P.O. Box 4241, Station A
Toronto, ON M5W 5R3
Telephone: 1-800-846-5970
**ivari.ca**

# Policy Change Application

## 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 Owner and/or Insured . It also tells you about your rights and choices.

In summary:

**ivari uses your personal information for the following purposes:**

- Verifying your identity;
- Evaluating your application and any applications or forms you submit in the future 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.

**We collect personal information through the application process.** When required as part of our evaluation of your application and 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.

**It is optional to provide your Social Insurance Number (SIN) on this application.** However, if you have a universal life policy or a policy with cash value and you do not provide your SIN here, then ivari will need to obtain your SIN before we can process certain transactions, if requested in the future (as required by tax legislation). If you decide to provide your SIN, then we may also use it as necessary for the purposes described in this **Privacy Notice** or our Privacy Policy.

**When required, ivari may share your personal information with trusted third parties,** including service providers retained by ivari to assist in administering ivari policies, the Medical Information Bureau ("MIB, LLC"), 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 you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**For the purposes specified in this Privacy Notice, personal information provided in this application may go through an automated decision-making process.**

**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.**

### Notice regarding MIB, LLC

Information regarding your insurability will be treated as confidential. ivari or its reinsurers may, however, make a brief report thereon to Medical Information Bureau, or MIB, LLC, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

Personal information disclosed to MIB, LLC may include your name, birth jurisdiction, occupation and any other information used to determine your insurability. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

MIB receives personal information about Canadian consumers, and the collection, use and disclosure of such information is governed by the *Personal Information Protection and Electronic Documents Act* (PIPEDA) and provincial laws, as may be amended or replaced from time to time. If a brief report is made to MIB by a company, then it will be stored and safeguarded for such period as may be allowed by law.

MIB has agreed to protect such information in a manner that is substantially similar to the privacy and security practices of MIB's Canadian member companies, and in accordance with applicable laws. As a U.S. based company, MIB. is bound by, and such personal information may be disclosed in accordance, with applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations; provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws. **To review MIB's Consumer Privacy Policy, please visit: (https://www.mib.com/privacy_policy.html).**

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB by emailing **canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal *Fair Credit Reporting Act.* The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

ivari, and its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life 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.**

**CONSENT REQUIRED FOR THIS APPLICATION AND POLICY**

ivari needs your consent to the following so we can receive and process this application:

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. **When underwriting is required,** I authorize ivari and/or its reinsurers to make a brief report of my personal health information to Medical Information Bureau ("MIB, LLC").
4. 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 three points above, then I represent that I have authority to consent on behalf of the minor Insured(s).

| Signature of **Insured** | Signature of **Owner 1,** if not an Insured | Signature of **Owner 2,** if not an Insured |
|---|---|---|
| **If the Insured is a minor the signature of the parent or legal guardian who is signing the application for this child is required** | | |

**OPTIONS REGARDING YOUR PERSONAL INFORMATION**

You may withdraw your consent to any one of these options anytime without affecting your ivari policy.

***Optional added-benefit services available to you (for Owners only)***

ivari has retained certain third parties for the purpose of offering you optional added-benefit services. If you opt-in to receive communications about enrolling in the programs available to you, then we will disclose only your name and contact information (including your address, email, and/or phone number), and current insurance coverage. We will not disclose your health or financial information. For more information about the services currently available to you, please consult your advisor.

**Owner 1:** ◯ Yes ◯ No **Owner 2:** ◯ Yes ◯ No

***Promotional communications about ivari products and services you may be eligible (for Owners only)***

ivari may communicate with you about other ivari products and services that you may be eligible for, using email, text or other electronic means. ivari may retain third party marketers for the purpose of sending you these promotional communications. If you opt-in to receive these promotional communications, we will disclose only your name, contact information, and current insurance coverage. We will not disclose date of birth or health or financial information.

**Owner 1:** ◯ Yes ◯ No **Owner 2:** ◯ Yes ◯ No

***Disclosing information used for underwriting to your advisor and their supporting associates (for Insured only)***

*When underwriting is required:*

We may collect personal information from you in supplementary forms, phone interviews or other communications with you or a medical professional, for the purposes described in this **Privacy Notice** and the Privacy Policy.

*If you opt-in below:*

We may disclose personal information collected from you after the application is submitted to the advisor identified on this application, and their supporting associates, which may include their managing general agency (or distributor), market intermediaries, and their employees and subcontractors. We will only disclose this personal information for the purpose of allowing your advisor to help you with your insurance options.

This authorization will only remain in effect for 45 days after ivari issues a policy or sends a letter indicating that the insurance request has been declined.

**Insured:** ◯ Yes ◯ No

## Access your ivari 24/7

If you want to look at your ivari policy, make changes to your contact information or simply check out anything to do with your policy, you can view your information in a safe and secure environment by logging in at **myivari.ca**.

## Questions?

Please contact your independent insurance advisor or write to us at
Client Services Department, ivari, P.O. Box 4241, Station A, Toronto, ON M5W 5R3.

# Guidelines for the advisor

Use this application when applying for any changes to in force Life and Critical Illness policies such as:

- Addition of lives/coverage for Term and Critical Illness Protection insurance only
- Reinstatement
- Reduce or remove rating or change in risk classification
- Changes to non-smoker
- Addition of Children's Insurance Rider
- Change of Death Benefit Option (DBO)
- Increase in Face Amount
- Conversion with underwriting
- Change of Cost of Insurance (COI)
- Substitution of life
- Replacement of an existing ivari policy/coverage

Use ***Policy Service Application (PS339)*** for:

- **Decrease in Face Amount/Benefit**
- **Cancellation of Rider or Coverage**
- **Term Exchange**

## For quicker processing:

1. Indicate the type of change on the Requested change page.
2. ALL pages of the *Policy Change Application* must be submitted.
3. For multi-life request (other than children under the Children's Rider), submit a second *Policy Change Application* for each life.
4. For replacements of insurance policies/coverages attach applicable disclosure forms, as per provincial legislation.
5. There is an administration fee per life for Cost of Insurance and Death Benefit Option changes if underwriting is required.
6. All Owner signatures are required on every *Policy Change Application* submitted.
7. For Joint-Last-to-Die policies, evidence of insurability is required on all lives insured regardless who is applying for the change.

## Important for replacements or conversions to a universal life policy only:

1. Multi-life option is not available.
2. Submit a signed illustration.
3. Ensure all questions shown as **MANDATORY FOR UNIVERSAL LIFE POLICIES** are answered.
4. If the Policy Owner is an entity (i.e. a corporation, non-corporate entity or trust) please complete the ***Policy Ownership for Corporate & Non-Corporate Entities or Trusts form (IP-LP1747)***.
5. If PAD is requested, please complete a new ***Pre-Authorized Debit (PAD) for Insurance Products form (PS375)*** and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction

# Requested changes

Indicate the requested change and complete the required section for that change.

| CHANGE TYPE (SELECT ALL THAT APPLY) | PAGES AND SECTIONS TO BE COMPLETED | ADDITIONAL REQUIREMENTS |
|---|---|---|
| ☐ **Conversion with face increase or Conversion with class of risk change** | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1** to **8, 12** to **24** and **29** to **32** | • Signed Illustration and Supplement to the Insurance Application<br>• If Owner is an entity, complete ***Policy Ownership for Corporate & Non-corporate entities or Trusts form (IP-LP1747)*** |
| ☐ **Replacement of an ivari insurance coverage/ policy to an inforce policy**<br>• For a replacement to a New Policy use ivari 360 eApp | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1** to **7, 9** (section 10), **12** to **24** and **29** to **32** | • Signed Illustration and Supplement to the Insurance Application<br>• Replacement form or LIRD<br>• Order requirements(s) based on Age and amount chart<br>• If Owner is an entity, complete ***Policy Ownership for Corporate & Non-corporate entities or Trusts form (IP-LP1747)*** |
| ☐ **Change to Non-Smoker rates** | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1, 2, 4, 5, 9** (section 11), **12** to **24** and **29** to **32** | • Order Urine/HIV |
| ☐ **Reduce or remove a rating or change in risk classification** | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1** to **5, 9** (section 12), **12** to **24** and **29** to **32** | • For avocation and travel ratings, submit avocation or travel questionnaire |
| ☐ **Reinstatement** | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1** to **7, 10** (section 13), **12** to **24** and **29** to **32**<br>**Note:** All pages and sections must be answered and completed. Reinstatement cannot be approved with a delivery requirement. | • Submit all back premiums to current date |
| ☐ **Change of Cost of Insurance to Level with Increasing Death Benefit** | Pages **ii** (provide consent to the **Privacy Notice**)<br>If Net amount at Risk increases, Pages **1** to **5, 10** (section 14), **12** to **24** and **29** to **32** | • Include administration fee of $150 for each Insured being underwritten |
| ☐ **Change of Death Benefit Option for policies with YRT/ART cost of insurance** | Pages **ii** (provide consent to the **Privacy Notice**)<br>If Net amount at Risk increases, Pages **1** to **5, 10** (section 15), **12** to **24** and **29** to **32** | • Include administration fee of $150 for each Insured being underwritten |
| ☐ **Addition of a rider/coverage** | Pages **ii** (provide consent to the **Privacy Notice**)<br>Pages **1** to **7, 10** (section 16), **11** to **24,** and **29** to **32**<br>If adding children's insurance rider, also complete Pages **26** and **27** | • Order requirement(s) based on Age and amount chart |

For **NON-FACE TO FACE** changes refer to **ivari's non-face-to-face insurance application guidelines** on **ivari.ca.** A signed delivery receipt will not be required for policy change unless requested by Underwriting.

