Equitable™
Head Office
One Westmount Road North
P. O. Box 1603 Stn. Waterloo, Waterloo, Ontario N2J 4C7
TF: 1 800 668 4095 **F:** 519 883 7404
equitable.ca

APPLICATION FOR CHANGE – G2

Change Request for Policy #: _____ Owner(s): _____

Insured(s): _____ Owner's Address: _____

Insured(s) date of birth (dd/mm/yyyy): _____

Owner's Phone #: _____

Owner's email: _____

Owner's Country of Birth: _____

SIGN UP FOR CLIENT ACCESS!

View your account information online 24/7. Please contact Equitable® for assistance in setting up your access to our secure Client Access website.

PURPOSE OF POLICY (Mandatory for all policy changes)

Indicate the purpose of the policy:

- ☐ Short Term Savings
- ☐ Retirement / Long Term Savings
- ☐ Business / Key Person Protection / Buy Sell Agreement
- ☐ Income Creation
- ☐ Income / Family Protection
- ☐ Legacy / Inheritance / Estate Protection
- ☐ Gift
- ☐ Mortgage / Debt Insurance
- ☐ Education Purposes
- ☐ Other _____

REQUESTED CHANGE – Please indicate the requested change and complete the required sections for that change indicated on page 2.

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.

Requirements may vary, based on actual change requested. Advisors refer to online administration guide on Equitable's Website EQUINET: www.equitable.ca/advisorhome for sections required. Policy owners please contact your advisor or Equitable at the phone number above.

- ☐ **Addition – (A)** - benefit type riders
- ☐ **Addition of Children's Protection Rider – (CPR)** (Only allowed on Stand Alone Term Individually Owned Policies, not Equimax, Equiliving or Universal Life.) $_____ (minimum $10,000, maximum $30,000).
- ☐ **Addition of Critical Illness Riders (CI):** ☐ 10 Year Renewable Term ☐ Level to 75 ☐ Level to 100 ☐ 20 Pay to 75* ☐ 20 Pay for Life* (*20 Pay available on Equimax and Universal Life plans only)
- ☐ **Addition of Return of Premiums Rider to Critical Illness Insurance Policy (ROP):**
  - ☐ Return of Premiums on Death ☐ Return of Premiums at Expiry* (*available on 10 Year Renewable to Age 75 plans only)
  - ☐ Return of Premiums at Surrender/Expiry** (**available on Level Pay and 20 Pay Plans)
- ☐ **Deletion / Decrease (D) –** riders, benefits, lives.
- ☐ **Smoker to Non Smoker Status (S)**
- ☐ **Exchange Option (E) –** 10 Year Term plans to 20 Year Term plans (coverage must be in effect for at least 1 year and no more than 5 years)
- ☐ **Rating Reconsideration (R) –** removal or reduction
- ☐ **Change Privilege for Critical Illness (CP) :** Refer to policy contract for available options
- ☐ **Change to Dividend Option (DIV) –** Paid Up Additions
- ☐ **Death Benefit Option (DBO) change to Level only**
- ☐ **Cost of Insurance (COI) change to Level or Yearly Renewable Term (done at original rates/attained age)**
- ☐ **Separate Policy Option (SPO) or Option to Elect Individual Policies (OTE)**
- ☐ **Other –** _____

APPLICATION FOR CHANGE – G2

Type of Change:	Complete the following Sections on this Form 374G2										
		1	2	3	4	5	6	7	8	9	Other:
A		X	X	X	X	X	X		X	X	**see notes below for underwriting requirements**
CPR		X						X	X	X	
CI		X	X	X	X	X	X		X	X	Before completing please review Pre Qualifying Questions on form 347 **see notes below for underwriting requirements**
ROP		X	X	X	X	X	X		X	X	Addition of Return of Premiums at Surrender/Expiry rider: complete sections 1, 8 and 9 only
D		X							X	X	
S		X	X	X	X	X	X		X	X	Urine
E		X							X	X	
R		X	X	X	X	X	X		X	X	
CP		X							X	X	
DIV		X	X	X	X	X	X		X	X	
DBO		X							X	X	
COI	Level	X							X	X	
	YRT	X	X	X	X	X	X		X	X	
SPO		X							X	X	Form 671NOC, 671BCF, Form 378, Void Cheque – Illustration for UL plans only

