

# Declaration of insurability



Check the appropriate box according to the type of coverage you wish to change or add.

**In all cases, complete sections A, B, C, D, H, I, J and K as well as sections indicated at right.**

For Policy Number(s):		<b>Complete sections</b>
<b>Adult Coverages</b>		
<input type="checkbox"/> Reinstatement		
<input type="checkbox"/> Renewal of 5 year Renewable and Convertible Term		
<input type="checkbox"/> Change to Non-Smoker rates		
<input type="checkbox"/> Review of Rating		<b>E2, E3, E4, E5, F</b>
<input type="checkbox"/> Other (Specify)		
<b>Children's Coverages</b>		<b>Complete sections</b>
<input type="checkbox"/> Reinstatement of Child's Life Coverage		<b>E2 (questions 4, 5, 6), F</b>
<input type="checkbox"/> Reinstatement of Child's Critical Illness		<b>E2 (questions 4, 5, 6), F, G</b>
<input type="checkbox"/> Addition of Children's Protection Rider ( <input type="checkbox"/> Regular <input type="checkbox"/> Enhanced)		<b>E1</b>
<input type="checkbox"/> Addition of Child to Existing Children's Protection Rider		

## A - Policy information

Life Insured A		Life Insured B	
First Name	Last name	First Name	Last name
Occupation	Date of Birth (DD/MM/YYYY)	Occupation	Date of Birth (DD/MM/YYYY)
Present Address		Present Address	
City, province	Postal Code	City, province	Postal Code
Owner(s) <input type="checkbox"/> Life Insured A OR <input type="checkbox"/> Life Insured B OR <input type="checkbox"/> Life Insured A & B Jointly OR			
Relationship to Life Insured			
First Name	Middle Initial	Last Name	Occupation
Present Address (street, city, province)		Postal Code	Date of Birth (DD/MM/YYYY)
First Name	Middle Initial	Last Name	Occupation
Present Address (street, city, province)		Postal Code	Date of Birth (DD/MM/YYYY)
Billing/Communication Address (if different from Owner's): <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Other (Specify)			
First Name	Middle Initial	Last Name	Occupation
Present Address (street, city, province)		Postal Code	

## B – Insurance History Questions

To be completed by all proposed life insureds specified in Section A.

For life insurance, if a Proposed Insured has applied for other insurance in the last 12 months with Standard Life or with another Insurance Company, the total sum insured applied for during this period will be added together to determine the necessary underwriting requirements.

## B - Information regarding proposed insured(s) and owner

Option a,b,c,d,e,f	Type of insurance	Amount	Accidental death benefit amount	Company	Date issued (dd/mm/yyyy)	Purpose
		\$				<input type="checkbox"/> Business <input type="checkbox"/> Personal
		\$				<input type="checkbox"/> Business <input type="checkbox"/> Personal
		\$				<input type="checkbox"/> Business <input type="checkbox"/> Personal
		\$				<input type="checkbox"/> Business <input type="checkbox"/> Personal

### C - Personal physician

To be completed for all Insureds, including children.

Indicate the name and address of your personal physician, the reason and date last seen, and the results including any recommended treatment or referral.

Proposed Insured 1		Proposed Insured 2	
Name of doctor		Name of doctor	
Address		Address	
Telephone Number	Date last seen (DD/MM/YYYY)	Telephone Number	Date last seen (DD/MM/YYYY)
Reason		Reason	
Results including recommended treatment or referral		Results including recommended treatment or referral	

### D - Family history

To be completed for each Insured, including children.

Circle all applicable disorders.