# Policy Change Application

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**ivari.ca**

## General information

Policy no. _____

**1** ○ **EXISTING INSURED** ○ **NEW INSURED** (for term & critical illness protection only)

**2** **Main purpose of insurance:** **MANDATORY FOR UNIVERSAL LIFE POLICIES**

○ Key person insurance ○ Retirement planning ○ Estate planning ○ Life protection ○ Partnership

**Insured** *("Insured" refers to "Proposed Insured" when applying for new insurance coverage)*

**3**

| First name | Last name |
|---|---|
| | |

**MANDATORY FOR UNIVERSAL LIFE POLICY**

| Identification document† | Identification document number† | Document expiry date (MM/YYYY) | Issuing jurisdiction and country |
|---|---|---|---|
| | | | |

†***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority, Permanent Resident Card, Provincial and Territorial Photo Card. Copy of photo ID is not required unless requested by ivari.***

**4** Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female

Former/Maiden name: _____ SIN: _____ *(Optional)*

**5** Current residential address: *(P.O. Boxes and General Delivery not accepted as residential address)*

Address: _____ Apt./Suite #: _____

City: _____ Province: _____ Postal code: _____

Home phone: _____ Mobile phone: _____ Business phone: _____

**6** Is your country of birth Canada? ○ Yes ○ No If ***"yes"***, provide province of birth: _____

If ***"no"***, a) provide country of birth: _____

b) have you lived in Canada for a minimum of 3 years? ○ Yes ○ No

If ***"no"***, i) how long have you been in Canada: _____ Years _____ Months

ii) What is the Insured's residency status?

○ Canadian citizen

○ Landed immigrant/Permanent resident

○ Contract worker *(other than seasonal worker, provide copy of work permit)*

○ Student permit *(provide copy of student permit)*

○ Officially accepted under Convention refugee *(provide a copy of your document)*

○ Other _____ *(provide a copy of your status document)*

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## Insured *(continued)*

**7** Is the Insured currently: ○ Employed ○ Not working ○ Juvenile *(under the age of 16)* ○ Student *(16 years and older)*

**If "Employed":**

a) Name of employer: _____ Number of years: _____ months: _____

b) Employer's address: _____

c) Occupation: _____ In what industry are you employed?* _____

d) Duties: _____

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

**If "Not working":**

a) Provide reason: _____

b) Are you financially dependent on a spouse or a partner or parents? ○ Yes ○ No

i) If ***"yes",*** what is the annual Canadian earned Income of your dependent? _____

If ***"no",*** what is the amount of your financial support _____ and source _____

ii) If ***"yes",*** is there insurance coverage on your dependent (spouse, partner, or parents)? ○ Yes ○ No

If ***"yes",*** what is the amount of insurance in force or applied for? _____

**If a "Juvenile":** *(under the age of 16):*

a) If the Insured is less than 2 years old, was the child born prematurely? ○ Yes ○ No ○ N/A

If ***"yes",*** provide details: _____

b) Who does the child live with?

○ Parent ○ Legal guardian ○ Grandparent ○ Other (provide details): _____

c) Is there any insurance coverage in force or pending on the owner(s)? ○ Yes ○ No

If ***"yes",*** Owner 1 Life $ _____ CI $ _____

Owner 2 Life $ _____ CI $ _____

If ***"no",*** explain why: _____

d) Who is answering the medical questions for this child?

○ Parent ○ Legal guardian ○ Grandparent ○ Other (provide details): _____

e) Who is signing for this child?

○ Parent ○ Legal guardian (proof of guardianship is required)

First name: _____ Last name: _____

f) Does this juvenile have any siblings? ○ Yes ○ No

If ***"yes",*** do any of the siblings have any life or critical illness insurance in force or pending? ○ Yes ○ No

If ***"yes",*** provide details of life or critical illness insurance in force or pending:

| NAME OF SIBLING | COMPANY | TYPE OF INSURANCE PLAN | AMOUNT | STATUS |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If ***"no", insurance***, explain why: _____

**If a "Student"** (16 years and older): ○ Full time ○ Part time

a) Name of educational institution: _____

b) Field of study: _____

c) Expected date of graduation: _____

d) Are you employed? ○ Yes ○ No If ***"yes",*** name of employer: _____

Occupation: _____ In what industry are you employed?* _____

Duties: _____

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

# Financial information

***NOTE: Not to be completed if requesting a change to non-smoker rates.***

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**Personal financial details:**

a) Annual earned Canadian income: $ _____

b) Annual Canadian income from other sources: $ _____

Provide details regarding other sources: _____

_____

c) Approximate Canadian net worth (current assets less current liabilities): $ _____

d) Total of current Canadian assets (such as cash and savings on hand, non-registered savings, registered savings, TFSA (Tax-Free Savings Account) or other investments? $ _____

e) Total of current Canadian liabilities (such as mortgage, personal loan, car loan, line of credit, funeral expense or other expenses)? $ _____

f) In the last 5 years, have you filed for personal or business bankruptcy or have not yet received a discharge or are you currently involved in a bankruptcy proceeding or consumer proposal? ○ Yes ○ No

If ***"yes",*** provide details and if applicable date of discharge:

_____

_____

_____

## 8 Owner information THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNERS

**Note:**
- **The current Owner(s) must sign on page 30.**
- To change the Owner complete the ***Notice of Transfer of Ownership form (PS371)*.**
- If this is a conversion of a Children's Insurance Rider, the Owner(s) will automatically be the child converting unless indicated otherwise in the Owner(s) section of this application.

a) **Select the Policy Owner(s) below:**

☐ Insured
- must complete questions b) on page 5 and page 7 when applying for universal life

☐ Other as identified below:
- Individual(s) other than Insured – must complete Owner section a) below, b) on page 5 and page 7 when applying for universal life

**CURRENT INDIVIDUAL OWNER 1** Legal name (First, last and/or legal company/entity name)

| Date of birth (DD/MM/YYYY) | Relationship to Insured | SIN (Optional) |
|---|---|---|
| Occupation | In what industry are you employed?* | |
| Current residential address *(P.O. Boxes and General Delivery not accepted as residential address)* | | Apt./Suite # |
| City | Province | Postal code |
| Home phone | Mobile phone | Business phone |

| Identification document† | Identification document number† | Document expiry date (MM/YYYY) | Issuing jurisdiction and country |
|---|---|---|---|
| | | | |

†***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.***
*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ Yes ○ No

If ***"no,"*** provide details of current status: _____

**CURRENT INDIVIDUAL OWNER 2** Legal name (First, last and/or legal company/entity name)

| Date of birth (DD/MM/YYYY) | Relationship to Insured | SIN (Optional) |
|---|---|---|
| Occupation | In what industry are you employed?* | |
| Current residential address *(P.O. Boxes and General Delivery not accepted as residential address)* | | Apt./Suite # |
| City | Province | Postal code |
| Home phone | Mobile phone | Business phone |

| Identification document† | Identification document number† | Document expiry date (MM/YYYY) | Issuing jurisdiction and country |
|---|---|---|---|
| | | | |

†***Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.***
*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ Yes ○ No

If ***"no,"*** provide details of current status: _____

**Business financial information (if Corporation/entity owner)**

- For entity/corporation owned policies complete the ***Confidential Business Financial Questionnaire (UW-BFINQ361)*** or provide financial statements. *(NOTE: Not to be completed or provided if requesting a change to non-smoker rates.)*
- Corporation, non-corporate entity or trust – must complete the CORPORATION/ENTITY OWNER section below and when applying for Universal Life the ***Policy Ownership for Corporate & Non-corporate Entities or Trusts form (IP-LP1747)***

## CURRENT CORPORATION/ENTITY OWNER

Legal company/Entity name

Corporation/Entity relationship to Insured

| Name of signing officer | Title of signing officer |
|---|---|
| Name of signing officer | Title of signing officer |

### Corporation/entity Owner's address

| Current address *(P.O. Boxes and General Delivery not accepted)* | | Apt./Suite # |
|---|---|---|
| City | Province | Postal code |

Business phone

b) **Politically Exposed Persons and/or Heads of International Organizations** **MANDATORY FOR UNIVERSAL LIFE POLICIES**

Is a premium and/or lump sum payment equal to or greater than $100,000 being made or to be made? . . . . . ○Yes ○No

If the answer is ***"yes"***, each Owner must complete the ***Politically Exposed Persons and/or Heads of International Organizations form (IP-LP1165)*** and submit it along with the application.

