Equitable Life of Canada®

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DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE

All sections must be completed

1. LAPSED POLICY

Lapsed Policy Number:

LIFE 1: First name	Last Name	Date of birth (dd/mm/yyyy)
LIFE 2: First name	Last Name	Date of birth (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.

2. GENERAL INFORMATION

If "YES" answer to any questions complete "Details" below.

To be completed by all Proposed Lives Insured:	LIFE 1		LIFE 2	
	YES	NO	YES	NO
1. Do you intend to travel outside of North America or change your Country of residence, in the next 12 months? (If "YES", provide country, reason for travel, date of departure, length of stay)	☐	☐	☐	☐
2. 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.)	☐	☐	☐	☐
To be completed by all Proposed Lives Insured exact age 16 and over				
3. What is your current occupation? _____				
4. 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? (If "YES", complete Aviation Questionnaire.)	☐	☐	☐	☐
5. 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? (If "YES", complete Avocation Questionnairre.)	☐	☐	☐	☐
6. Has your driver's licence been suspended within the last 10 years, and/or have you had any driving offences (excluding parking tickets) within the last 3 years? (If "YES", provide driver's licence no. date and details of violation and or suspension)	☐	☐	☐	☐
7. In the last 10 years have you been charged with or convicted of or pleaded guilty to any criminal offence or financial services regulatory offence (including securities regulators), or are any such charges pending? (If "YES", provide the nature of the offence, date charged, sentence details, date when sentence and any probation completed	☐	☐	☐	☐
8. a) Have you used any form of marijuana or hashish within the last 5 years? (if "YES" specify amount, frequency, date last used)	☐	☐	☐	☐
b) Was it prescribed by a physician? (if "YES" specify name and address of the physician and for what condition was it prescribed)	☐	☐	☐	☐
9. a) Do you drink alcoholic beverages? (If "YES", specify type and ounces per week.)				
b) Have you ever received advice, treatment or counselling pertaining to your use of alcohol?	☐	☐	☐	☐
(If "YES", to 9 (a) or (b) complete Alcohol (no 1325) questionnaire.	☐	☐	☐	☐
c) Have you ever used unprescribed drugs or experimented with drugs or narcotics such as ecstasy, cocaine, LSD, heroin, amphetamines, barbiturates, anabolic steroids or similar agents?	☐	☐	☐	☐
(If "YES", to 9(c) Drug Use (no 1326) questionnaire.)				

2. GENERAL INFORMATION

Details of all "Yes" answers.

Question #	Life #	Provide Details

3. SMOKING DECLARATION (TO BE COMPLETED BY ALL LIVES TO BE INSURED)

Have you smoked any cigarettes or used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months?

LIFE 1		LIFE 2	
YES	NO	YES	NO
☐	☐	☐	☐

Life #	Type	Frequency	Dates last used

4. STATEMENT OF HEALTH (TO BE COMPLETED FOR ALL LIVES TO BE INSURED OVER EXACT AGE 16 FOR LIFE COVERAGE AND ALL AGES FOR CRITICAL ILLNESS COVERAGE)

Do not provide any information about genetic tests. A "genetic test" is a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, monitoring, diagnosis or prognosis.

Do include information about treatment for or symptoms, complaints or indication of a genetic condition. When asked about family history, include any genetic conditions in your response.

Person to be insured – Life 1

Given Name	Last Name	Height ☐ ft/in ☐ cm	Weight ☐ lbs ☐ kg

Weight changes in the past year? ☐ Yes ☐ No	Gain ☐ lbs ☐ kg	Loss ☐ lbs ☐ kg	Reason for weight changes:

Name & address of your usual medical advisor
(If none, state last consult)

Date last consulted (dd/mm/yyyy)	Reason/symptoms	Any diagnosis and treatment? ☐ Yes ☐ No (If "Yes" provide details)
Duration of illness	Any follow-up advised? (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If "Yes" provide details)	

Person to be insured – Life 2

Given Name	Last Name	Height ☐ ft/in ☐ cm	Weight ☐ lbs ☐ kg

Weight changes in the past year? ☐ Yes ☐ No	Gain ☐ lbs ☐ kg	Loss ☐ lbs ☐ kg	Reason for weight changes:

Name & address of your usual medical advisor
(If none, state last consult)

Date last consulted (dd/mm/yyyy)	Reason/symptoms	Any diagnosis and treatment? ☐ Yes ☐ No (If "Yes" provide details)
Duration of illness	Any follow-up advised? (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If "Yes" provide details)	

Family History

Has any family (father, mother, brother or sister) member ever been diagnosed with:
• Alzheimer's disease • amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) • cancer (include type) • diabetes (include type)• heart disease • hepatitis • Huntington's chorea • multiple sclerosis • Parkinson's disease • stroke • polycystic kidney disease • retinitis pigmentosa • any other hereditary disease or disorder • any other motor neuron disease

LIFE 1 ☐ Yes ☐ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age If Alive	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

LIFE 2 ☐ Yes ☐ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age If Alive	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

4. STATEMENT OF HEALTH

Personal History

Have you ever been treated for or had any symptoms, complaints, or indication of:	LIFE 1 YES	LIFE 1 NO	LIFE 2 YES	LIFE 2 NO
1. Heart and circulatory system: • aneurysm • angina • blood clot • chest pain or shortness of breath • pacemaker • heart attack (myocardial infarction) • coronary artery disease (CAD) including Bypass/angioplasty • heart murmur • high cholesterol (hyperlipidemia) • high blood pressure (hypertension) • peripheral vascular disease (poor circulation) • irregular heart beat, pulse • transient ischemic attack (TIA) • stroke or cerebrovascular accident (CVA) • any other disease or disorder of the heart or blood vessels	☐	☐	☐	☐
2. Abnormal growths or malignancy: • abnormal mammogram • cancer • leukemia • lump/cyst • lymphoma • polyp • tumour • basal cell carcinoma • melanoma • any other growths or malignancies	☐	☐	☐	☐
3. Blood, glandular and endocrine system: • abnormal blood sugar • diabetes • gestational diabetes • goiter • hyperthyroidism/hypothyroidism • lymph, adrenal or pituitary gland disease or disorder • a bleeding disorder • anemia • hemophilia • any other thyroid or endocrine disease or disorder • any other blood disease or disorder	☐	☐	☐	☐
4. Gastrointestinal system • cirrhosis • Crohn's disease • diverticulitis • hepatitis (including carrier state) • irritable bowel syndrome • jaundice • pancreatitis • persistent diarrhea • rectal or intestinal bleeding • ulcer (peptic or gastric) • ulcerative colitis • any other disease or disorder of the esophagus, intestine, rectum, pancreas, stomach, or liver	☐	☐	☐	☐
5. Ears, eyes, nose, throat and mouth(excluding routine check-ups, tonsillectomy, adenoidectomy, sinusitis, or other disorder requiring eyeglasses, contact lenses or ear tubes): • blindness • blurred or double vision • deafness • glaucoma • impaired hearing • impaired sight • labyrinthitis • optic neuritis • tinnitus • any other disease or disorder of ears, eyes, nose, throat, or mouth	☐	☐	☐	☐
6. Respiratory system: • asthma • chronic obstructive pulmonary disease (COPD)• chronic bronchitis • cystic fibrosis• emphysema • persistent cough • sarcoidosis • sleep apnea• tuberculosis • any other respiratory disease or disorder	☐	☐	☐	☐
7. Mental Health: • attention deficit disorder • burnout • anxiety • chronic fatigue • depression • eating disorder • bipolar disorder • schizophrenia • suicide attempt or ideation• any other psychological, developmental, emotional, or behavioural disorder	☐	☐	☐	☐
8. Skin and connective tissue: (excluding poison ivy, contact dermatitis, acne, rosacea, sunburn and eczema) • dysplastic nevi or nevus • lupus • psoriasis • scleroderma • any other lesions, freckles or moles that have changed in size, colour or bleed • any other skin disease or disorder	☐	☐	☐	☐
9. Kidney, bladder, and reproductive system: • abnormal pap smear • abnormal prostate specific antigen (PSA) • hysterectomy • kidney stone(s) • nephritis • uterine fibroid • sexually transmitted infection • sugar, blood, or protein in the urine • any other kidney or bladder disease or disorder • any other reproductive, prostate or breast related disease or disorder	☐	☐	☐	☐

