



Express Application Form Life Insurance and Critical Illness Insurance

This Express Application Form does not include insurability questions or a product section, therefore, your application cannot be processed without the Client Illustration from Wealthcare. Please ensure it is attached. Insurability questions will be asked either through a Tel-Express interview with a nurse, a Paramedical, or a Medical examination, depending on the medical requirements (illustrated in Wealthcare). If instead, you wish to ask insurability questions and complete a product section please use our Comprehensive Application form.

A1 • Representative* Information	Representative Name	Representative Code (6 digits)	% Split	Sales Office Name	Sales Office Code (5 alpha numeric)
<p>IMPORTANT: Information needed to process this application form and to pay your commission. Missing information will cause delays. The servicing representative (for Standard Life's records) will be the person who signs this application form, unless otherwise indicated. Please print clearly throughout application form.</p>	<input type="checkbox"/> I do not have a representative code with Standard Life. This is my first application.				
	<input type="checkbox"/> I do not have a representative code with Standard Life. This is my first application.				
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A2 • Product Choice	<input type="checkbox"/> Perspecta (UL)	<input type="checkbox"/> Whole Life	<input type="checkbox"/> Term 10/20	<input type="checkbox"/> Protecta (CI)
<p>Perspecta Statement Frequency <input type="checkbox"/> Yearly (Default) <input type="checkbox"/> Quarterly Include Transaction Details <input type="checkbox"/> Yes (Default) <input type="checkbox"/> No</p> <p>Please ensure the Client Illustration is attached. Your application cannot be processed without it. Remember for Perspecta (UL) and Whole Life the Client Illustration must always be signed.</p>				

A3 • Underwriting Requirements	Proposed Insured 1	Proposed Insured 2
<p>I have ordered the following Underwriting Requirements:</p> <p>For Perspecta the client signature page from the Illustration must be attached to this application.</p> <p>Underwriting Requirements ordered date (DD/MM/YYYY) <input style="width: 100px;" type="text"/></p> <p>APS from Dr. <input style="width: 150px;" type="text"/> Name <input style="width: 150px;" type="text"/> at <input style="width: 150px;" type="text"/> Address and Tel. <input style="width: 150px;" type="text"/></p> <p>Underwriting Requirements ordered from <input type="checkbox"/> Keyfacts <input type="checkbox"/> Medisys <input style="width: 100px;" type="text"/> <input type="checkbox"/> Exam-One <input type="checkbox"/> BodiMetric <input type="checkbox"/> Hooper Holmes <input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/></p>	<input type="checkbox"/> Paralife <input type="checkbox"/> Stress ECG <input type="checkbox"/> Medilife <input type="checkbox"/> ADL <input type="checkbox"/> Medilife (internist) <input type="checkbox"/> MVR <input type="checkbox"/> UHIV <input type="checkbox"/> Inspector Report <input type="checkbox"/> BCP <input type="checkbox"/> Financial statements <input type="checkbox"/> APS <input type="checkbox"/> SHIV <input type="checkbox"/> ECG <input type="checkbox"/> Tel-Express (complete A4)	<input type="checkbox"/> Paralife <input type="checkbox"/> Stress ECG <input type="checkbox"/> Medilife <input type="checkbox"/> ADL <input type="checkbox"/> Medilife (internist) <input type="checkbox"/> MVR <input type="checkbox"/> UHIV <input type="checkbox"/> Inspector Report <input type="checkbox"/> BCP <input type="checkbox"/> Financial statements <input type="checkbox"/> APS <input type="checkbox"/> SHIV <input type="checkbox"/> ECG <input type="checkbox"/> Tel-Express (complete A4)
	<p>Attach bar-coded label</p>	

A4 • Tel-Express Processing	Refer to Underwriting Requirements to see if this is an available option for each Proposed Insured. Tel-Express processing is a telephone interview gathering medical and lifestyle information that is conducted by a Paramedical Services nurse. The telephone interview is TAPED. All responses are held in the strictest confidence. You should have available at the time of the interview your driver's license number as well as the names of doctors, dates seen and any medication recommended. Paramedical service is available local time – Monday to Friday, between 7:30 AM and 9:00 PM.
<p>Please provide for each insured the name and address of the attending physician or medical facility. In addition indicate the preferred date and time for gathering this medical and lifestyle information.</p>	

A5 • Important Instructions to Standard Life	

A – Basic Information

Language of Correspondence	<input type="checkbox"/> English	<input type="checkbox"/> French	
<input type="checkbox"/> New Application	OR	<input type="checkbox"/> Addition to existing Policy Number:	<input type="text"/>

B – Proposed Insured(s) and Owner Details

B1 • Proposed Insured

For more than 2 applicants, use additional applications as required. Delete the application number on each additional application and enter the number of the first one. Submit all applications together.