Proposed Insured 1	Mother		Father		Brother(s)		Sister(s)	
a. Indicate number of brothers and sisters								
b. Indicate state of health if living of each family member								
c. Indicate how many family members and the age at which any family member has been diagnosed with and/or died from any of the following:	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed
Diabetes								
Stroke								
Brain aneurysm								
Motor Neurone Disease including ALS (Amyotrophic lateral sclerosis i.e. ALS or Lou Gehrig's disease) and muscular dystrophy								
Multiple Sclerosis								
Alzheimer's Disease								
Parkinson's Disease								
Huntington's chorea								
Polycystic kidney								
Other Kidney disorder								
Hyperlipidemia or "high cholesterol", high blood pressure								
Heart attack, angina								
Any other heart or circulatory problem								
Colon polyps								
Cancer or any tumor (specify type and whether malignant or benign)								
Cystic fibrosis								
Autism								
Other:								
Proposed Insured 2	Mother		Father		Brother(s)		Sister(s)	
a. Indicate number of brothers and sisters								
b. Indicate state of health if living of each family member								
c. Indicate how many family members and the age at which any family member has been diagnosed with and/or died from any of the following:	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed	Age at Death	Age Diagnosed
Diabetes								
Stroke								
Brain aneurysm								
Motor Neurone Disease including ALS (Amyotrophic lateral sclerosis i.e. ALS or Lou Gehrig's disease) and muscular dystrophy								
Multiple Sclerosis								
Alzheimer's Disease								
Parkinson's Disease								
Huntington's chorea								
Polycystic kidney								
Other Kidney disorder								
Hyperlipidemia or "high cholesterol", high blood pressure								
Heart attack, angina								
Any other heart or circulatory problem								
Colon polyps								
Cancer or any tumor (specify type and whether malignant or benign)								
Cystic fibrosis								
Autism								
Other:								

**E - Personal history**

**E1 – Children’s Personal Medical History**

ECPR/CPR only  
 To be completed for all Insureds applying for Children Protection Rider or Enhanced Children’s Protection Rider.  
 Make sure you complete section D *Family History* on page 2.  
 If you answered yes to any of the questions in Section E1 *Children’s Personal Medical History*, go to page 4+5 and complete all questions in Sections F2, F3, F4.

		Proposed Child 1			Proposed Child 2		
		ft	in.	cm	ft	in.	cm
1.	Height						
	Weight		lbs	kg		lbs	kg
	Change of weight in the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gain <input type="checkbox"/> Loss	lbs	kg	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gain <input type="checkbox"/> Loss
	Reason for change in weight						
2.	Is any child currently under treatment by medication or other means?	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.	Has any child ever had surgery or any specialized test, or is any surgery, test or investigation planned?	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.	Does any child to be covered have or had any congenital heart disease, hemophilia, physical handicaps including blindness or deafness, mental impairment including autism, cerebral palsy, developmental delay including Down’s Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		

**E2 – Have you**

Questions 1 to 6 to be completed by each insured age 16 and over.  
 Children complete questions 4, 5, 6 only.

**Check Yes or No and circle all applicable AFFIRMATIVE responses/conditions/situations and provide details for all YES answers in section G *Additional Medical & Personal History Details* on page 6.**

	Proposed Insured 1	Proposed Insured 2
1. ever been convicted of or pleaded guilty to any criminal offences or are any such charges pending (other than related to driving)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. during the past 2 years participated in or do you intend to participate in hazardous sports such as scuba diving, parachuting, motor racing, hang-gliding, bungee jumping, etc? If yes, complete hazardous activities questionnaire No. 659.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. piloted an aircraft within the past two years or do you intend to do so in the future? If yes, complete hazardous activities questionnaire No. 659.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. within the past two years travelled outside of North America or Western Europe? If yes, provide details including location, length of stay and purpose of travel.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. any intention to reside or travel outside of North America or Western Europe? If yes, provide details including location, length of stay, and purpose of travel.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. ever had an application for life, critical illness, health or disability insurance, reinstatement or change either: rated, declined, postponed, modified, or not proceeded with?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**E3 – Have you**

To be completed by each insured age 16 and over.

	Proposed insured 1	Proposed insured 2
1. in the past 5 years, been convicted of or pleaded guilty to any moving violations or been involved in an accident involving extensive damage, injuries or death or have you any such changes pending? If so, please provide details in Section I <i>Additional Medical &amp; Personal History Details</i> on page 6, including types of offenses, dates, speeds involved, as well as driver’s license No.	<input type="checkbox"/> Yes <input type="checkbox"/> No  Licence No.	<input type="checkbox"/> Yes <input type="checkbox"/> No  Licence No.
2. within the past 5 years refused a breathalyser or been convicted of or pleaded guilty to driving while impaired? If so, please provide details in Section I <i>Additional Medical &amp; Personal History Details</i> on page 6, as well as driver’s license No.	<input type="checkbox"/> Yes <input type="checkbox"/> No  Licence No.	<input type="checkbox"/> Yes <input type="checkbox"/> No  Licence No.