# Financial information

***NOTE: Not to be completed if requesting a change to non-smoker rates.***

**OWNER** (To be completed if the Owner is not the Insured)

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**Personal financial details:**

a) Annual earned Canadian income: $ _____

b) Annual Canadian income from other sources: $ _____

Provide details regarding other sources: _____

_____

c) Approximate Canadian net worth (current assets less current liabilities): $ _____

d) Total of current Canadian assets (such as cash and savings on hand, non-registered savings, registered savings, TFSA (Tax-Free Savings Account) or other investments? $ _____

e) Total of current Canadian liabilities (such as mortgage, personal loan, car loan, line of credit, funeral expense or other expenses)? $ _____

f) In the last 5 years, have you filed for personal or business bankruptcy or have not yet received a discharge or are you currently involved in a bankruptcy proceeding or consumer proposal? ○ Yes ○ No

If ***"yes",*** provide details and if applicable date of discharge:

_____

_____

_____

# Declaration of tax residency MANDATORY FOR UNIVERSAL LIFE POLICIES

## CURRENT INDIVIDUAL OWNER 1

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

## CURRENT INDIVIDUAL OWNER 2

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**We would like to remind you that if we do not receive a response from you, ivari will be required to report your policy to CRA as an incident of undeclared information in accordance with the *Income Tax Act* (ITA). In addition, you may be subject to a penalty from CRA under subsection 281(3) and subsection 162(6) of the ITA for each failure to provide self-certification information to ivari.**

Please answer the following three statements. Depending on your situation, you may answer ***"yes"*** to more than one.

| | | CURRENT INDIVIDUAL OWNER 1 | | CURRENT INDIVIDUAL OWNER 2 | |
|---|---|---|---|---|---|
| | | YES | NO | YES | NO |
| a) | **I am a tax resident of Canada.** | ○ | ○ | ○ | ○ |
| b) | **I am a tax resident or a citizen of the United States.** | ○ | ○ | ○ | ○ |

If ***"yes,"*** to statement b), provide your Taxpayer Identification Number (TIN) from the United States:

Current Individual Owner 1 _____ Current Individual Owner 2 _____

The U.S. Taxpayer Identification Number (TIN), as defined in CRA Guidance, is a unique nine-digit number, assigned by the U.S. Government to an individual or entity, that is a specified U.S. person and used to identify the individual or entity for purposes of administering U.S. tax laws. Here are the acceptable examples, Individual Taxpayer Identification Number (TIN), Employer Identification Number (EIN) and Social Security Number (SSN).**

| | | | | | |
|---|---|---|---|---|---|
| c) | **I am a tax resident in a country other than Canada or the United States.** | ○ | ○ | ○ | ○ |

If ***"yes,"*** to statement c), provide your country of tax residence and Taxpayer Identification Numbers (TIN):

### CURRENT INDIVIDUAL OWNER 1

| COUNTRY OF TAX RESIDENCE | TAXPAYER IDENTIFICATION NUMBER (TIN) OR ACCEPTABLE EQUIVALENT |
|---|---|
| | |
| | |

### CURRENT INDIVIDUAL OWNER 2

| COUNTRY OF TAX RESIDENCE | TAXPAYER IDENTIFICATION NUMBER (TIN) OR ACCEPTABLE EQUIVALENT |
|---|---|
| | |
| | |

A foreign Taxpayer Identification Number (TIN), as defined in CRA Guidance, is a unique combination of letters or numbers, assigned by a jurisdiction to an individual or entity and used to identify the individual or entity for purposes of administering the tax laws of the specific jurisdiction. Here are the acceptable examples, Social Security Number (SSN), Non-Canadian Social Insurance Number (SIN), Citizen identification number, Personal Identification Number (PIN), Service code/number, Resident registration number and Business/company registration code/number.**

**For more information, please refer to *"Enhanced financial account information reporting"* found on the CRA website.

It is understood and agreed that we may require, in addition to the completion of the Health history section of this application, any other evidence of insurability as we may deem necessary before approving the requested change.

**Note:** A conversion/replacement will be effective on the policy's monthly anniversary date closest to the date the policy/coverage was approved.

## 9 Conversion with a ○ Class of risk change or ○ Increase in insurance coverage

Complete this section and pages 12 to 24. All lives insured under a Joint Last-to-Die coverage must also complete these requirements. **Note:** For universal life policies, submit a signed Illustration and *Supplement to the Insurance Application.*

**NOTE ON BENEFICIARY DESIGNATIONS:**

**For Life and Critical Insurance policies:** The beneficiary on your current policy will be carried over to the new policy unless a ***Change of Beneficiary form (PS367)*** is submitted.

**For Critical Illness Protection Riders converting to a Critical Illness Protection policy:** If you named a specific beneficiary on your original Critical Illness Rider, it will be carried over to the new policy only if the legislation in your province allows you to name a beneficiary. Otherwise, the Critical Illness Benefit and Early Detection Benefit Beneficiary for the new policy will be the Insured. If the Insured is a minor, the beneficiary will be the Owner, if living, or the Owner's estate, if deceased. Return of Premium on Death proceeds on the new policy will be payable to the Owner, if living, or the Owner's estate, if deceased.

**NOTE ON CHANGE OF OWNERSHIP:** If there is a change in ownership, you must submit a ***Notice of Transfer of Ownership form (PS371)*** signed by the original Owner(s) and the new Owner(s) otherwise the original Owner(s) will be carried over to the new policy.

| CURRENT PLAN TO BE CONVERTED | CURRENT FACE AMOUNT/BENEFIT | NEW FACE AMOUNT/BENEFIT | NEW PLAN NAME |
|---|---|---|---|
| ☐ Base plan | $ | $ | |
| ☐ Additional rider/coverage | $ | $ | |
| ☐ Additional rider/coverage | $ | $ | |
| ☐ Additional rider/coverage | $ | $ | |

a) If the above indicated face amount/benefit to be converted is less than the current face amount/benefit, is the amount remaining under the current policy to be terminated? ..... ○ Yes ○ No

If ***"yes"***, balance will be terminated on the date the new policy becomes effective.
If ***"no"***, what amount will remain in force under the current policy? (must meet current plan minimum) $ _____

b) If you are less than 55 years of age, do you wish to carry over any of the following riders to the new policy (if applicable): (**Note:** Accidental Death Benefit (ADB) riders cannot be carried over).

i) Accidental Death & Dismemberment (AD&D) ..... ○ Yes ○ No

ii) Waiver of Premium ..... ○ Yes ○ No

If ***"yes"***, are you able to perform all the duties of your normal occupation? ..... ○ Yes ○ No

c) If you are less than 65 years of age, do you wish to carry over the Children's Insurance Rider to the new policy (if applicable)? ..... ○ Yes ○ No

Premium quoted: $ _____ Initial premium/deposit: $ _____

Mode of premium/deposit details:

○ Annually ○ Semi-annually ○ Quarterly ○ Monthly PAD ○ Quarterly PAD ○ Semi-annual PAD ○ Annual PAD

Provide source of premium/deposit (where is the premium/deposit coming from?): _____

## 10 Replacement

Complete this section and pages 12 to 24. All lives insured under a Joint Last-to-Die coverage must also complete these requirements. **Note:** For universal life policies, submit a signed Illustration and *Supplement to the Insurance Application.*

**NOTE ON BENEFICIARY DESIGNATIONS:** The beneficiary on your current policy will be carried over to the new policy unless a ***Change of Beneficiary form (PS367)*** is submitted.

**NOTE ON CHANGE OF OWNERSHIP:** If there is a change in ownership, you must submit a ***Notice of Transfer of Ownership form (PS371)*** signed by the original Owner(s) and the new Owner(s) otherwise the original Owner(s) will be carried over to the new policy.