4. STATEMENT OF HEALTH - CONTINUED

Personal History

Have you ever been treated for or had any symptoms, complaints, or indication of:	LIFE 1		LIFE 2	
	YES	NO	YES	NO
10. Musculoskeletal system: ..... • arthritis • chronic fatigue • chronic pain syndrome • fibromyalgia • muscular dystrophy • numbness or weakness of any arm or leg • paralysis • any other disease or disorder of the muscles, joints, limbs, back or bones	☐	☐	☐	☐
11. Nervous system: ..... • Alzheimer's disease • amyotrophic lateral sclerosis (ALS)• cerebral palsy • cognitive impairment • coma • dementia • developmental delay or Down's syndrome • dizziness or vertigo • epilepsy or seizures • fainting or syncope • loss of sensation, speech or balance • multiple sclerosis (MS) • Parkinson's disease • any other motor neuron disease or disorder • tremor • severe headache • post concussion syndrome • Autism • any other congenital neurological disease or disorder • any other disease or disorder of the brain or nervous system	☐	☐	☐	☐
12. Immune system: ..... • AIDS • HIV • any other immune system disease or disorder	☐	☐	☐	☐
13. In the last 5 years have you had any of the following medical or diagnostic tests:..... • ECG • X-ray • CT scan • MRI • Colonoscopy • ultrasound • biopsy • blood test • any other medical or diagnostic tests	☐	☐	☐	☐
14. In the last 5 years have you had an illness or injury which prevented you from performing your usual activities or the regular duties of your occupation for a period exceeding 2 weeks?	☐	☐	☐	☐
15. Do you have any symptoms, complaints or indication, including persistent or undiagnosed pain, regarding your health for which you have not yet consulted a physician or received medical treatment?	☐	☐	☐	☐
16. Do you have any medical conditions, not addressed in the previous questions, for which you have been or are being investigated, under observation, tested or treated for, or for which you are currently awaiting investigation, observation, testing, test results or treatment?				

Personal History – Details of all "Yes" answers.

Question #	Life #	Date	Details

5. CHILDREN'S STATEMENT OF HEALTH

Complete for: a) All children to be insured under Children's Protection Rider
b) Signature of all children who have attained age 16, 18 in Quebec, is required in Section "9"

Print full name of each child to be insured	Gender	Date of birth (dd/mm/yyyy)	Nearest age	Height	Weight	Name and address of usual medical advisor
1.	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
2.	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
3.	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
4.	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
5.	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	

	YES	NO
1. Has any application for Insurance on any of the children been declined, postponed or modified in any way?	☐	☐
2. If any of the children are 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 or have you been told the child is not meeting developmental or growth milestones?	☐	☐
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. Have any of the children been treated, tested for or had a symptom or indication of autism, cancer, cerebral palsy, congenital heart disease, cystic fibrosis, Down's syndrome, developmental delay or muscular dystrophy?	☐	☐
6. Do any of the children to be insured NOT live with the owner? Please state below the relationship to the children, date last seen and frequency of visits.	☐	☐

Details of all "Yes" answers.

Question #	Life #	Provide Details

6. FINAL PROTECTION – SMOKING DECLARATION AND PERSONAL HISTORY

Please Note: To qualify for reinstatement of Final Protection policies all questions 6.2 to 6.12 must be answered "NO".

