P.O. Box 4241, Station A
Toronto, ON M5W 5R3
ivari.ca

Insured's Request for Living Benefits

1 Policy details

INSURED

Policy number(s)	Policy Face Amount/Sum Insured(s) $

Name of Insured *(First and last name)*	Date of birth (DD/MM/YYYY)
Address	Apt./Suite #

City	Province/territory/state	Country	Postal/zip code

Home phone	Mobile phone	Business phone
Email address	Occupation	In what industry are you employed?*

POLICY OWNER IF OTHER THAN INSURED

Name of Owner *(First and last name)*	Date of birth (DD/MM/YYYY)
Address	Apt./Suite #

City	Province/territory/state	Country	Postal/zip code

Home phone	Mobile phone	Business phone
Email address	Occupation	In what industry are you employed?*

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

2 Benefit request details TO BE COMPLETED BY THE INSURED

Describe exact nature of your illness or injury:

Date you were first treated for your illness or injury? (DD/MM/YYYY) _____

Date of your most recent consultation with a medical professional regarding your illness or injury? (DD/MM/YYYY) _____

PRIOR ILLNESS OR INJURY:

a) Have you had the same kind of illness or injury before? ○ Yes ○ No

b) If ***"yes,"***

i) When? _____

_____

ii) By whom were you treated? _____

PROGNOSIS:

a) Has a medical professional diagnosed that your condition is terminal? ○ Yes ○ No

b) If ***"yes,"*** what life expectancy have you been given? _____

NAME AND ADDRESS OF YOUR DOCTOR(S): **PLEASE PROVIDE INFORMATION FOR ALL THE DOCTORS YOU HAVE SEEN IN THE PAST 5 YEARS**

1.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone number
	City	Province/territory/state	Country	Postal/zip code
2.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone number
	City	Province/territory/state	Country	Postal/zip code
3.	Name			Date of last visit (DD/MM/YYYY)
	Address			Telephone number
	City	Province/territory/state	Country	Postal/zip code

Most recent hospitalization (if applicable):

a) From: (DD/MM/YYYY) _____ to: (DD/MM/YYYY) _____

b) Name and address of hospital: _____

_____

_____

3 Claim request

I request to withdraw an amount from the fund value of my universal life insurance policy in accordance with the terms of my contract.

Amount requested $_____ or maximum amount* $ _____

*Maximum amount = Total account value minus 3 monthly deductions/premiums.

Note: If the policy has a Level Death Benefit, the Face Amount/Sum Insured will be reduced by the requested amount.

4 Notice regarding collection, use and disclosure of personal information – (Privacy Notice)

ivari's Privacy Policy, available at **ivari.ca,** tells you how ivari will handle your personal information as an Insured and/or Owner. It also tells you about your rights and choices.

In summary:

ivari uses your personal information for the following purposes:

- Verifying your identity;
- Evaluating any forms you submit about the insurance policies you have in place with ivari;
- Administering and servicing the policy;
- Supporting business operations necessary for us to service the policy;
- Conducting investigations and analyzing claims; and
- Complying with our legal and regulatory obligations (such as tax reporting, compliance with anti-money laundering and anti-terrorist financing laws, and prudential and market conduct laws) and/or any legal or regulatory orders (for example, a court order, subpoena) against ivari.

When required as part of our claims analysis, we may also collect your personal information from external sources such as health care facilities or providers, investigative agencies and/or consumer and credit reporting agencies, and others.

When required, ivari may share your personal information with trusted third parties, including service providers retained by ivari to assist in administering ivari policies, ivari's reinsurers; your financial institution, your independent insurance advisor and their supporting associates, market intermediaries, your beneficiaries and assignees, your family physician or treating medical practitioner and other insurance companies to whom a claim for benefits may be submitted.

It is possible that your personal information may be transferred, stored, handled, or processed outside your jurisdiction and that authorities in those jurisdictions may have access to it.

In some cases, you have a **right to withdraw consent** to the use and sharing of your personal information. You also have the **right to see and correct** the information we have about you, and to **obtain information about any fully automated decisions** we make using your information. Mail your written request to: **Chief Privacy Officer, ivari, 200-5000 Yonge Street, Toronto, Ontario M2N 7E9 or email: privacyoffice@ivari.ca.**

You can see ivari's full Privacy Policy online at ivari.ca. Please make sure you read it carefully so that you understand it in full. Please note that we may update this Privacy Policy from time to time.

CONSENT REQUIRED FOR THIS FORM AND POLICY

The following consents are required to proceed with and submit this form to ivari:

1. I give my consent to the collection, use and disclosure of my personal information as described in the **Privacy Notice** and in ivari's Privacy Policy on **ivari.ca.**
2. I authorize ivari to collect my personal information from third parties for the purposes described in and in accordance with ivari's Privacy Policy.
3. If I am giving my consent on behalf of one or more minor Insured(s) (under the age of 18 years in Quebec or under the age of 16 years in all other provinces) to the points above, then I represent that I have authority to consent on behalf of the minor Insured(s).

Signature of **Insured**

Signature of **Owner**

5 Certification

"I" means the Insured and Owner(s) of the Policy. By signing below, I certify that:

- I am authorized to give instructions in respect of the policy identified on this form.
- I have read and fully understood the contents of this form, and I acknowledge and agree to its terms.
- I hereby declare and agree that the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief and are the basis for the consideration of a Living Benefits claim.
- I agree and understand that any false or misleading information on this request form may make me liable to ivari for any payment made by ivari as a result of this request. I hereby agree to refund to ivari, the amount of any payments made in the event that such amounts should not have been paid in respect of this request.
- I acknowledge that receipt of a Living Benefit may, depending on all of the facts, be a taxable event with respect to which I am advised by ivari to consult a tax advisor for more details.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from ivari. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

I, the Insured/Owner acknowledge that the Policy will be amended to include the Living Benefit Amendment.

Signature of Insured

Date: (DD/MM/YYYY) _____

Address:

Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

Signature of Irrevocable Beneficiary

Date: (DD/MM/YYYY) _____

Address:

Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

Signature of Owner (if other than Insured)

Date: (DD/MM/YYYY) _____

Address:

Signature of Witness

Date: (DD/MM/YYYY) _____

Address:

ivari™ P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-855-806-5057 • **claimsdepartment@ivari.ca**

The fastest and easiest way to send us your completed and signed forms is through our online tool, *Send documents* on ivari.ca. By using this tool, forms are sent instantly and securely.

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