**E4 – Do you presently use alcoholic beverages?**

To be completed by each insured age 16 and over.

	Proposed Insured 1			Proposed Insured 2			
	<input type="checkbox"/> Yes (complete below)	<input type="checkbox"/> No		<input type="checkbox"/> Yes (complete below)	<input type="checkbox"/> No		
<b>Daily</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)	<b>Daily</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)
<b>Weekly</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)	<b>Weekly</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)
<b>Monthly</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)	<b>Monthly</b>	Wine (4 oz)	Spirits (2 oz)	Beer (8 oz)

**E5 – Smoking Habits and Use of Nicotine Products**

Indicate if you use or have used any of the following products as well as the quantity and the date last used.  
To be completed by each insured age 16 and over.

	Proposed insured 1					Proposed insured 2				
	Details Yes No	Qty	Frequency Day Month Year	Date last used (DD/MM/YYYY)	Details Yes No	Qty	Frequency Day Month Year	Date last used (DD/MM/YYYY)		
Cigarettes	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Cigarillos	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Cigars (any type)	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nicotine Patch	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nicotine Gum	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Chewing Tobacco	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pipe	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Marijuana	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Other (e.g. Betel Nuts)	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

**F - Medical questions**

**F1 – Build: What is your current height and weight?**

To be completed for each Insured except for CPR/ECPR.

	Proposed Child 1			Proposed Child 2		
	ft	in.	cm	ft	in.	cm
Height						
Weight		lbs	kg		lbs	kg
Change of weight in the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> Gain <input type="checkbox"/> No <input type="checkbox"/> Loss	lbs	kg	<input type="checkbox"/> Yes <input type="checkbox"/> Gain <input type="checkbox"/> No <input type="checkbox"/> Loss	lbs	kg
Reason for change in weight						

**F2 – Are you**

To be completed for each Insured.  
Check YES or NO, and circle all applicable (affirmative) situations/conditions/responses and provide details for all YES answers in Section I Additional Medical & Personal History Details on page 6.

	Proposed insured 1	Proposed insured 2
1. presently taking any prescribed or non-prescribed medication or have you been recommended to follow any treatment or to see another medical professional? If yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. within the past 5 years refused a breathalyser or been convicted of or pleaded guilty to driving while impaired? If so, please provide details in Section I Additional Medical & Personal History Details on page 6, as well as driver's license No.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. presently awaiting a medical consultation or any test results? If yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**F3 – Have you ever had any known indication of or been advised to seek testing, treatment or advice for any disorder of the**

To be completed for each Insured.  
Check YES or NO, and circle all applicable (affirmative) situations/conditions/responses and provide details for all YES answers in Section I Additional Medical & Personal History Details on page 6.

	Proposed Insured 1	Proposed Insured 2
1. brain or nervous system such as: dizziness or fainting spells, convulsions, epilepsy, head injury, persistent headaches, nervous breakdown, depression, burnout, paralysis, "tingling", "numbness", slurred speech, tremor, Parkinson's disease or memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. lungs or respiratory system such as: shortness of breath, persistent cough, chronic bronchitis, emphysema, asthma, pleurisy, tuberculosis or sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. heart, arteries or other parts of the circulatory system such as: chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, angina, stroke, transient ischemic attack (TIA), or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. gastrointestinal system such as: ulcer, colitis, gallstones, hepatitis including carrier state, jaundice or other disorder of the liver, pancreas, stomach, bowel or rectum?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. genital or urinary system such as: sugar, protein, albumin, pus or blood in the urine, sexually-transmitted disease, kidney stone or other disorder of the kidney, bladder, prostate, breast or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. glands including: diabetes, thyroid gland, or swollen glands or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. joints, bones, muscles or limbs such as: arthritis, rheumatism, gout, back trouble and/or disc disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. blood including anemia, leukemia or hemophilia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. immune system including any unexplained infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**F4 – Have you**

To be completed for each Insured  
Check YES or NO, and circle all applicable (affirmative) situations/conditions/responses and provide details for all YES answers in Section H *Additional Medical & Personal History Details* on page 6.