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
6.1 Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids, or smoked marijuana or hashish within the last 12 months?	☐	☐	☐	☐
6.2 In the past two (2) years, have you had an application for life insurance (other than group insurance or group mortgage insurance) rejected or postponed?	☐	☐	☐	☐
6.3 Are you presently hospitalized, in a nursing facility, bedridden or confined to a wheelchair, or have you been advised that this is required due to your present condition?	☐	☐	☐	☐
6.4 In the past two (2) years, have you had an amputation as a result of disease?	☐	☐	☐	☐
6.5 In the past two (2) years, have you been diagnosed, hospitalized, or treated (other than by medication) or presently under investigation for any of the following conditions:				
a) Angina, heart attack, heart failure, or cardiomyopathy?	☐	☐	☐	☐
b) Cancer (other than basal cell carcinoma)?	☐	☐	☐	☐
c) Leukemia?	☐	☐	☐	☐
d) Lymphoma?	☐	☐	☐	☐
e) Chronic kidney disease?	☐	☐	☐	☐
6.6 In the past two (2) years, have you been prescribed a new medication or required an increase in your medication for any of the following conditions:				
a) Angina, heart attack, heart failure, or cardiomyopathy?	☐	☐	☐	☐
b) Cancer (other than basal cell carcinoma)?	☐	☐	☐	☐
c) Leukemia?	☐	☐	☐	☐
d) Lymphoma?	☐	☐	☐	☐
e) Chronic kidney disease?	☐	☐	☐	☐
6.7 In the past two (2) years have you been diagnosed or hospitalized for:				
a) Chronic respiratory condition that required the administration of oxygen	☐	☐	☐	☐
b) Liver disease (other than fatty liver)?	☐	☐	☐	☐
c) Diabetic coma or insulin shock?	☐	☐	☐	☐
d) Cerebrovascular accident (stroke)?	☐	☐	☐	☐
6.8 In the past five (5) years have you received an organ transplant or bone marrow transplant or were you advised that one was required due to your condition?	☐	☐	☐	☐
6.9 In the past five (5) years have you had a cancer reoccurrence or cancer diagnosed in more than one location?	☐	☐	☐	☐
6.10 Have you ever tested positive for HIV or undergone treatments (including medication) for AIDS or AIDS-related complex?	☐	☐	☐	☐
6.11 Have you ever been diagnosed or undergone treatments (including medication) for any of the following conditions: amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease or dementia?	☐	☐	☐	☐
6.12 Have you been diagnosed or treated for any incurable terminal illness (for which you have been advised that you have less than 12 months' life expectancy)?	☐	☐	☐	☐

7. LIVING PROTECTION – SMOKING DECLARATION AND PERSONAL HISTORY

Please Note: To qualify for reinstatement of Living Protection policies all questions 7.2 to 7.6 must be answered "NO".

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
7.1 Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids, or smoked marijuana or hashish within the last 12 months?	☐	☐	☐	☐
7.2 In the past two (2) years, have you had an application for critical illness insurance or life insurance declined or postponed or modified in any way?	☐	☐	☐	☐
7.3 Have you: i) ever been investigated for; ii) ever been advised to have an investigation for; iii) a pending investigation for; iv) ever been treated for; v) any symptoms, complaints or indication of; or, vii) ever had any symptom, complaints or indication of:				
a) Coronary artery disease, angina, shortness of breath, chest pain, angioplasty, bypass, heart surgery, heart attack, stroke, transient ischemic attack (TIA) or any other cerebrovascular disease or disease of the heart or the blood vessels?	☐	☐	☐	☐
b) Diabetes, abnormal blood sugar, abnormalities of the thyroid, pituitary, lymph or adrenal glands, chronic kidney disease or endocrine disorder?	☐	☐	☐	☐
c) Cancer or other malignant disease such as leukemia or lymphoma, or tumor, abnormal PAP test (without a follow up normal test), or recurrent colon polyps (without a follow up normal colonoscopy)?	☐	☐	☐	☐
d) Breast disease or disorder, breast mass, breast cyst, abnormal mammogram or breast biopsy or undiagnosed breast pain or prostate disorder, prostate nodule or abnormal PSA or ultrasound results?	☐	☐	☐	☐
e) AIDS, HIV or AIDS-related illness, persistently enlarged lymph glands, chronically abnormal blood work or any immunological disorder?	☐	☐	☐	☐
f) Hepatitis B or C (including hepatitis B carrier state), abnormal liver function tests, biopsy or ultrasound results or any form of liver disease?	☐	☐	☐	☐
g) Crohn's, ulcerative colitis, persistent, undiagnosed abdominal pain, rectal bleeding, or any other disorder of the colon, rectum, stomach or esophagus other than esophageal reflux or ulcer controlled with medication or irritable bowel syndrome?	☐	☐	☐	☐
7.4 In the last 5 years have you:				
a) been treated or counseled for alcohol or drug use, or joined or been advised to join an organization or program due to your alcohol or drug use?	☐	☐	☐	☐
b) used narcotics, cocaine, heroin, morphine, demerol, LSD, hashish, hallucinogens, amphetamines, barbiturates, tranquilizers, or anabolic steroids or any drugs not prescribed by a licensed physician, or methadone whether prescribed by a physician or not?	☐	☐	☐	☐
7.5 Have 2 or more of your immediate family members (mother, father, brother or sister) been diagnosed with or treated for, heart disease, aneurysm, stroke, polycystic kidney disease, or cancer prior to age 60.	☐	☐	☐	☐
7.6 Does your current weight exceed the weight indicated for your height in the tables below?	☐	☐	☐	☐