***Please attach a completed Life Insurance Replacement Declaration (LIRD) or Replacement/Comparison Disclosure form(s).***

Current policy number: _____ New policy number: _____

Current plan name being replaced: _____ New plan name: _____

Current face amount/benefit: $ _____ New face amount/benefit: $ _____

Additional rider(s)/Coverage(s): _____ Amount: $ _____

**MODE OF PAYMENT** Initial premium/deposit of: $ _____

**Pre-Authorized Debit:** ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

If PAD is requested, please complete a new ***Pre-Authorized Debit (PAD) for Insurance Products form (PS375)*** and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction.

Preferred date of withdrawal (days 1-28 only) _____

**Direct billing:** ○ Quarterly ○ Semi-annually ○ Annually

**For universal life policies:** Provide source of premium/deposit (where is the premium coming from?): _____

## 11 Change to Non-smoker

Complete this section and pages 12 to 24. **Order a urine/HIV specimen.**
All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Please indicate all policies you wish to change.

Policy number(s): _____ , _____ , _____ , _____

If universal life plan: Will the planned periodic premium/deposit change? . . . . . ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit* $ _____ *Note: Must meet plan minimum premium.

Policy number(s): _____ , _____ , _____ , _____

## 12 Reduce or remove rating or change in risk classification

○ For Lifestyle (avocation and travel) ratings reconsideration on ***Life coverages***, complete this section and submit the appropriate avocation or travel questionnaire.

○ For all other ratings reconsideration or change in risk classification, complete this section and pages 12 to 24.
All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Please indicate all policies you wish to change.

Policy number(s): _____ , _____ , _____ , _____

If universal life plan: Will the planned periodic premium/deposit change? . . . . . ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit* $ _____ *Note: Must meet plan minimum premium.

Policy number(s): _____ , _____ , _____ , _____

## 13 Reinstatement

Complete this section and pages 12 to 24. Reinstatement process cannot be started unless ALL questions are answered.

Lapsed policy number: _____

Reinstate the policy in accordance with its provisions. Back premiums to current date of $ _____ to be paid by:

○ Cheque made payable to ivari attached or

○ Withdrawal from bank account upon approval of reinstatement (Complete ***Pre-Authorized Debit (PAD) for Insurance Products form (PS375)***, see below for additional instructions for pre-authorized debit)

Note: ivari may deposit any payment without prejudice to its right to decline to reinstate the policy.

**MODE OF PAYMENT**

**Pre-Authorized Debit:** ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

If PAD is requested, please complete a new ***Pre-Authorized Debit (PAD) for Insurance Products form (PS375)*** and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction.

Preferred date of withdrawal (days 1-28 only) _____

**Direct billing:** ○ Quarterly ○ Semi-annually ○ Annually

**For universal life policies:** Provide source of premium/deposit (where is the premium coming from?): _____

## 14 Change of Cost of Insurance to Level with Increasing Death Benefit

Underwriting is required if the Net Amount At Risk increases as a result of a change in the Cost of Insurance. If underwriting is required, **please submit the applicable administration fee** and complete: pages 12 to 24. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Indicate administration fee to be paid by:

○ Cheque for Administration fee payable to ivari attached or

○ Withdraw Administration Fee from bank account for a one time withdrawal from the bank account on file

Current policy number: _____

☐ Level Cost of Insurance with Increasing Death Benefit Option

## 15 Change of Death Benefit Option for policies with YRT/ART cost of insurance

Underwriting is required if the Net Amount At Risk increases as a result of a change in the Death Benefit option. If underwriting is required, **please submit the applicable administration fee** and complete: pages 12 to 24. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

Indicate administration fee to be paid by:

○ Cheque for Administration fee payable to ivari attached or

○ Withdraw Administration Fee from bank account for a one time withdrawal from the bank account on file

Current policy number: _____ ○ Increasing to level ○ Level to increasing

## 16 Addition of rider/Coverage on

Indicate only one answer – either Existing Insured or New Insured, specify coverage/rider details in **section 17** and complete pages 12 to 24. All lives insured under a Joint Last-to-Die coverage must also complete these requirements.

○ Existing Insured(s) or

○ New Insured(s) for Term insurance and Critical Illness Protection Policies only

Current policy number: _____

## 17 Insurance applied for addition of rider/coverage

☐ **UNIVERSAL LIFE COVERAGE**

Coverage amount (indicate additional coverage amount only): $ _____

For conversions and replacements to a universal life policy, submit a signed Illustration including the *Supplement to the Insurance Application*.

Will the planned periodic premium/deposit change? . . . . . ○ Yes ○ No

If ***"yes"***, new planned periodic premium/deposit* $ _____ *Note: Must meet plan minimum premium.

☐ **TERM LIFE COVERAGE**

| **Term riders** | Face amount† | **Additional benefit** | Face amount†† |
|---|---|---|---|
| ☐ 10 Year Rider | $ _____ | ☐ Children's Insurance Rider | $ _____ |
| ☐ 20 Year Rider | $ _____ | If applying for a Children's Insurance rider complete pages 26 to 27. For the base insured (parent) also complete pages 12 to 24. | |
| ☐ 30 Year Rider (Available only on a Term 30 policy) | $ _____ | ††**Minimum $5,000 to a maximum of $30,000 (must be in units of $5,000)** | |
| ☐ Other _____ | $ _____ | | |

†**Only enter the additional coverage/benefit being requested.**

| **Critical Illness Protection Rider*** ** | Benefit† | | Benefit† |
|---|---|---|---|
| ○ Term 10 CI – 4 conditions | $ _____ | ○ Term 10 CI – 25 conditions | $ _____ |
| ○ Term 20 CI – 4 conditions | $ _____ | ○ Term 20 CI – 25 conditions | $ _____ |
| ○ Term to age 65 CI – 4 conditions | $ _____ | ○ Term to age 65 CI – 25 conditions | $ _____ |

***The Critical Illness Benefit applied for cannot exceed the total life insurance face amount applied for.**
†**Only enter the additional coverage/benefit being requested.**

☐ **CRITICAL ILLNESS PROTECTION**

| **Additional coverage** | Benefit† | | Benefit† |
|---|---|---|---|
| ○ Term 10 CI – 4 conditions | $ _____ | ○ Term 10 CI – 25 conditions | $ _____ |
| ○ Term 20 CI – 4 conditions | $ _____ | ○ Term 20 CI – 25 conditions | $ _____ |
| ○ Term to age 65 CI – 4 conditions | $ _____ | ○ Term to age 65 CI – 25 conditions | $ _____ |

†**Only enter the additional coverage/benefit being requested.**

Early Detection Benefit and Childhood Critical Illness Covered Conditions are only available with the 25 conditions critical illness protection products.

**Note on beneficiary designations:** For critical illness, the Critical Illness Benefit and Early Detection Benefit Beneficiary will be the Insured. If the Insured is a minor, the beneficiary will be the Owner, if living, or the Owner's estate, if deceased.

Return of Premium on Death proceeds will be payable to the Owner, if living, or the Owner's estate, if deceased. If you wish to designate other beneficiaries for critical illness, complete the ***Change of Beneficiary form (PS367)***.

## 18 Other changes or remarks

Current policy number: _____

# Insurance history

***Complete the Insurance history, Personal history and Health history section only when requesting the following changes: additions, replacements, reinstatements and conversions requiring underwriting.***

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**19** a) Do you have any insurance in force or pending: life insurance, critical illness, disability, long-term care with ivari or any other company? If ***"yes",*** complete the table below. . . . . ○ Yes ○ No

| COMPANY | AMOUNT OF INSURANCE | TYPE OF INSURANCE PLAN | | | | PERSONAL/ BUSINESS | | ISSUE YEAR | IN FORCE | PENDING | REPLACING | NAME OF NEW REPLACING COMPANY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | LIFE | CI | DI | LTC | P | B | | | | | |
| | $ | ○ | ○ | ○ | ○ | ○ | ○ | | ○ | ○ | □ | |
| | $ | ○ | ○ | ○ | ○ | ○ | ○ | | ○ | ○ | □ | |
| | $ | ○ | ○ | ○ | ○ | ○ | ○ | | ○ | ○ | □ | |
| | $ | ○ | ○ | ○ | ○ | ○ | ○ | | ○ | ○ | □ | |
| | $ | ○ | ○ | ○ | ○ | ○ | ○ | | ○ | ○ | □ | |

**NOTE: If replacing an ivari policy attach a completed Life Insurance Replacement Disclosure (LIRD), where applicable, or Replacement/Comparison Disclosure form.**

b) Is the insurance applied for in this application replacing an existing ivari policy/coverage? . . . . . ○ Yes ○ No

If ***"yes",*** provide policy number(s) _____

Does the Owner instruct ivari to cancel the above stated policy/coverage only when the new policy being applied for is in force? . . . . . ○ Yes ○ No

*(The premium under the existing policy is required until this new policy is in force. Failure to do so may result in a lapse/termination of insurance coverage and may result in the inability to offer a reinstatement.)*

c) Has any application, reinstatement, modification for life, critical illness, long-term care, or disability insurance ever been rated, declined, postponed, cancelled, rescinded or modified in any way? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

| COMPANY | DATE (MM/YYYY) | DETAILS |
|---|---|---|
| | | |
| | | |
| | | |

# Personal history

## INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**For Insureds 16 years of age or greater, complete questions 20 a) – f).**
**If additional space is required, please provide answers in the "Remarks section".**

**20** a) Have you ever smoked or used cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts, traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe, Pipe, chewing tobacco or any other smoking cessation products, or used tobacco in any other form? ○ Yes ○ No

If ***"yes",*** complete the following.

