

DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE
A. Terminated/Lapsed Policy

Terminated/Lapsed Policy Number: _____

Life 1: _____ Date Of Birth: _____
Given Name Surname DD/MM/YYYY

Life 2: _____ Date of Birth: _____
Given Name Surname DD/MM/YYYY

Please Note:

- if policy reinstatement is approved, all premiums overdue will be required to reinstate the policy at the time of approval.
- Please resume pre-authorized chequing withdrawals using new banking particulars. A VOID sample cheque is attached.
- Please resume pre-authorized chequing withdrawals using banking particulars already on file.

B. General Information

(to be completed for all lives to be insured)

If "YES" answer to any questions 1 to 7, complete "Details" below.

1. 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?
2. 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?
3. 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.) _____
4. Within the next 12 months, do you intend to change your Country of residence?
5. Have you traveled outside North America within the last 24 months? (If yes, provide country, purpose of travel, date of departure, date of return.).....
6. Do you intend to travel outside North America within the next 12 months? (If yes, provide country, purpose of travel, date of departure, date of return.).....
7. 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? (If yes, provide date, name of company and reason.)

LIFE 1		LIFE 2	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers

Question #	Life #	Details.

C. Smoking Declaration

(to be completed by all lives to be insured)

1. Have you smoked any cigarettes or marijuana within the last 12 months?
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):

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

LIFE 1 Types _____ LIFE 2 Types _____

Frequency _____ Date last used _____ Frequency _____ Date last used _____

D. Statement of Health – Non Medical (to be completed for all lives to be insured over exact age 16 for life coverage and all ages for Critical Illness coverage)

PERSON TO BE INSURED - LIFE 1	
Surname	Given Names
Height	Weight <input type="checkbox"/> lbs <input type="checkbox"/> Kg
Weight changes past year?	Gain <input type="checkbox"/> lbs <input type="checkbox"/> Kg Loss <input type="checkbox"/> lbs <input type="checkbox"/> Kg
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Duration of Illness (If "Yes" provide details)	
Any follow-up advised? (e.g. tests, surgery, hospitalization) <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", provide details)	

PERSON TO BE INSURED - LIFE 2	
Surname	Given Names
Height	Weight <input type="checkbox"/> lbs <input type="checkbox"/> Kg
Weight changes past year?	Gain <input type="checkbox"/> lbs <input type="checkbox"/> Kg Loss <input type="checkbox"/> lbs <input type="checkbox"/> Kg
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Duration of Illness (If "Yes" provide details)	
Any follow-up advised? (e.g. tests, surgery, hospitalization) <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", provide details)	

E. Children's Statement of Health - Non Medical

- Complete for:
- a) All children to be insured under Children's Protection Rider
 - b) LIFE 1 or LIFE 2 under the exact age of 16 (Section "D" also required for all ages when applying for Juvenile Critical Illness)
 - c) Signature of all children who have attained age 16, 18 in Quebec, is required in Section "F"

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.								

LIFE 1		LIFE 2	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Details of all "Yes" answers.

Question#	Life#	Date	Provide Details

F Legal Information

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

1. 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. 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 this Declaration are true, complete and correctly recorded, and 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.
3. The insurance being applied for reinstatement in this Declaration or such insurance approved by the Company shall not take effect unless: (i) a Notice of Reinstatement is issued by the Company; (ii) I/we have paid all premiums in arrears with interest; (iii) 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 (iv) that I know of nothing affecting the insurability of the lives to be insured not disclosed in this Declaration, the original Application and any other evidence of insurability provided by me/us.
4. I/We know of nothing not disclosed in this Declaration affecting the insurability of the person(s) to be insured.
5. I/we have received the Notice Regarding the MIB, and authorize any physician, practitioner, hospital, clinic or other medical related facility, insurance company, MIB, or any other organization, institution or person that has any MIB records or knowledge of the person(s) to be insured or their health, to give full particulars of such information, including any prior medical history, to The Equitable Life Insurance Company of Canada or its reinsurers. A photostatic copy of this authorization will be as valid as the original.
6. This Declaration may be transmitted to the Company electronically and received by the Company as the Applicant/Owner's application for policy reinstatement.
7. 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 AND 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, THE ORIGINAL APPLICATION AND ANY ADDITIONAL EVIDENCE OF INSURABILITY PROVIDED BY ME/US SHALL RENDER ANY INSURANCE REINSTATED IN CONNECTION WITH THIS DECLARATION VOIDABLE BY THE COMPANY.

Signed at _____ (city) _____ (province) _____ (day) _____ (month) _____ 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)

LIFE 1 _____

*** Signature of Person to be Insured**

Other _____

*** Signature of Person to be Insured**

LIFE 2 _____

*** 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

*If other than Life 1 or Life 2

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