Equitable Life of Canada®

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FINAL PROTECTION AND LIVING PROTECTION APPLICATION FOR CHANGE AND REINSTATEMENT

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:

Request for Policy #: _____ **Owner(s):** _____ **Life Insured(s):** _____

Owner's Address: _____

Life Insured(s) Date of Birth: _____ **Owner's Country of Birth:** _____

Owner's Phone #: _____ **Owner's Email:** _____

NOTE. No charges apply for change processing. A $50 CHARGE WILL APPLY TO REVERSE THE CHANGE. The reversal is only available within 21 calendar days from the date the change was processed.

FINAL PROTECTION – REQUESTED CHANGE

Please indicate the requested change or reinstatement and complete the required sections for that change.
Note: requirements may vary, based on actual change requested.

- ☐ **Deletion of** _____ – Life Insured: (Sections 1, 4, 5)
- ☐ **Decrease to** _____ – face amount: (Sections 1, 4, 5) $5,000 minimum
- ☐ **Smoker to Non Smoker Status** – (Sections 1, 2, 4, 5)
- ☐ **Reduced Paid Up Policy** – (Sections 1, 4, 5)
- ☐ **Reinstatement** – (Sections 2, 4)
  - ☐ 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.

LIVING PROTECTION

Please indicate the requested change or reinstatement complete the required sections for that change.
Note: requirements may vary, based on actual change requested.

- ☐ **Deletion of Return of Premium on Expiry and/or Return of Premiums on Death** _____ – (Sections 1, 4, 5)
- ☐ **Decrease to** _____ – face amounts: (Sections 1, 4, 5) $10,000 minimum
- ☐ **Smoker to Non Smoker Status** – (Sections 1, 3, 4, 5)
- ☐ **Change Privilege – 10 year renewable term to level to age 75 only** – (Sections 1, 4, 5)
- ☐ **Reinstatement** – (Sections 2, 3)
  - ☐ 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.

1. Plan Specifications Once Change Completed

Life Insured(s) Name	Face Amount of Coverage	Premium

Mode: ☐ Annual ☐ Monthly Total _____

2. Final Protection - Smoking Declaration and Personal History

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. Please Note: To qualify for non-smoker status all questions 1 to 12 must be answered "NO".

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
1. Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids within the last 12 months?	☐	☐	☐	☐
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?	☐	☐	☐	☐
3. Are you presently hospitalized, in a nursing facility, bedridden or confined to a wheelchair, or have you been advised that any one of these are required due to your condition?	☐	☐	☐	☐
4. In the past two (2) years, have you had an amputation as a result of disease?	☐	☐	☐	☐
5. In the past two (2) years, have you been diagnosed, hospitalized, treated or, 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. In the past two (2) years, have you been prescribed a new medication or required an increase in 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?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
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?	☐	☐	☐	☐
9. In the past five (5) years have you had a cancer reoccurrence or cancer diagnosed in more than one location?	☐	☐	☐	☐
10. Have you ever tested positive for HIV or undergone treatments (including medication) for AIDS or AIDS-related complex?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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)?	☐	☐	☐	☐

3. Living Protection - Smoking Declaration and Personal History

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.
Please Note: To qualify for non-smoker status all questions 1 to 5 must be answered "NO"

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
1. Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids within the last 12 months?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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, vi) 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?	☐	☐	☐	☐
4. In the past 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?	☐	☐	☐	☐
c) used marijuana more than twice a week with or without a doctor's prescription?	☐	☐	☐	☐
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	☐	☐	☐	☐
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

4. 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 acknowledge that the Company may use automated processing with respect to the issuance and administration of the policy(ies) I/we have applied for.
5. I/we have received the Notice Regarding the MIB, LLC, 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.
6. 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
7. I/We consent to the obtaining of a 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.

5. Legal Information

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

1. The statements and answers in this Application 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 and change being applied for in this Application or such insurance and change approved by the Company shall not take effect unless: (i) this Application is approved by the Company; and (ii) an Endorsement confirming the insurance and change is issued by the Company.
3. I/We know of nothing not disclosed in this Application, the original Application and any other evidence of insurability provided by me/us, affecting the insurability of the person(s) insured.
4. This Application may be transmitted to the Company electronically and received by the Company as the Applicant/Owner's application for policy change.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT/OWNER AND PERSON(S) INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE AND CHANGE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY OF THE PERSON(S) INSURED, OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION, THE ORIGINAL APPLICATION AND ANY ADDITIONAL EVIDENCE OF INSURABILITY PROVIDED BY ME/US SHALL RENDER ANY INSURANCE AND CHANGE IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

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

Signatures(s) of Applicant/Owner(s)

LIFE 1		LIFE 2	

Signature of Person Insured

Signature of Person Insured

Witness to all Signatures

Assignee Signature if the policy is assigned

Signature of Beneficiary (if irrevocable)

NOTICE REGARDING THE MIB, LLC

Information regarding the insurability of the Person(s) 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

6. Advisor's Information (Please Print):

MGA Name: _____ MGA #: _____

MGA Phone #: _____ MGA Fax #: _____

MGA E-Mail Address: _____

	Advisor's Name	Servicing Agent	Advisor's #	%	Advisor's Phone #	Advisor's Fax #
1)						
2)						

Advisor's Signature: _____ Date: _____

Advisor's E-Mail Address: _____

All correspondence to Advisor in ☐ English ☐ French

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 1.800.722.6615.