Have you smoked/used in the last 12 months? ○ Yes ○ No

Have you smoked/used in the last 24 months? ○ Yes ○ No

| PRODUCTS | QUANTITY | FREQUENCY | DATE LAST USED (DD/MM/YYYY) |
|---|---|---|---|
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |

b) Have you ever used marijuana or cannabis/cannabinoids products in any form? ○ Yes ○ No

If ***"yes",*** in what form and on average, what is the quantity you typically consume.

| FORM OF CONSUMPTION | FREQUENCY | QUANTITY (MEASUREMENT) | QUANTITY (AMOUNT) | DATE LAST USED (DD/MM/YYYY) |
|---|---|---|---|---|
| | ○ Day ○ Week ○ Month ○ Year ○ Single use | | | |
| | ○ Day ○ Week ○ Month ○ Year ○ Single use | | | |
| | ○ Day ○ Week ○ Month ○ Year ○ Single use | | | |

i) Do you mix the marijuana or cannabis with tobacco? ○ Yes ○ No

ii) Is your usage for medicinal purposes? ○ Yes ○ No

If ***"yes",***

What condition is being treated? _____

Is it physician prescribed? ○ Yes ○ No

Name of physician: _____

c) Are you currently or have you ever used any drugs such as amphetamines (ecstasy, speed), cocaine, hallucinogens (acid, LSD), opiates (heroin, morphine) anabolic steroids or any other type not previously mentioned, other than marijuana or cannabis/cannabinoids? ○ Yes ○ No

| TYPE | QUANTITY | FREQUENCY | DATE LAST USED (DD/MM/YYYY) |
|---|---|---|---|
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |
| | | ○ Day ○ Week ○ Month ○ Year ○ Single use | |

Have you ever received or been advised to receive, counselling or treatment for drug usage? ○ Yes ○ No

If ***"yes",*** provide date of treatment: (DD/MM/YYYY) _____

## Personal history *(continued)*

### INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**If additional space is required, please provide answers in the "Remarks section".**

d) Do you currently consume or ever consumed alcohol such as Beer, Wine or Liquor? . . . . . ○ Yes ○ No

If ***"yes",*** complete questions i), ii) and iii).

i) On average, how many alcoholic drinks do you typically consume? . . . . . ○ Yes ○ No

| TYPE | QUANTITY (MEASUREMENT) | QUANTITY (AMOUNT) | FREQUENCY |
|---|---|---|---|
| | | | ○ Day ○ Week ○ Month ○ Year ○ Single use |
| | | | ○ Day ○ Week ○ Month ○ Year ○ Single use |
| | | | ○ Day ○ Week ○ Month ○ Year ○ Single use |

ii) Have you reduced your alcohol consumption?. . . . . ○ Yes ○ No

If ***"yes",*** provide details and date of reduction

iii) Have you ever asked for, received, been advised to receive counselling or treatment for alcohol consumption? ○ Yes ○ No

If ***"yes",*** complete table below.

| DATE OF TREATMENT (DD/MM/YYYY) | DURATION OF TREATMENT | FOLLOW-UP NEEDED |
|---|---|---|
| | | |
| | | |
| | | |

### DRIVING HISTORY

e) i) In the last 2 years have you had speeding violations more than 30km over speed limit, at fault accident(s), hit and run, impaired driving (Alcohol or Marijuana), driving with a suspended license or reckless driving? ○ Yes ○ No

ii) In the last 2 years have you had more than 2 driving violations such as speeding less than 30km over the speed limit or careless driving such as cell phone use, stop sign violation, improper turn, improper passing, failure to yield, distracted driving, no seatbelt or other violations not mentioned?. . . . . ○ Yes ○ No

If ***"yes",*** to questions i) or ii), complete table below:

| VIOLATION | DATE (DD/MM/YYYY) | DETAILS |
|---|---|---|
| | | |
| | | |
| | | |

## Personal history *(continued)*

### INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

### OFFENCE HISTORY

f) i) In the last 10 years, have you been charged or convicted of any of the following any criminal offence such as assault, theft, fraud, robbery, financial crime (money laundering, tax evasion, conspiracy), drug possession, forgery, burglary or other offenses? ○ Yes ○ No

ii) Do you have any charges currently pending? ○ Yes ○ No

iii) In the last 10 years, have you had your driver's licence suspended or revoked? ○ Yes ○ No

If ***"yes",*** to questions i), ii) or iii), complete table below:

| DATE (DD/MM/YYYY) | STATUS | DURATION | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**For Insureds of all ages complete questions g) to i).**
**If additional space is required, please provide answers in the "Remarks section".**

### TRAVEL

g) With the exception of travelling 6 months or less per year within North America, the Caribbean or European Union countries, do you have any plans to travel or reside outside of Canada in the next 12 months? ○ Yes ○ No

If ***"yes",*** complete table below.

| CITY | COUNTRY | PURPOSE OF TRAVEL | LENGTH OF STAY | # OF TIMES PER YEAR |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### AVOCATION/SPORTS

h) In the last 12 months, have you piloted an aircraft other than with a commercial/major airline carrier, or do you intend to do so in the next 12 months? ○ Yes ○ No

i) In the last 12 months, have you engaged in any hazardous or extreme sports including, but not limited to, mixed martial arts, combat sports, ski jumping, bungee jumping, base jumping, motorized vehicle racing, cliff diving, scuba diving, sky diving, parachuting, sky surfing, hang-gliding and mountain climbing, out of bound snowmobiling, out of bound skiing, other non-ordinary sports or do you intend to do so in the next 12 months? ○ Yes ○ No

If ***"yes",*** indicate the activity and provide as much details a possible such as start date, end date, if no longer participating, locations, frequency, type and characteristics, accidents, injuries along with any other pertinent information pertaining to the activity otherwise additional questionnaires will be required.

# Health history

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**INSTRUCTIONS:** When answering the health questions, you are required to provide ivari with true and complete information. **DO NOT** provide or disclose information about *any genetic tests you have taken or plan to take. A genetic test is a type of medical test which analyzes DNA, RNA, or chromosomes. You must, however, provide information about all other types of medical tests.*

**For Insureds of all ages. *All questions must be answered.***
**If additional space is required, please provide answers in the "Remarks section".**

**21** a) Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

In the last 12 months have you lost more than 10 lbs./5kg ..... ○ Yes ○ No
(excluding weight loss following childbirth)

If ***"yes",*** i) Weight loss in: _____ lbs. or _____ kg

ii) Provide reason for weight loss: ○ Diet/Exercise ○ Medical condition

If medical condition, provide details: _____

_____

_____

b) Do you have a family doctor or clinic/health care facility that you use regularly? ..... ○ Yes ○ No

If ***"yes",*** provide the name of the doctor and the name of the clinic or health care facility:

Name of doctor/clinic: _____

Address: _____

Date of last visit with your family doctor or clinic/health care facility ***(If unknown leave blank)***: (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? .... ○ Yes ○ No

If ***"yes",*** provide details: _____

_____

c) Are you using any medications or supplements not previously disclosed? ..... ○ Yes ○ No

If ***"yes",*** complete table below:

| MEDICATION | DOSAGE | REASON FOR MEDICATION | PRESCRIBING PHYSICIAN, IF DIFFERENT FROM YOUR FAMILY DOCTOR (NAME/ADDRESS/PHONE) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

d) Are you under medical investigation, awaiting test results or advised to undergo a diagnostic test that has not yet been performed or for which you have not yet received the results? ..... ○ Yes ○ No

