



TERM 10 TO TERM 20 EXCHANGE FORM

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.

SECTION 1 – OWNER/INSURED INFORMATION			
Policy Number	Owner Name (first, middle, last)	Date of Birth (dd/mm/yyyy)	
Address (number, street and apartment)		Email Address	
Joint Owner Name (first, middle, last)		Date of Birth (dd/mm/yyyy)	
Address (number, street 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)	

SECTION 2 – PURPOSE OF POLICY (Mandatory for all policy changes)												
<p>Indicate the purpose of the policy:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; padding: 5px;"><input type="checkbox"/> Short Term Savings</td> <td style="width: 33%; padding: 5px;"><input type="checkbox"/> Retirement / Long Term Savings</td> <td style="width: 33%; padding: 5px;"><input type="checkbox"/> Business / Key Person Protection / Buy Sell Agreement</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Income Creation</td> <td style="padding: 5px;"><input type="checkbox"/> Income / Family Protection</td> <td style="padding: 5px;"><input type="checkbox"/> Legacy / Inheritance / Estate Protection</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Gift</td> <td style="padding: 5px;"><input type="checkbox"/> Mortgage / Debt Insurance</td> <td style="padding: 5px;"><input type="checkbox"/> Education Purposes</td> </tr> <tr> <td colspan="3" style="padding: 5px;"><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Short Term Savings	<input type="checkbox"/> Retirement / Long Term Savings	<input type="checkbox"/> Business / Key Person Protection / Buy Sell Agreement	<input type="checkbox"/> Income Creation	<input type="checkbox"/> Income / Family Protection	<input type="checkbox"/> Legacy / Inheritance / Estate Protection	<input type="checkbox"/> Gift	<input type="checkbox"/> Mortgage / Debt Insurance	<input type="checkbox"/> Education Purposes	<input type="checkbox"/> Other _____		
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<input type="checkbox"/> Other _____												

SECTION 3 – COVERAGE AMOUNTS TO BE EXCHANGED TO 20-YEAR TERM			
Insured	Term 10 Current Amount	Term 20 New Amount	Term 10 Remaining Amount
Life 1			
Life 2			

Note: Any face amount of the existing 10-year term not accounted for will be canceled.



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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.



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SECTION 6 - ADVISOR'S INFORMATION

ADVISOR'S INFORMATION

MGA Name: _____ MGA No: _____

MGA Phone: _____ MGA Fax: _____ MGA Email: _____

Advisor's Name	Advisor's No	Servicing	Commission %	Advisor's Phone
		<input type="checkbox"/>		
		<input type="checkbox"/>		
		<input type="checkbox"/>		

All correspondence to Advisor in English French

Advisor's Email Address: _____ Supervisor's Email Address: _____

Advisor's Signature _____ Supervising Advisor's Signature _____

Date (dd/mm/yyyy) _____ Date (dd/mm/yyyy) _____

- Has there been prior contact with Head Office regarding the Proposed Life Insured(s)?
(If "YES" give dates and reference of last Head Office letter, and person or department contact in Advisor's Notes below.)
- Do you know of:
 - Any criticism of the Proposed Life Insured(s) or Owner(s) character, habits, mode of living, or business reputation, past or present?
(If "YES", provide details in Advisor's Notes below)
 - Any additional information which would assist in underwriting this application?
(If "YES", provide details in Advisor's Notes below)
- I have held and viewed the documentation provided by the Proposed Life Insured(s) and the Owner(s) for verification of their identity, and confirmation of the information provided on this Application
- I have made a reasonable effort to determine if the Owner(s) are acting on behalf of a third party.

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"/>

ADVISOR'S NOTES

Empty box for Advisor's Notes



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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 in force. 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.