1. ever had cancer, any cyst, tumor, lump, or skin lesion?
2. within the past 5 years, had or been recommended to have any electrocardiograms, blood tests, X-Rays or other tests?
3. within the past 5 years, consulted a physician not mentioned above or been a patient in a hospital or other medical facility?
4. ever used any illegal drugs such as narcotics, amphetamines, barbiturates, cocaine, heroin, LSD, crystal meth, ecstasy, or other similar agents? If yes, complete drug-use questionnaire No. 2148.
5. ever decided or been advised to reduce your consumption of alcohol or drugs, or to seek treatment or counselling because of the use of alcohol or drugs? If yes, complete a drug-use questionnaire No. 2148 and/or an alcohol-use questionnaire No. 2149.
6. ever decided or been advised to seek treatment or counselling because of gambling activities?
7. had, been told you may have, or been advised to have tests for: AIDS (HIV), or have you received information indicating possible exposure to the AIDS (HIV) virus?
8. any symptoms not yet investigated or are there any investigations or tests pending?
9. within the past 90 days apart from normal childbirth, been admitted or advised to be admitted to a hospital or other medical facility or have you had any surgery performed or recommended?
10. ever been off work for more than 2 consecutive weeks due to an illness, disability or injury?
11. had any serious illness, surgical operation, accident or injury not mentioned above?

**Proposed Insured 1**

**Proposed Insured 2**

1.  Yes  No
2.  Yes  No
3.  Yes  No
4.  Yes  No
5.  Yes  No
6.  Yes  No
7.  Yes  No
8.  Yes  No
9.  Yes  No
10.  Yes  No
11.  Yes  No

1.  Yes  No
2.  Yes  No
3.  Yes  No
4.  Yes  No
5.  Yes  No
6.  Yes  No
7.  Yes  No
8.  Yes  No
9.  Yes  No
10.  Yes  No
11.  Yes  No

**G - Children's Critical Illness Only**

**G1**

To be completed for each child reinstating Critical Illness coverage.

Check YES or NO, and circle all applicable (affirmative) situations/conditions/responses and provide details for all YES answers in Section I *Additional Medical & Personal History Details* on page 6

1. Was any grandparent diagnosed with diabetes, heart disease, Huntington's chorea, polycystic kidneys, cancer, stroke or Alzheimer's disease? If yes, go to F2 below.
2. Has the child been diagnosed with or have any symptoms of any of the following conditions:
  - a. developmental retardation, or cystic fibrosis
  - b. neurological impairment including attention deficit disorder, autism, cerebral palsy, hyperactivity, motor neurone disease, muscular dystrophy
3. If the child's age is currently less than 1 year old, was the birth premature by more than 4 weeks?
4. What is the amount of Critical Illness coverage on the parents of each child?

**Proposed Insured 1**

**Proposed Insured 2**

1.  Yes  No
2.  Yes  No
3.  Yes  No
4.  Yes  No

1.  Yes  No
2.  Yes  No
3.  Yes  No
4.  Yes  No

	mother
	father

	mother
	father

**G2**

To be completed if question No. 1 in Section G1 is answered YES.

Proposed Child 1 - family member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death
Grandmother (paternal)					
Grandfather (paternal)					
Grandmother (maternal)					
Grandfather (maternal)					
Proposed Child 2 - family member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death
Grandmother (paternal)					
Grandfather (paternal)					
Grandmother (maternal)					
Grandfather (maternal)					



### I - Premium Payment

<b>Premium payment</b>	Selected/Premium(s) due <small>(Cheque attached)</small>	Amount \$						
<b>Future billing</b>	<input type="checkbox"/> Annual direct billing <input type="checkbox"/> Semi-annual direct billing							
<b>Pre-authorized debit</b> <small>(Please attach a specimen cheque for reinstatements or new agreements.)</small>	<input type="checkbox"/> New pre-authorized debit agreement : <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> Add to existing PAD agreement:    Policy Number _____ (DD/MM/YYYY) _____ <input type="checkbox"/> Draw Date Requested (Draw dates cannot be after the issue date or the 29 <sup>th</sup> , 30 <sup>th</sup> , or 31 <sup>st</sup> of any month.)							
<b>Banking information</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Depositor(s) (as shown on bank records)</td> <td style="width:25%;">Bank transit number</td> <td style="width:25%;">Account number</td> </tr> <tr> <td>Bank name</td> <td>Address (Street/City/Province)</td> <td>Postal code</td> </tr> </table>		Depositor(s) (as shown on bank records)	Bank transit number	Account number	Bank name	Address (Street/City/Province)	Postal code
Depositor(s) (as shown on bank records)	Bank transit number	Account number						
Bank name	Address (Street/City/Province)	Postal code						
<b>Additional information</b>	Increase PAD Withdrawal by \$ _____ <input type="checkbox"/> Loan repayment: _____ <input type="checkbox"/> CAF deposit: _____							