If ***"yes",*** provide details: _____

_____

_____

## Health history *(continued)*

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**If additional space is required, please provide answers in the "Remarks section".**

e) In the past 3 three years (Other than requested by a governmental screening program, including immigration tests), have you undergone any diagnostic test including but not limited to: ultrasound, stress electrocardiogram, CT scan, Magnetic Resonance Imaging (MRI), biopsy, mammogram, colonoscopy, PSA testing, coronary calcium scan or any other diagnostic test? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

| DIAGNOSTIC TEST | DATE (DD/MM/YYYY) | AREA/LOCATION (BODY PART SUCH AS STOMACH, KNEE, BRAIN ETC) | DETAILS (SUCH AS DIAGNOSIS, TREATMENT, MEDICATION, COMPLICATION, FOLLOW-UP ETC) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

f) Do you have any symptoms/pain or complaints such as or related to abdominal pain, weakness, dizziness, fatigue or unspecified pain for which you have not yet consulted a doctor or sought treatment? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

| SYMPTOMS | OTHER | DATE OF FIRST OCCURRENCE (DD/MM/YYYY) | DATE OF LAST OCCURRENCE (DD/MM/YYYY) | DETAILS/TREATMENT |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

g) Do you plan to consult a physician or other health professional or undergo an operation in the near future? . . . ○ Yes ○ No

If ***"yes",*** provide details: _____

# Health questions

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**22** a) **Elevated blood pressure:** Have you ever had, or ever been told you had, or received treatment or advice for elevated blood pressure? ○ Yes ○ No

If ***"yes",*** provide details:

i. Date of diagnosis: (MM/YYYY) _____

ii. Treatment: ○ Diet ○ Exercise

iii. Medication Name(s) and dosage: _____

Has your medication or dosage changed in the last year? ○ Yes ○ No

iv. Was your last reading reported as normal? ○ Yes ○ No

v. How often do you see a doctor for your condition? ○ Monthly ○ Annually ○ On Occasion ○ Never

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

b) **Cholesterol:** Have you ever had, or ever been told you had, or received treatment or advice for cholesterol? ○ Yes ○ No

If ***"yes",*** provide details:

i. Date of diagnosis: (MM/YYYY) _____

ii. Treatment: ○ Diet ○ Exercise

iii. Medication Name(s) and dosage: _____

Has your medication or dosage change in the last year? ○ Yes ○ No

iv. Was your last reading reported as normal? ○ Yes ○ No

v. How often do you see a doctor for your condition? ○ Monthly ○ Annually ○ On Occasion ○ Never

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

c) **Heart Condition:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for heart attack, angina, coronary heart disease, irregular heartbeat, palpitation, arrhythmia, heart murmur, valve disease, peripheral vascular disease, cerebrovascular disorder, stroke, transient ischemic attack, aneurysm, blood clot, thrombosis, congestive heart failure, inflammatory heart disease, cardiomyopathy, any other disease or disorder of the heart, blood vessels or circulatory system? ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Heart attack ☐ Angina ☐ Coronary heart disease ☐ Irregular heartbeat
☐ Arrhythmia ☐ Heart murmur ☐ Valve disease ☐ Peripheral vascular disease
☐ Stroke ☐ Transient ischemic attack ☐ Aneurysm ☐ Blood clot
☐ Congestive heart ☐ Inflammatory heart disease ☐ Cardiomyopathy ☐ Palpitation
☐ Cerebrovascular disorder ☐ Thrombosis
☐ Any other disease or disorder of the heart, blood vessels or circulatory system

## Health questions *(continued)*

### INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

d) **Cancer, Tumour or Growths:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for your prostate, breast, colon, kidney, lung, liver, ovary, pancreas, skin, thyroid, uterus, bladder, leukemia, melanoma, a mass, benign lesion or growth, tumours, cyst, nodule, Hodgkin or Non-Hodgkin lymphoma, polyp, lesion or any other cancer/tumour/growths? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

| | | | | |
|---|---|---|---|---|
| ☐ Prostate | ☐ Breast | ☐ Colon | ☐ Kidney | ☐ Lung |
| ☐ Liver | ☐ Ovary | ☐ Pancreas | ☐ Skin | ☐ Thyroid |
| ☐ Uterine | ☐ Bladder | ☐ Leukemia | ☐ Melanoma | ☐ Mass |
| ☐ Benign lesion or growth | ☐ Tumours | ☐ Cyst | ☐ Nodule | ☐ Lesion |
| ☐ Polyp | ☐ Hodgkin or non-hodgkin lymphoma | | | |
| ☐ Any other growth conditions | | | | |

### BLOOD, GLANDULAR OR ENDOCRINE CONDITIONS

e) **Diabetes:** Have you ever had, or ever been told you had, or received treatment or advice for Type 1 or Type 2 diabetes, diabetes mellitus, impaired glucose tolerance, gestational diabetes, or other types? ..... ○ Yes ○ No

If ***"yes",*** provide details:

i. Which of the following currently represents your condition?
- ○ Type 1 (juvenile or insulin-dependent diabetes)
- ○ Type 2 (adult on-set)
- ○ Impaired glucose intolerance or pre-diabetes
- ○ Unknown/other type of diabetes
- ○ Gestational diabetes: ○ History or ○ Current: Are you currently pregnant? ..... ○ Yes ○ No

ii. Date of diagnosis: (MM/YYYY) _____

iii. What is the type of treatment for your diabetes: ○ Diet ○ Oral medication ○ Insulin ○ None

iv. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

v. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

## Health questions *(continued)*

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

f) **Thyroid Disorder:** Have you ever had, or ever been told you had, or received treatment or advice for thyroid disorder? ○ Yes ○ No

If ***"yes",*** provide details:

i. Do you know which diagnosis was made? ○ Yes ○ No

If ***"yes",*** ○ Hypothyroidism ○ Hyperthyroidism ○ Goiter ○ Other _____

ii. Date of diagnosis: (MM/YYYY) _____

iii. Have you had any treatments, medications, surgery or investigation for your condition? ○ Yes ○ No

If ***"yes",*** provide details such as date, surgery, lesion excised, medication, dosage, duration, frequency, follow-ups or other investigations:

_____

_____

iv. Was Malignancy excluded? ○ Yes ○ No

If ***"no",*** provide details: _____

_____

_____

v. Is the condition under control? ○ Yes ○ No

If ***"yes",*** since when? (MM/YYYY) _____

If ***"no",*** provide details about your condition: _____

_____

_____

vi. Have you been hospitalized because of this condition? ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

vii. Do you have symptoms, complication or are you off work/disabled due to your condition? ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

## Health questions *(continued)*

### INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

g) **Anemia Disorder:** Have you ever had, or ever been told you had, or received treatment or advice for anemia disorder? ..... ○ Yes ○ No

If ***"yes",*** provide details:

i. Your condition: _____

ii. Date of diagnosis: (MM/YYYY) _____

iii. Have you had any treatments, medications, surgery or investigation for your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details such as date, medication, dosage, duration, frequency, follow-ups or other investigations:

_____

_____

iv. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

v. Are you fully recovered from this condition? ..... ○ Yes ○ No

If ***"yes",*** since when? (MM/YYYY) _____

If ***"no",*** provide details about your condition: _____

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

### OTHER BLOOD, GLANDULAR OR ENDOCRINE CONDITIONS

h) Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Coagulation defect, Pro-coagulant, Thalassemia, Idiopathic thrombocytopenic purpura or any other conditions? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Coagulation defect ☐ Pro-coagulant ☐ Thalassemia ☐ Idiopathic thrombocytopenic purpura
☐ Any other blood, glandular or endocrine conditions

i) **Mental Health Condition:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for mood disorder, depression, adjustment disorder, stress, psychosis, bipolar, personality disorder, generalized anxiety disorder, eating disorder, schizophrenia, had any suicide attempts, any suicide thoughts or ideas, other mental or mood disorder? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Mood disorder ☐ Depression ☐ Adjustment disorder
☐ Bipolar ☐ Personality disorder ☐ Generalized anxiety disorder
☐ Psychosis ☐ Schizophrenia ☐ Had any suicide attempts
☐ Stress ☐ Eating disorder ☐ Any suicide thoughts or ideas
☐ Other mental or mood disorder

j) **Attention deficit disorder:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Concentration Disorder or any other Hyperactivity condition? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Attention deficit disorder (ADD) ☐ Concentration disorder ☐ Attention deficit hyperactivity disorder (ADHD)
☐ Other hyperactivity condition