Type of Change:	Complete the Following Sections on Form 350												
		1	2	3	4	5	6	7	9	10	11	17	19	Other
OTE	Term	X	X	X				X	X	X	X	X	X	Form - 671NOC
	Equimax	X	X	X	X				X	X	X	X	X	Form - 671NOC Signed Illustration
	Equation Generation IV	X	X	X		X	X		X	X	X	X	X	Form - 671NOC Signed Illustration

**refer to evidence of insurability schedule form 1343 for underwriting requirements.

SECTION 1 – PLAN SPECIFICATIONS ONCE CHANGE COMPLETED

Insured(s) Name	Plan Description	Amount	Premium
		Mode: ☐ Annual ☐ Monthly	**Total:**

SECTION 2 – SMOKING DECLARATION – for "Yes" answers, specify types and date last used

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

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

(If YES, specify types, frequency of use and date last used.) _____

SECTION 3 – FINANCIAL INFORMATION

(Complete for all coverage amounts) Note: Owner to complete Personal Section if insurance is for any child(ren)
Employment information:

1. What is your occupation and occupation duties?

_____

2. What is your employer's name and address?

_____

3. Have you ever declared bankruptcy, personal or business, whether discharged or not?
(If "YES", advise whether personal or business, date declared and date discharged.)

_____

LIFE 1 – PERSONAL	
Annual earned income	$
Other income: Amount	$
Other income: Source	
Net Worth	$
Purpose of Insurance Coverage	$

LIFE 2 – PERSONAL	
Annual earned income	$
Other income: Amount	$
Other income: Source	
Net Worth	$
Purpose of Insurance Coverage	$

LIFE 1 – BUSINESS	
Percentage of Ownership	%
Annual Sales (Current Year)	$
Annual Sales (Previous Year)	$
Net Profit	$
Fair Market Value	$
Outstanding Loans/Liabilities	$

LIFE 2 – BUSINESS	
Percentage of Ownership	%
Annual Sales (Current Year)	$
Annual Sales (Previous Year)	$
Net Profit	$
Fair Market Value	$
Outstanding Loans/Liabilities	$

To Follow: ☐ Financial Statement ☐ Letter of Explanation

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL

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.

To be completed by all Proposed Lives Insured: (Completion of this section is not required if a paramedical is required)
For children under the exact age of 16, questions to be answered by parent or legal guardian who has full knowledge of child's medical history.

PERSON TO BE INSURED – LIFE 1

Given: _____

Last Name: _____

Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lbs ☐ kg

Weight changes past year? ☐ Yes ☐ No

Gain: _____ ☐ lbs ☐ kg Loss: _____ ☐ lbs ☐ kg

Reason for weight change: _____

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: _____

Last Name: _____

Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lbs ☐ kg

Weight changes past year? ☐ Yes ☐ No

Gain: _____ ☐ lbs ☐ kg Loss: _____ ☐ lbs ☐ kg

Reason for weight change: _____

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)

_____

If the child is less than 2 years of age, was the birth premature by less than 36 weeks gestation 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?

If "YES", identify the child and provide details (including dates, doctor name, medications, dosage etc.) and birth weight below.

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL (CONTINUED)

FAMILY HISTORY

Has any family (father, mother, brother or sister) member ever been diagnosed with:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- Alzheimer's disease
- Cancer (include type)
- Huntington's chorea
- Stroke
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Diabetes (include type)
- Multiple sclerosis
- Polycystic kidney disease
- Hepatitis
- Parkinson's disease
- Retinitis pigmentosa
- Any other hereditary disease or disorder
- Any other motor neuron disease

If "Yes", please complete the chart below:

Life #	Family member: Father, Mother, Sisters, Brothers	Disease	Age at diagnosis	Actual Age if Alive	Age at Death	Cause of Death

PERSONAL HISTORY

Have you ever been treated for or had any symptoms, complaints, or indication of:

1. Heart and circulatory system:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- abnormal mammogram
- cancer
- leukemia
- lump/cyst
- lymphoma
- polyp
- tumour
- basal cell carcinoma
- melanoma
- any other growths or malignancies

3. Blood, glandular and endocrine system:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL (CONTINUED)

5. Ears, eyes, nose, throat and mouth(excluding routine check-ups, tonsillectomy, adenoidectomy, sinusitis, or other disorder requiring eyeglasses, contact lenses or ear tubes):

LIFE 1	LIFE 2
☒ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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)

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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

10. Musculoskeletal system:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- AIDS
- HIV
- any other immune system disease or disorder

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL (CONTINUED)

13. In the last 5 years have you had any of the following medical or diagnostic tests:

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

- 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?

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

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?

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

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?

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

Details Of "Yes" Answers

Question #	Life #	Provide Details

SECTION 5 – INSURANCE HISTORY

To be completed by all Proposed Lives Insured:

1. Do you have any other Insurance in force? . . . . . ☐ Yes ☐ No ☐ Yes ☐ No

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

If "YES", please complete the following:

Life #	Name of Company	Year Issued	Sum Insured: Personal	Sum Insured: Business	Sum Insured: Critical Illness
			$	$	$
			$	$	$
			$	$	$
			$	$	$

SECTION 5 – INSURANCE HISTORY (CONTINUED)

To be completed by all Proposed Lives Insured under exact age 16:

2. Are there any existing Life or Critical Illness Insurance policies or pending applications, on the lives of the parents of the child? (If Yes, provide type of insurance and amounts. If No, provide reason.)

3. Are there any existing Life or Critical Illness Insurance policies or pending applications on the lives of all siblings of the child? (If Yes, provide type of insurance and amounts. If No, provide reason.)

Question #	Life #	Provide Details

SECTION 6 – GENERAL INFORMATION

To be completed by all Proposed Lives Insured:

1. Have you been a resident of Canada for less than 24 months? (If "YES", give previous country of residence, current immigration status and date of arrival)

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

2. 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.)

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

3. 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 and details including which company and why)

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

4. Do you have an application for LIFE, DISABILITY, GROUP or CRITICAL ILLNESS insurance now pending with any other company? (if YES, provide company name, plan type, amount applied for)

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

5. Will this contract, if issued, replace a Life Contract now in force, with this or any other company? (If "YES", specify in "Details" section and forward completed Disclosure Statement(s))
If replacing Equitable Policy, indicate policy number in "Details" section.

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

SECTION 6 – GENERAL INFORMATION (CONTINUED)

To be completed by all Proposed Lives Insured exact age 16 and over

	LIFE 1	LIFE 2
6. 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.)	☐ Yes ☐ No	☐ Yes ☐ No
7. 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 Questionnaire.)	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you been convicted of, have pending charges for, or pleaded guilty to driving under the influence of alcohol and/or drugs, or refused a breathalyzer sample in the last 10 years? (If "YES", provide Driver's License No., date and details of violation)	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been convicted of, have pending charges for, or pleaded guilty to any other driving offences (excluding parking tickets) in the last 3 years? (If "YES", provide Driver's Licence No., date and details of violation)	☐ Yes ☐ No	☐ Yes ☐ No
10. In the last 10 years have you been charged with or convicted of or pleaded guilty to any criminal offence, or are any criminal charges pending? (if YES provide nature of offence, date charged, sentence details, date sentence and any probation completed)	☐ Yes ☐ No	☐ Yes ☐ No
11. a) Have you used any form of marijuana or hashish within the last 5 years? (if "Yes" specify amount, frequency, date last used)	☐ Yes ☐ No	☐ Yes ☐ No
b) Was it prescribed by a physician? (if "Yes" specify name and address of the physician and for what condition was it prescribed)	☐ Yes ☐ No	☐ Yes ☐ No
12. a) Do you drink alcoholic beverages? (If "Yes", specify type and ounces per week.)	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you ever received advice, treatment or counselling pertaining to your use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No
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 12(b) or (c), complete Alcohol or Drug Use questionnaire.)	☐ Yes ☐ No	☐ Yes ☐ No

Details Of "Yes" Answers

Question #	Life #	Provide Details

SECTION 7 – CHILDREN'S STATEMENT OF HEALTH FOR CPR

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 8

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.

