



The Exchange Option is available as of the 1st anniversary of the coverage and prior to the 5th policy anniversary or age 65 (whichever comes first).

A full or partial amount of the 10 Year Term plan may be exchanged subject to minimum face amounts.

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.

Policy Number	Owner Name (fir	Owner Name (first, middle, last)			
Address (number, str	street and apartment)		Email Address		
Joint Owner Name	(first, middle, last)			Date of Birth (dd/mm/yyyy)	
Address (number, str	eet and apartment)		Email Address		
Insured Name (first,	middle, last)			Date of Birth (dd/mm/yyyy)	
Insured Name (first, middle, last)				Date of Birth (dd/mm/yyyy)	
,	madio, idoly				
SECTION 2 – PU	RPOSE OF POLICY (Mandator	ry for all policy changes)			
SECTION 2 - PU Indicate the purpose Short Term Savin Income Creation Gift	RPOSE OF POLICY (Mandator of the policy:	erm Savings Busi tection Lego surance Edu	ness / Key Person Pro acy / Inheritance / Est cation Purposes	tection / Buy Sell Agreement	
SECTION 2 - PU Indicate the purpose Short Term Savin Income Creation Gift Other	RPOSE OF POLICY (Mandator of the policy: gs	erm Savings Busi tection Lego surance Edu	acy / Inheritance / Est cation Purposes	tection / Buy Sell Agreement	
SECTION 2 - PU Indicate the purpose Short Term Savin Income Creation Gift Other SECTION 3 - CC	RPOSE OF POLICY (Mandator of the policy: gs	erm Savings Busi tection Lego surance Edu	acy / Inheritance / Est cation Purposes	tection / Buy Sell Agreement	
SECTION 2 - PU Indicate the purpose Short Term Savin Income Creation Gift Other SECTION 3 - CC	RPOSE OF POLICY (Mandator of the policy: gs	erm Savings Busings Legalstection Legalstection Educ	acy / Inheritance / Est cation Purposes	tection / Buy Sell Agreement tate Protection	



SECTION 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 receiving the Notice regarding the MIB and authorize the Company to obtain information from the MIB, LLC.
- 5. I/we consent to the obtaining of a consumer reports (credit reports) containing personal and/or credit information.
- 6. 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.
- 7. I/we 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), my/our 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. My/our personal information collected by the testing facility may be processed and stored by such facility in Canada and/or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
- 8. I/we 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.
- 9. I/we 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.
- 10. I/we agree that this Application may be transmitted to the Company electronically and received by the Company as the Owner's original application for insurance.
- 11. 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

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.



SECTION 5 - LEGAL INFORMATION

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

- 1. The statements and answers in all parts of this Application are true, complete, and correctly recorded.
- 2. The insurance being applied for in this Application or such insurance as approved and issued by the Company shall not take effect unless:
 a) a policy change is issued by the Company and the policy change is delivered or accepted in the manner specified in 3c; and b)
 the first policy change premium is paid; and c) there is no change in the insurability of the Person(s) to be Insured between the date this
 Application was signed by the Person(s) to be Insured and: i) the date of delivery of the Critical Illness policy change to the Owners; or,
 ii) the date of delivery of the life policy change to the Owners resident in Provinces and Territories other than Quebec; or, iii) the date the
 Application for a life policy change is accepted by the Company without modification for Owners resident in Quebec.
- Knowledge of or notice to any person shall not constitute knowledge of or notice to the Company unless disclosed in this Application.
 No person, other than an Authorized Officer of the Company shall have authority to place the Company under any risk or obligation or approve insurability.
- 4. 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 an Endorsement.
- 5. If the Application is made by an Owner (other than the Person to be Insured): a) 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 the Owner, subject to the provisions of such policy (policies). b) the person(s) on whose life (lives) this insurance is applied for consents to the insurance being placed on his/her (their) life (lives).
- 6. They know of nothing not disclosed herein affecting the insurability of the Person(s) to be Insured.
- 7. If a Return of Premiums rider is added to an existing Critical Illness Insurance policy, the new rider will be amended to provide that premiums to be returned pursuant to the rider only include premiums paid on or after the effective date of the rider.
- 8. I/we acknowledge receiving from my/our Advisor, disclosure and an explanation of the companies the Advisor represents, licensing, commission, additional compensation, conflicts of interest, and the MIB Notice.
- 9. The Company is authorized 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 insurablity.

 Yes

 No

FAILURE TO DISCLOSE EVERY FACT WITHIN THE OWNER(S), 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 AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY, SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

Signed at		this	of		20	
[city]	(province)	(da	y)	(month)		
Signature of Person to be Insured		*Signature of Person	to be Insured			
iignature of Owner(s) (if other than Person to be In	isured)	Signature of Joint Ov	vner			
gnature of Advisor/Witness to all signatures		Assignee signature required if the policy is assigned				

^{*}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)



	OR'S INFORMATION							
ADVISOR'S INFORMAT	ION							
MGA Name:				MGA No:				
MGA Phone:	MGA Fax:	x: MGA Email:						
Advisor's Name		Advisor's No Servicing Commission % Adv			Advisor'	visor's Phone		
All correspondence to A	dvisor in □ English □ French							
Advisor's Email Address:		Supervisor's Email	l Address:					
Advisor's Signature		Supervising Advisor's Signature						
Date (dd/mm/yyyy) Date (dd/mm/yyyy)								
						Yes	No	
business reputat (If "YES", provid b) Any additional i (If "YES", provide	the Proposed Life Insured(s) or Own on, past or present? e details in Advisor's Notes below nformation which would assist in u details in Advisor's Notes below)		n\$					
	ewed the documentation provided eir identity, and confirmation of the							
I. I have made a rea	sonable effort to determine if the C	Owner(s) are acting on beha	alf of a third	party				
ADVISOR'S NOTES								



CONFIRMATION OF ADVISOR/BROKER DISCLOSURE

The Insurance product you are applying for is underwritten and supplied by Equitable, licensed to conduct business in all provinces and territories of Canada. The advisor/broker soliciting this insurance application is a licensed independent broker representing Equitable through an independent agency, and will receive compensation from Equitable if a policy is issued and comes into effect, and will continue receiving ongoing compensation if you continue to keep the policy inforce. The advisor/broker may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business the advisor/broker places with Equitable during a given time period. You are not obligated to transact any other business with Equitable, the advisor/broker or any other person or entity as a condition of the Application.

Please note: Equitable® 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® 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.