## Health questions *(continued)*

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

**EYES, EARS, NOSE, THROAT, LUNG, RESPIRATORY CONDITION**

k) **Asthma:** Have you ever had, or ever been told you had, or received treatment or advice for Asthma? ..... ○ Yes ○ No

i. Date of diagnosis: (MM/YYYY) _____

ii. How many times do you experience symptoms? ○ Daily ○ Weekly ○ Monthly ○ Occasionally

iii. Date of last attack or symptoms: (MM/YYYY) _____

iv. Provide name of medication and dosage: _____

v. Have you had any exams or tests for you condition? ..... ○ Yes ○ No

If ***"yes",*** provide details, such as type of exams/test, results, dates, follow-up and other investigations:

vi. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

vii. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

**OTHER EYES, EARS, NOSE, THROAT, LUNGS, RESPIRATORY SYSTEM**

l) Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for sleep apnea, blindness, deafness, nose, throat, lung, pneumothorax, sarcoidosis, cystic lung disease, abscess of the lung, pulmonary fibrosis, bronchiectasis, Chronic Obstructive Pulmonary Disorder (COPD) or any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Sleep apnea ☐ Blindness ☐ Deafness
☐ Lung ☐ Pneumothorax ☐ Sarcoidosis
☐ Pulmonary fibrosis ☐ Bronchiectasis ☐ Nose
☐ Throat ☐ Abscess of the lung ☐ Cystic lung disease
☐ Chronic obstructive pulmonary disorder (COPD)
☐ Any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system

m) **Back, muscles and bones disorders:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for back disorder, lower back injury (partial), herniated disk, arthritis, rheumatoid condition, amputation, any other bones, muscles or back conditions? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Back disorder ☐ Lower back injury (partial) ☐ Arthritis
☐ Amputation ☐ Herniated disk ☐ Rheumatoid condition
☐ Any other bones, muscles or back conditions

## Health questions *(continued)*

**INSURED**

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

n) **Gastrointestinal conditions:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for ulcerative colitis, Crohn's disease, pancreatitis, liver disorder, hepatitis, fatty liver, alcoholic liver disease, non-alcoholic liver disease, cirrhosis, Barrett's esophagus, intestinal problems or any other gastrointestinal conditions? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Ulcerative colitis ☐ Crohn's disease ☐ Pancreatitis ☐ Liver disorder
☐ Hepatitis ☐ Fatty liver ☐ Alcoholic liver disease ☐ Non-alcoholic liver disease
☐ Cirrhosis ☐ Barrett's esophagus ☐ Intestinal problem
☐ Any other gastrointestinal conditions

o) **Kidney, bladder, and reproductive organs:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for your kidney, renal failure, chronic kidney failure disease, nephritis, kidney stone, urinary track disorder, your bladder, blood in the urine, abnormality in the urine, abnormal protein levels, sexually transmitted disease, female organ problems/disorders, abnormal pap, male genital organ problems/disorders, prostate, abnormal PSA (Prostatic Specific Antigen) levels, any other disease or disorder of the kidney, bladder and reproductive organs? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Kidney ☐ Abnormality in the urine ☐ Nephritis ☐ Chronic kidney failure disease
☐ Kidney stone ☐ Urinary track disorder ☐ Bladder ☐ Sexually transmitted disease
☐ Renal failure ☐ Abnormal protein levels ☐ Blood in the urine ☐ Female organs problem/disorders
☐ Abnormal pap ☐ Male genital organs problem/disorder ☐ Prostate
☐ Abnormal PSA (prostatic specific antigen) levels
☐ Any other disease or disorder of the kidney, bladder and reproductive organs

p) **Neurological condition and brain disorders:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Alzheimer's Disease, autism spectrum disorder, cerebral palsy, epilepsy, seizure, cognitive or developmental disorder, down syndrome (trisomy 21 syndrome), multiple sclerosis, Parkinson's Disease, chronic headaches, head or brain injuries, muscular dystrophy, meningitis, paralysis, neuritis, neuropathy, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's disease), lesion or any other disease or disorder of the brain or the nervous system? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Alzheimer's disease ☐ Autism spectrum disorder ☐ Cerebral palsy ☐ Epilepsy
☐ Cognitive or developmental disorder ☐ Muscular dystrophy ☐ Multiple sclerosis ☐ Parkinson disease
☐ Head or brain injuries ☐ Motor neuron disease ☐ Meningitis ☐ Paralysis
☐ Neuropathy ☐ Chronic headaches ☐ Lesions ☐ Seizure
☐ Down syndrome (trisomy 21 syndrome) ☐ Neuritis
☐ Amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease)
☐ Any other disease or disorder of the brain or the nervous system

q) **Immune system:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for immune deficiency syndrome, Lupus, AIDS, Scleroderma, test results indicating exposure to the HIV virus, any other disease or disorder of the immune system ? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Immune deficiency syndrome ☐ Lupus
☐ Test results indicating exposure to the HIV virus ☐ AIDS
☐ Any other disease or disorder of the immune system ☐ Scleroderma

## Health questions *(continued)*

### INSURED

| Name | Date of birth: (DD/MM/YYYY) |
|---|---|
| | |

### ADDITIONAL MEDICAL HISTORY

r) Have you ever had or ever been told you had, any disease, condition, abnormality or hereditary disorder not already mentioned? ○ Yes ○ No

If ***"yes",*** provide details _____

s) Are you consulting or have to consult any doctor other than already mentioned or your family doctor or clinic/ health care facility previously noted? ○ Yes ○ No

If ***"yes",*** provide details _____

# Family history

**23** Has any family member (whether living or deceased) ever suffered from, or currently has: polycystic kidney disease, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), heart disease, stroke, cancer (specify type), diabetes, kidney disease, heart attack, multiple sclerosis, Alzheimer's Disease or Parkinson's or any hereditary disorder? ○ Yes ○ No

If ***"yes",*** complete the table below.

| FAMILY MEMBER | CONDITION | AGE AT ONSET | AGE IF LIVING | AGE AT DEATH | CAUSE OF DEATH |
|---|---|---|---|---|---|
| | | | | | |
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# Remarks section

Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

| QUESTION # | NAME OF INSURED | DETAILS (Provide dates, diagnosis, results of investigations, names of medical advisors, medfacilities and treatment.) |
|---|---|---|
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# Children's Insurance Rider

**INSTRUCTIONS** ***Complete this section on behalf of a child applying for a Children's Insurance Rider who is between 15 days and up to and including age 18.***

**24** a) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

b) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

c) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

d) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

## Children's Insurance Rider *(continued)*

**Refer to children named in question 24**

If ***"yes,"*** to any question(s), identify the child and provide additional information in the **"Remarks section".**

| | | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|---|
| | | YES | NO | YES | NO | YES | NO | YES | NO |
| **25** | Has there ever been an application for life or critical illness insurance on any of these children that was declined, postponed, offered with restrictions or modified with a rating in any way? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **26** | Has any child to be insured ever had any illness, impairment or injury that required treatment, surgery or hospitalization? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **27** | Was any child to be insured born prematurely? If ***"yes,"*** provide birth weight in the **"Remarks section"** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **28** | Has any child to be insured consulted, or been treated by, any physician or other practitioner for any known or suspected heart problem, cancer, mental impairment or acquired immunodeficiency syndrome or ever tested positive for HIV or exhibited any delay in physical or mental development? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **29** | Has any child to be insured been prescribed any medication or had or been advised to have any treatment or diagnostic test, whether or not completed? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **30** | Is any child to be insured not a legal child or a child of the Insured(s) whose legal adoption has not yet been made final? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **31** | Are there any other health issues not described above? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**32** Are there any children on whom coverage is not being requested? ○ Yes ○ No
If ***"yes,"*** provide details.

## Grouped Policies

**INSTRUCTIONS**

If you wish to have this policy issued on the same day as another policy or policies for families, partnership or other business reasons, please give the names of the other Insured(s) below:

- **Not applicable to any policy with a Critical Illness Protection Rider or any Critical Illness Protection policy**
- **Policy will not be held from issue beyond 30 days from approval.**

Group with:

_____ _____ or _____
*(First name)* *(Last name)* *(Policy number)*

_____ _____ or _____
*(First name)* *(Last name)* *(Policy number)*

## Disclosures – Important information about ivari's policies

**VARIABILITY OF UNIVERSAL LIFE POLICY PERFORMANCE**

There are many variables that can affect an insurance policy's performance. Interest rates and the performance of the securities markets, in particular, can fluctuate significantly and can have a negative or a positive impact on the policy's non-guaranteed benefits and values.

The benefits and values outlined in the illustration are not guaranteed, as they are based on assumptions that are subject to change. They are neither an estimate nor a guarantee of future policy performance.

**EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS PROTECTION**

Any Critical Illness Benefit, if applied for, contains exclusions, a survival period and a moratorium period. Refer to your policy wording for details.

**ADVISOR COMPENSATION**

This application deals with an insurance product supplied, underwritten, and issued by ivari, a company licensed to offer insurance products in all provinces and territories in Canada. The independent insurance advisor/distributor soliciting this application is a licensed insurance advisor representing ivari and will receive compensation from ivari upon the completion of this transaction. The Owner(s) and Insured(s) are not obligated to transact any other business with ivari, the advisor/distributor or any other person or entity as a condition of this application.

**TAX CONSIDERATIONS (FOR OWNERS ONLY)**

Applicable tax laws and CRA interpretations may change and ivari does not guarantee the tax treatment of its products or contractual benefits under applicable laws. It is your responsibility to determine how applicable laws apply to you at any time. Please consult a qualified legal and/or tax advisor in order to obtain an opinion in relation to your particular circumstances.

