: \_\_\_\_\_ Loss: \_\_\_\_\_ Reason: \_\_\_\_\_

2. a) Have you smoked any cigarettes or marijuana within the last 12 months?  Yes  No

If **Yes**, date last used \_\_\_\_\_

b) Have you used any other tobacco products within the last 12 months?  Yes  No (If **Yes**, specify types and date last used.)

Types \_\_\_\_\_ Date last used \_\_\_\_\_

Any misstatement or misrepresentation in the answers to this question #2 shall render any insurance reinstated in connection with this Declaration voidable by The Equitable Life Insurance Company of Canada (the "Company").

3. Within the past 5 years or since this policy was issued (whichever is the shorter period) have you: YES NO

A. Attended a medical practitioner, hospital, sanatorium, or clinic? .....

B. Had any diagnostic test eg. electrocardiogram, x-ray, laboratory test etc.? .....

C. Ever been diagnosed, treated for, or have any indication of possible exposure to: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder? .....

D. Have you been absent from work as a result of sickness or injury for 5 or more consecutive days within the past 5 years? ...

4. Is your health now impaired in any way? .....

If questions 3(a), (b), (c) or (d) or 4 have been answered **Yes** please provide details below:

Question Number	Name and Address of each practitioner, hospital, clinic	Date	Reason	Tests Performed	Results	Diagnosis & Treatment Received

5. Additional details:

**GENERAL**

YES NO

1. Since this policy was issued have you ever had an application for insurance on your life declined, postponed, rated or modified in any way? (Company name \_\_\_\_\_) .....

2. Do you engage in any hazardous sport or hobby (eg. scuba diving, sky diving, etc.) or have you within the past 3 years made or do you intend to make any flights other than as a fare paying passenger on a scheduled airline? .....

(If **Yes** complete the appropriate questionnaire)

❖ **If policy includes the Family Plan or Children's Protection Rider, complete questions on reverse.** ❖

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 Declaration 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 Declaration, any reinstated policy, if approved, and any supplementary documents. The information retained 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 this Declaration are true, complete and correctly recorded and I/we agree: (a) that these statements and answers, the statements and answers made in the original application for the policy and any additional evidence of insurability provided by me/us, shall together be used to determine insurability; (b) that the policy shall not be considered reinstated unless and until: (i) I have paid all premiums in arrears with interest; (ii) no change has taken place in the insurability of the lives to be insured since completion of this Declaration and the date the Company's Notice of Reinstatement is delivered to me; and (iii) that I know of nothing affecting the insurability of the lives insured not disclosed in this Declaration, the original application and any other evidence of insurability provided by me/us.
- if policy reinstatement is declined or if additional evidence of insurability required by the Company is not furnished, or if all of the requirements of subparagraph 2(b) (i) (ii) and (iii) have not been satisfied, the policy shall not be and shall not have been reinstated.
- They have received the Notice Regarding the Medical Information Bureau, and authorize any physician or practitioner, facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give full particulars thereof, including any prior medical history, to The Equitable Life Insurance Company of Canada or its reinsurer(s). A photostatic copy of this authorization will be as valid as the original.
- I/We consent to the obtaining of a consumer report containing personal and/or credit information.

**FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT/OWNER, PERSON(S) TO BE INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR REINSTATEMENT, 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 DECLARATION SHALL RENDER ANY INSURANCE REINSTATED IN CONNECTION WITH THIS DECLARATION VOIDABLE BY THE COMPANY.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
 Witness to Signature(s) (Unrelated Adult)

\_\_\_\_\_  
 Signature of Life Insured or Applicant of Child's Policy

\_\_\_\_\_  
 Signature of Owner if other than Life Insured of Adult's Policy (required on 3rd party policies)

Head Office Endorsements	<b>COMPANY USE ONLY</b>	
	Decision	Date

370(2003/06/26)MR

**NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (To be detached and given to the Life Insured)**

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, The Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

We or our reinsurer(s) may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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**INSTRUCTIONS:**

An application for reinstatement will normally be considered on the basis of a completed Declaration of Insurability (form 370) only, provided:

- a) The policy has lapsed within 60 days (30 days if the applicant is over 65 years old) of the date of this Declaration; and
- b) The application for reinstatement would be considered under the non-medical rules if this was an application for new insurance.

If a case does not satisfy the above requirements, form 370 should be completed and Head Office should be contacted to determine any additional insurability requirements. The fee for additional insurability requirements must be paid by the applicant.

**Note:** If previously paid by pre-authorized chequing, this method of payment will be resumed using bank information on record unless advised otherwise.

Please resume pre-authorized chequing withdrawals using new banking particulars. A void sample cheque is attached.

**FAMILY PLAN BENEFIT OR CHILDREN'S PROTECTION RIDER**

1. List all those covered by the Family Plan Benefit or Children's Protection Rider **at the issue** of the Policy.

- a) Insured spouse / partner:
- b) Children:

2. Particulars of children to be insured **since** date of issue of the Policy.

Name of Child Age 18 or under	Date of Birth			Current		Name and address of Physician	Date Seen	Reason	Treatment & Duration
	D	M	Y	Ht	Wt				

3. I certify there has been no change in the health or insurability of any of the above since the policy was issued and that they are all in good health as at the date shown below, except as follows:

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Life Insured

\_\_\_\_\_  
Child exact age 16 or over

\_\_\_\_\_  
Applicant