Age Nearest: which birthday is less than 6 months away: your last or your next?

SIN is required for tax purposes. (applicable to Perspecta and Whole Life)

Proposed Insured 1

Mr Mrs Miss Ms Other:

First Name and Initial		
Last Name		
Maiden Name (if different)		
Date of Birth (DD/MM/YYYY)	Age Nearest	SIN (see note left margin)
/ /		
Place of Birth: Province	Country	

Permanent Canadian Resident Yes No
 Type of Resident:
 Canadian Citizen Other (Please provide details in Section A5)
 Landed Immigrant
 Years in Canada
 Sex Male Female
 Smoker Class Applied for Smoker Non-Smoker
 Circle Profile: 1 2 3 4 5 (for Perspecta, Whole Life and Term 10/20)
 Do you understand and speak English? Yes No

Proposed Insured 2

Mr Mrs Miss Ms Other:

First Name and Initial		
Last Name		
Maiden Name (if different)		
Date of Birth (DD/MM/YYYY)	Age Nearest	SIN (see note left margin)
/ /		
Place of Birth: Province	Country	

Permanent Canadian Resident Yes No
 Type of Resident:
 Canadian Citizen Other (Please provide details in Section A5)
 Landed Immigrant
 Years in Canada
 Sex Male Female
 Smoker Class Applied for Smoker Non-Smoker
 Circle Profile: 1 2 3 4 5 (for Perspecta, Whole Life and Term 10/20)
 Do you understand and speak English? Yes No

Home address

Street Address		Unit/Apt.
City		
Province	Postal Code	
Tel - Res. - -	Fax - -	
E-mail		

Same as Proposed Insured 1

Street Address		Unit/Apt.
City		
Province	Postal Code	
Tel - Res. - -	Fax - -	
E-mail		

Employment details

Occupation	
Tel - Bus. - -	Earned Annual Income \$
Net Worth \$	Other Annual Income \$
Employer's Name	Years with this employer
Street Address	Unit/Suite
City	
Province	Postal Code
Nature of Business	

Occupation	
Tel - Bus. - -	Earned Annual Income \$
Net Worth \$	Other Annual Income \$
Employer's Name	Years with this employer
Street Address	Unit/Suite
City	
Province	Postal Code
Nature of Business	

Insured(s) ID verification

Valid proof of the insured's identity must be obtained through a government issued identification document (an expired document is not valid). A driver's license is the easiest way to provide this to us. If you don't have a driver's license you can choose one of the other documents listed.

Driver's License Number	Province of Issue
I don't have a driver's license, I have indicated another document below: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Record of Landing <input type="checkbox"/> Permanent Resident card <input type="checkbox"/> Provincial Medical Card (except if issued in ON, MB, NB and PEI)	
Province of Issue (if applicable)	Document #

Driver's License Number	Province of Issue
I don't have a driver's license, I have indicated another document below: <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Record of Landing <input type="checkbox"/> Permanent Resident card <input type="checkbox"/> Provincial Medical Card (except if issued in ON, MB, NB and PEI)	
Province of Issue (if applicable)	Document #

B2• Beneficiary Designation

You need to tell us who gets the money once it becomes payable under your coverages. If you don't tell us, we will designate a default beneficiary for you as follows:

- For Life Insurance, the beneficiary will be the owner or the owner's estate.
- For Child Protection Riders, the beneficiary will be the owner.
- For Critical Illness Benefits, the beneficiary will be the insured.
- For Critical Illness Return of Premium on Death (ROPD) and/or Return of Premium on Surrender (ROPS), the beneficiary will be the owner or the owner's estate.

Where a minor is designated as a beneficiary it is recommended that a trustee be appointed for claims purposes.

Add any special instructions to Section A5.