Note: Effective January 1, 2017, new tax rules for life insurance policies have taken effect. If a policy was issued prior to 2017, certain changes made to an existing policy may impact its policy's tax status. Ensure you talk to your advisor to fully understand how any changes may affect your existing policy.

## Insured's direction on use and disclosure of personal information ("Insured's Direction")

As the Insured identified below, I have read and fully understand the contents of the **Privacy Notice** and ivari's Privacy Policy on ivari.ca, and I acknowledge and consent to the collection, use and disclosure of my personal information by ivari, ivari's employees, authorized representatives of ivari responsible for administering my file ("ivari"), and ivari's reinsurers.

**I specifically authorize and direct for the purposes of evaluating my insurance application and any forms submitted thereafter, administering and servicing my policy, and investigation and claim analysis:**

- any physician, other medical and health care providers and/or facilities, and related facilities, agencies and service providers, any insurance company, MIB, LLC, or any other entity or individual identified in the **Privacy Notice** or Privacy Policy that now has or may in future have any information concerning me or my health to disclose to ivari my personal information as requested by ivari; and
- an authorized representative of ivari to perform such tests, examinations, x-rays, electrocardiograms and blood or urine tests as may be required by ivari. I understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus and the presence of medications, drugs, nicotine or their metabolites, and that ivari may release the results of these tests and examinations to my personal physician(s).

In the event of my death, I grant the beneficiary(ies) under this policy the right to request and to consent on my behalf to any collection and use of my personal information by ivari and ivari's authorized representatives from third parties, for the purposes of investigating, adjudicating and processing an insurance claim.

**A copy of this authorization and direction shall be valid as the original.**

**I have reviewed and understood the "Insured's Direction" and acknowledge and agree to the terms contained therein.**

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

_____
Signature of **INSURED**
**If the Insured is a minor the signature of the parent or legal guardian who is signing the application for this child is required.**

## Declaration

By signing, I confirm that:

1. I understand the language in which this application is written, or, if I do not, the details of this application have been fully explained to me in my preferred language and are completely understood by me.
2. I have read all the questions and answers in this application, and I understand the meaning and importance of them.
3. I have reviewed and discussed with my independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my satisfaction.
4. **I certify that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief.**
5. **I agree to immediately notify ivari of any errors, omissions or changes in the information provided to ivari.**

**ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge and agree that:

1. This application consists of all preceding pages in the application, any supplement to it (if applicable), and any other declaration made in connection with this application. Together all this information will form the basis for any policy/coverage issued.
2. This application does not include any "Temporary Insurance Agreement".
3. No information acquired by any representative of ivari will be binding on ivari unless set out in writing in this application.
4. Any policy, amendment, or endorsement issued on this application will not take effect unless all the following conditions are satisfied.
   a) The full premium payment amount is received by ivari under the policy as of the date of this application.
   b) The policy is delivered to the owner during the lifetime of the Insured(s) under the policy.
   c) All statements and answers given in this application continue to be true and complete on the date of delivery of the policy.
   d) No change has taken place in the insurability of any Insured(s) between the time this application is completed and the time the policy is delivered to the owner. This is not applicable to policy conversions, and term exchanges that do not require evidence of insurability.
5. Only the president together with a vice-president or corporate secretary of ivari has the authority to bind ivari or to make any change in this application or any policy issued. ivari will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend, or modify any of the terms or provisions in this application or any policy issued. However, ivari may make certain changes to this application as provided for in your policy contract. The Owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements, or amendments.
6. If the answer to any question(s) in this application is misstated or omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
7. All premium payments must be made payable to ivari.
8. I have received and fully understand the contents of the **Advisor Compensation** under **Disclosures** where applicable.
9. As the Owner(s), I acknowledge that I have an obligation under the *Income Tax Act* and other applicable tax legislation to notify ivari of any changes in my tax residency status. I acknowledge that the information contained in this application and information regarding my policy, contract and account may be reported to Canada Revenue Agency (CRA) or other tax authorities.

**I have reviewed and understood the "Disclosures – Important information about ivari's policies" and "Declaration" in this application, and acknowledge and agree to the terms contained therein.**

I, the undersigned Irrevocable Beneficiary under the above-mentioned policy, understand that the policyholder of the said policy has submitted a request for Policy change or Conversion. I am aware of the contents associated with these forms and consent to that request.

I have reviewed and discussed with my independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my satisfaction.

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

Signature of **INSURED**
**If the Insured is a minor the signature of the parent or legal guardian who is signing the application for this child is required.**

Advisor's signature

Signature of **OWNER 1**, **if not an Insured**

Signature of **OWNER 2**, **if not an Insured**

Print name of signing officer and title, if entity owned

Print name of signing officer and title, if entity owned

Irrevocable Beneficiary

Assignee Signature **(stamp required if Assignee is a financial institution)**

***If the Owner is an entity, the signature(s), name(s) and title(s) of the authorized signing officers thereof are required, as stated in the by-laws of the entity.***

# Independent Insurance Advisor's report

Third party determination must be completed for all applications. Every reasonable effort must be made by you to determine if the Owner(s) is/are acting on behalf of a third party. The ***Proceeds of Crime (Money Laundering) and Terrorist Financing Act*** requires each Insured's identity to be verified by referring to certain documents. The law also requires the existence of third parties, if any, to be determined and recorded.

When asked whether the Owner(s) is/are acting on behalf of a third party, the individual submitting the application answered:

○ No

○ Yes, complete and submit the ***Identity and Third Party Determination form (IP-LP782)***

○ Unable to determine; however, I have reasonable grounds to suspect there is a third party.

Provide details (attach separate page if necessary):

_____

_____

1. Applications should be completed, in person, with the client. Have you completed the application in the presence of all Insured(s)/ Owner(s)? (Video Conferencing is not considered in person).

   Advisor 1: ○ Yes ○ No If ***"no",*** explain why: _____

   Advisor 2: ○ Yes ○ No If ***"no",*** explain why: _____

   Advisor 3: ○ Yes ○ No If ***"no",*** explain why: _____

2. Is any advisor, the Insured, Owner, Beneficiary or Payor on this policy?

   Advisor 1: ○ Yes ○ No

   Advisor 2: ○ Yes ○ No

   Advisor 3: ○ Yes ○ No

3. Does any advisor have a relationship* with any Insured, Owner, Beneficiary or Payor?

   *A "relationship" includes family relationships (by blood, marriage or adoption), friendships, creditor relationships, and relationships involving financial dependency on the advisor, or relationships involving a corporation owned and/or controlled by the advisor and/or an advisor's family member.

   Advisor 1: ○ Yes ○ No If ***"yes",*** provide details: _____

   Advisor 2: ○ Yes ○ No If ***"yes",*** provide details: _____

   Advisor 3: ○ Yes ○ No If ***"yes",*** provide details: _____

4. By signing below, I acknowledge that I have disclosed, in writing, maintained in the client's file, where applicable, the following items to the Owner(s) of the policy resulting from this application:

   a) The company or companies I represent;

   b) That I will receive compensation in the form of bonuses *(such as commissions or a salary)*; and

   c) That I have disclosed any conflicts of interest that I may have with respect to this transaction.

   d) I attest that I have followed the ivari Code of Ethical Market Conduct in all aspects of this sale of insurance.

   e) That I am licensed in the province where the Owner resides.

   f) That I have disclosed the nature of relationship with company(ies) represented

   g) That I have disclosed that the consumer has the right to ask for more information

**Advisor's notes:** Do you have any knowledge of each Insured's personal habits, health, avocations, finances, or reputation that might affect the underwriting risk? If so, give details below.

_____

_____

_____

Advisor's email address: _____

**I hereby declare** that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief, and that I am not aware of additional information material to the Insured(s) except as stated in any advisor's notes. When applicable, I have verified the identity of the individuals who submitted the application by referring to the original, non-expired documents. I confirm that the information recorded was correctly copied from such document(s). Reasonable effort has also been exercised to determine if the Owner(s) is/are acting on behalf of a third party.

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

_____ _____
Signature of advisor Name of advisor

***The individual who wrote this application must be listed below as either Advisor 1, 2 or 3 and MUST have his/her own advisor code.***

Distributor name : _____ Code: _____

Advisor name (1): _____ Advisor code: _____ Share %: _____

Advisor name (2): _____ Advisor code: _____ Share %: _____

Advisor name (3): _____ Advisor code: _____ Share %: _____

**If shared, who is the servicing advisor?** ◯ **Advisor 1** ◯ **Advisor 2** ◯ **Advisor 3**