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

		Yes	No
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.	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 "Yes" Answers

Question #	Life #	Provide Details

SECTION 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 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 8 – 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.
3. 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 to me any adverse assessment of my insurability. ☐ 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 _____ (city) _____ (province) this _____ (day) of _____ (month) 20 _____ .

***Signature of Person to be Insured**

***Signature of Person to be Insured**

Signature of Witness to all signatures

Assignee signature required if the policy is assigned

Signature of Owner(s) (if other than Person to be Insured)

Signature of Beneficiary (if preferred or irrevocable)

Owner(s) S.I.N.

*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)**

SECTION 9 – 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	Advisor's Fax
		☐			
		☐			
		☐			

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)

SECTION 9 – ADVISOR'S INFORMATION (CONTINUED)

UNDERWRITING REQUIREMENTS

Name of Service Provider:

Underwriting Requirements	Life 1	Ordered	Life 2	Ordered	Comments/order number(s)
Non-Medical	☐	☐	☐	☐	
M.D. Medical	☐	☐	☐	☐	
Paramedical	☐	☐	☐	☐	
Electrocardiogram	☐	☐	☐	☐	
Blood Profile	☐	☐	☐	☐	
PSA	☐	☐	☐	☐	
Urine (HIV)	☐	☐	☐	☐	
Saliva (HIV)	☐	☐	☐	☐	
Inspection Report	☐	☐	☐	☐	
Financial Statements	☐	☐	☐	☐	
Avocation Questionnaire	☐	☐	☐	☐	
Health Questionnaire	☐	☐	☐	☐	
Order Shared Evidence	☐	☐	☐	☐	

Other:

		Yes	No
1.	Does the Owner(s) and the Proposed Life Insured(s) speak and read the language in which this application is written? (If "NO" how was the Application completed? Provide detail in Advisor's notes below).	☐	☐
2.	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.)	☐	☐
3.	Are you the Proposed Life Insured, Owner, payor or beneficiary on this policy?	☐	☐
4.	Are you a related party of the Proposed Life Insured(s) or Owner(s)? A related party includes: a) immediate family members such as a spouse, parent, grandparent, child, grandchild, or in-law b) a corporation where the Advisor or an immediate family member, individually or together own 50% or more of any class of shares of the corporation c) where the Advisor is incorporated, any director, officer, employee or agent of the Advisor, and any parent, subsidiary or affiliated corporation of the Advisor (If "YES" give details in Advisor's Notes below.)	☐	☐
5.	Do you know of: a) 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)	☐	☐
	b) Any additional information which would assist in underwriting this application? (If "YES", provide details in Advisor's Notes below)	☐	☐
6.	Was this sale derived from a financial needs analysis?	☐	☐
7.	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	☐	☐
8.	I have made a reasonable effort to determine if the Owner(s) are acting on behalf of a third party.	☐	☐

SECTION 9 – ADVISOR'S INFORMATION (CONTINUED)

	Yes	No
9. I have reviewed and explained the Sales Illustration to the Owner(s)	☐	
10. I confirm that I have disclosed the following to the Owners:	☐	
a) the life or critical illness policy, if issued, is underwritten and managed by Equitable Life of Canada;		
b) the company or companies I represent;		
c) I am an independent broker/advisor representing Equitable Life of Canada;		
d) I am a life agent licensed by the Insurance Council of British Columbia and/or the Financial Services Commission of Ontario, if applicable;		
e) I receive compensation and will continue receiving servicing/renewal commissions, if a policy is issued and comes into effect, and if it remains in force;		
f) I may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business I place with Equitable Life of Canada;		
g) I have disclosed any conflicts of interest I may have regarding this Application.		
11. I have reviewed the information provided in this Application with the proposed Owner(s) and to the best of my knowledge, it is complete and true	☐	

ADVISOR'S NOTES

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

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.