The re-resentation of a payment returned due to not-sufficient funds or funds not cleared can occur only once and must be within 30 days of the original debit. If the payment is returned a second time, the method of premium payment will be altered to annual, direct billing and cannot be changed until the next policy anniversary. The proportion of the annual premium calculated to the next policy anniversary becomes immediately payable. A new PAD agreement is required to return to the PAD method of payment.

### J - Declarations and Authorizations

**Each of the Undersigned:**

1. Agree that in addition to this application, a supplementary medical and lifestyle questionnaire(s) may be completed either: directly with the broker or in a TAPED telephone conversation with a medical professional, or during a visit with a medical professional. The Proposed Insureds agree that any such information will be used to consider the policy and the result of the underwriting assessment will be communicated to the broker. The Proposed Insureds agree as well to review this information upon receipt of the policy and to advise Standard Life immediately if there is any inaccurate, false information or a change in insurability between the time of application and the time of delivery which would render a policy null and void from the date of inception.
2. Understand that if any statements or answers recorded are found to be incorrect or incomplete (including, without limitation, those made for the purpose of justifying the use of non-smoker rates for a Proposed Insured), the coverage shall be null and void in respect of the Proposed Insured.
3. Authorize Standard Life, for underwriting and administration of insurance and claims paying purposes only: to gather only that information necessary for the object for the file from any person or organization that has personal information relating to him (or her) including other insurers, physicians and medical institutions, the Medical Information Bureau, investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the object of the file; to disclose only the necessary personal information relating to him (or her) to these same persons and organizations; and to request a personal investigation report relating to him (or her). This authorization is valid for the period required to achieve the ends for which it was requested. I acknowledge receipt of Medical Information Bureau notice.
4. Declare that the foregoing statements are true, complete and correctly recorded and shall form part of the application for life insurance with Standard Life or the purpose of evaluating the risk under the application for life insurance which has been made to Standard Life or for any claims purposes, the proposed insured authorizes any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, MIB Inc., or other organization, institution or person to give any information regarding him (or her) to Standard Life or its reinsurers. A photocopy of this authorization shall be as valid as the original.
5. Acknowledge that if this application is for an adult Critical Illness Insurance, the proposed insured has been made aware of the 2 Protecta products offered by Standard Life and that each covers a different number of illnesses (Protecta and Protecta Enhanced). The coverage selected herein is appropriate to him (or her) needs at this time.
6. Agree that where pre-authorized debit (PAD) withdrawals have been requested, Standard Life is authorized to make such withdrawals from the financial institution as indicated on the attached specimen cheque or any other account at any financial institution subsequently designated by him (or her). The proposed insured further authorizes such financial institution to deal with these withdrawals as though they were signed by him (or her).

It is understood and agreed that:

- I/We authorize Standard Life to begin deductions as instructed for regular recurring premium payments and regular investment plan payments. I may revoke my PAD authorization at any time by providing 10 days verbal or written notice. To obtain a cancellation form, or for more information on my right to cancel this PAD Agreement, I may contact my financial institution, Standard Life or visit [www.cdnpay.ca](http://www.cdnpay.ca). I may waive the right to receive pre-notification of the amount of the PAD and therefore agree that I do not require advance notice of the amount of PAD(s) before the debit is processed. I have certain recourse rights if any debit does not comply with this agreement. I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights. I may contact my financial institution, Standard Life or visit [www.cdnpay.ca](http://www.cdnpay.ca). If the policy is for individual coverage, then the PAD will be setup as a personal PAD and if the policy is for corporate coverage, then the PAD will be setup as a business PAD.
  - Draw dates must be between the 1<sup>st</sup> and 28<sup>th</sup> of the month. Under a Perspecta policy the Draw Date cannot be later than the Due Date.
  - If a draw date is not specified, withdrawals shall be made on the due date under the policy (Premium Due Date) and, if more than one policy is included in this Agreement, then one combined withdrawal shall be made on the earliest Premium Due Date. If the draw date is other than the Premium Due Date, the days of grace (31 days) commence from the Premium Due Date.
  - Standard Life requires at least 10 days' written or verbal notice to process any changes to this Agreement.
  - This Agreement may be terminated by either Standard Life or me upon 10 days' written or verbal notice.
  - Upon termination of this Agreement, the mode of premium payment will automatically be altered to yearly direct. If applicable, the proportionate balance of the yearly premium due to the next anniversary of each policy will become immediately payable.
  - Premium payments made under this Agreement are subject to the provisions of the policy(ies).
  - If, for any reason, a withdrawal made against my account is not honoured, Standard Life reserves the right to re-deposit NSF cheques and charge for handling these returned items.
7. Each of the proposed insureds authorizes any health care professional, hospital, public or private health or social services establishment, any insurance company, or any other institution or person that has any records or knowledge of me or my health, to provide and exchange such information or records to Standard Life's agents, distribution and marketing partners or its reinsurers.

**Minors:** A signature is required by all Life Insureds age 14 and over in the province of Quebec and age 16 and over in all other provinces.

If owned by Business/ Non Business Organization, supply signature of an authorized signing officer.

Province of Signature _____ this _____ day of _____, 20 _____	
Life Insured 1	Life Insured 2
Life Insured (minor)	Life Insured (minor)
Consenting parent/guardian (if juvenile application or any children's rider)	Owner (only required if different than proposed insured 1 or 2)
Payer (only required if different than Owner)	Owner (only required if different than proposed insured 1 or 2)

**K - Representative's Report**

K1

Name of Representative	% SPLIT	Representative Code

1. How long have you known: Life Insured A  Life Insured B  Owner

2. Are you related to any of the above?  Yes  No If "Yes" state relationship:

3. Do you know anything about the Insured(s) which might affect the risk, particularly concerning: (if "Yes" provide details)  
 a) present or past health?  Yes  No b) smoking habits?  Yes  No c) habits (drinking, drugs, etc.)?  Yes  No

4. Phone Numbers:

Life Insured A ( )	Owner ( )
Life Insured B ( )	Owner ( )

5. Details:


**K2 – Representative Signature**

1. I have ascertained the identity of the proposed Insured(s), Owner(s) and Premium Payer by examining the original and valid identification documents for each of them.  Yes  No  
 I hold a valid license in the jurisdiction where this application was signed.  Yes  No

2. **Third Party Determination:** I have made a reasonable effort to determine if the Owner(s) is acting on behalf of a third party. Will the Owner(s) be acting on behalf of a third party?  
 Yes (Complete form PC 5097)  No  
 I was unable to determine whether the Owner(s) is acting on behalf of a third party, or third parties, but I have reasonable grounds to suspect that this is the case. (Complete form PC 5097)

3. To the best of my knowledge the information supplied within this application for Insurance is accurate.

Representative's Name (in block letters)	Representative Signature	Date (DD/MM/YYYY)

**Disclosure Notice****MIB, Inc. (Medical Information Bureau)****To be handed to insured**

One of the prime objectives of Standard Life is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to ensure this low cost but also to ensure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your medical examination, if required, and any reports we may receive from doctors and hospitals who have attended you, and personal or credit information.

Information regarding your insurability will be treated as confidential.

We, or our reinsurers, may, however, make a brief report thereon to MIB, Inc., a non-profit membership corporation of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. will, upon request, supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in their file, you may contact MIB, Inc. and seek a correction. The address of their information office is MIB, Inc., 330 University Ave., Toronto, Ontario M5G 1R7. Telephone (416) 597-0590.

Standard Life, or its reinsurers, may also release information in your file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

The purpose of MIB, Inc. is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by MIB, Inc. may alert the insurer to the possible need for further investigation.

MIB, Inc. is not a repository of medical reports from hospitals and physicians and information in their file does not reveal whether applications for insurance are accepted, rated or declined.

**CONSUMER REPORT**

In the routine processing of applications for insurance, all life insurance companies, including Standard Life, may obtain personal investigation or consumer reports containing personal information about the Insured(s) and you may be contacted in this regard.