Height (in)	Weight (lbs)	Height (cm)	Weight (kgs)
56	174	142	79
57	180	145	82
58	186	147	84
59	196	150	88
60	199	152	90
61	206	155	93
62	213	157	97
63	220	160	100
64	227	163	103
65	234	165	106
66	241	168	109
67	249	170	113

Height (in)	Weight (lbs)	Height (cm)	Weight (kgs)
68	256	173	116
69	264	175	120
70	272	178	123
71	279	180	127
72	287	183	130
73	295	185	134
74	303	188	137
75	312	190	142
76	320	193	145
77	329	196	149
78	337	198	153

8. PRIVACY CONSENT

THE OWNER(S) AND LIFE INSURED(S) DECLARE AND AGREE THAT:

1. The personal information willingly provided by me/us to the independent insurance broker/advisor and/or the Company, collected on this Declaration or provided through any supplementary documentation and held in their files, will be used by the Company in connection with my policy, if approved, for the purposes of underwriting, servicing, administration, determining Canadian or foreign tax payor status, and claims processing and adjudication.
2. 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 the Company; the Company's sales distribution network; other insurers and participating reinsurer(s); service providers and other companies retained by the Company; Canadian or foreign tax authorities; and any other person or party whom I/we authorize.
3. My/our personal information may be processed and stored outside of Canada and may therefore be subject to the laws of those jurisdictions. If my/our policy is issued in Quebec, my/our personal information will be stored outside Quebec.
4. 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 Company or its reinsurers. I/we authorize the Company to disclose such information to my/our attending physician(s). A photostatic copy of this authorization will be as valid as the original.
5. I/we authorize the Company to provide my health, medical and lifestyle information obtained during its underwriting process, regardless of the source, to my advisor for the purposes of explaining to me any adverse assessment of my insurability. ☐ YES ☐ NO
6. I/We consent to the obtaining of consumer reports (credit reports) containing personal and/or credit information.

See www.equitable.ca for further details about the Company's privacy practices and for information about how to contact the Company's Privacy Officer.

9. LEGAL INFORMATION

THE OWNER(S) AND LIFE INSURED(S) DECLARE AND AGREE THAT:

1. 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.
2. 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; and (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.
3. I/We know of nothing not disclosed in this Declaration, the original Application and any other evidence of insurability provided by me/us, affecting the insurability of the person(s) to be insured.
4. This Declaration may be transmitted to the Company electronically and received by the Company as the Applicant/Owner's application for policy reinstatement.

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 INCLUDING ANY PART II, AND ANY WRITTEN STATEMENT GIVEN AS EVIDENCE OF INSURABILITY PROVIDED BY ME/US SHALL RENDER ANY INSURANCE REINSTATED IN CONNECTION WITH THIS DECLARATION VOIDABLE BY THE COMPANY

DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE

Signed at _____ _____ this _____ of _____ 20 _____.
(city) (province) (day) (month)

Signature(s) of Applicant(s)/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		LIFE 2	
	* Signature of Person to be Insured		* Signature of Person to be Insured

Other		
	** 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, LLC.

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, LLC., 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. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws. 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 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734; telephone number 1-866-692-6901, or privacy@mib.com for privacy questions. 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

Please note: Equitable Life® cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.668.4095.