	First Name	Last Name	Age	Relationship to Proposed Insured		%		
Beneficiary for Life Insurance Coverages								
Insured 1 <input type="checkbox"/>					<input type="checkbox"/> Primary Beneficiary			
Insured 2 <input type="checkbox"/>					<input type="checkbox"/> Contingent Beneficiary			
Insured 1 <input type="checkbox"/>					<input type="checkbox"/> Primary Beneficiary			
Insured 2 <input type="checkbox"/>					<input type="checkbox"/> Contingent Beneficiary			
Child Riders					<input type="checkbox"/> Primary Beneficiary			
					<input type="checkbox"/> Contingent Beneficiary			
Beneficiary for Critical Illness (CI) Coverages					CI Benefit	ROPD	ROPS	%
Insured 1 <input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insured 2 <input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insured 1 <input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insured 2 <input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name of Trustee for Minor Children								

If you live outside of Quebec: all beneficiaries are revocable (may be changed by owner) unless you write to Standard Life and tell us they are irrevocable.

If you live in Quebec: all beneficiaries are revocable except your spouse who is irrevocable (need spouse's permission to change). If you want your spouse to be a revocable beneficiary then initial this box.

In Quebec if you use share by percent (%) in unequal shares and one of the beneficiaries dies then the share belonging to that beneficiary will revert back to the Owner or to the Owner's estate if the Owner has died. However by designating Beneficiaries in equal shares this will not be the case.

The taxation of any benefits paid under a Protecta coverage remains subject to Canada Revenue Agency interpretation, which may change over time as a result of changes to the law or changes to administrative practices. Anyone purchasing Protecta coverage should discuss the implications with their accountant or tax advisor.

B3• The Designated Owner is:

For multiple owners and Business/Non Business Organization you must assign one person to deal with Standard Life.

If all owners predecease the life insured, the life insured will become the owner.

The *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and *Regulations* require that we obtain additional identification information in the case where the owner is a corporation or an entity, or is a charitable organization. Complete form PC 6330 (*Client Identification Supplementary Information*) if the owner is a corporation or entity or charitable organization.

Proposed Insured 1 (Go to B4) Proposed Insured 2 (Go to B4)

Jointly Proposed Insured 1 and 2 (Tell us which one will deal with Standard Life below) (Go to B4)

Business/Non Business Organization (Complete this section) Other (Complete this section)

Specify number of Owners: **Multiple owners:** Any document signed subsequent to this application by the designated Owner will have the same effect as if it had been signed by all Owners.

We are hereby appointing the following person to deal with Standard Life:

First & Last Name (and Company Name if applicable)			<input type="checkbox"/> Male	Date of Birth (DD/MM/YYYY)
			<input type="checkbox"/> Female	/ /
Street Address	Unit / Apartment	City		
Province	Postal Code	Tel - Res. - -	Tel - Bus. - -	
Occupation	Relationship to insured		SIN	

Owner ID verification

Valid proof of all owners identity must be obtained through a government issued identification document (an expired document is not valid). A driver's license is the easiest way to provide this to us. If you don't have a driver's license you can choose one of the other documents listed.

For Quebec, the Medical card cannot be requested, but is accepted if elected by the Proposed Insured for identification purposes.

For Business/Non business organization we require valid proof of the business existence. Choose one of the following most accessible documents listed and send us a copy.

Owner	Driver's License Number	Province of Issue	Expiry Date	Date of Birth (DD/MM/YYYY)
	Place of Birth: Province	Country	/	/
I don't have a driver's license, I have indicated another document below:				
<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Record of Landing <input type="checkbox"/> Provincial Medical Card (except if issued in ON, MB, NB and PEI) <input type="checkbox"/> Permanent Resident card				
Province of Issue (if applicable)		Document #		
Business/Non Business Organization				
<input type="checkbox"/> Certificate of Corporate Status <input type="checkbox"/> Any record that confirms the existence of a Business <input type="checkbox"/> Articles of Association <input type="checkbox"/> Articles/Letter or Incorporation <input type="checkbox"/> Partnership Agreement				
The legal Name of the Organization		Province of registration		
Address		Incorporation Number		

Multiple owner ID verification

Valid proof of all owners identity must be obtained through a government issued identification document (an expired document is not valid). A driver's license is the easiest way to provide this to us. If you don't have a driver's license you can choose one of the other documents listed.

For Quebec, the medical card cannot be requested, but is accepted if elected by the Proposed Insured for identification purposes.

For Business/Non Business Organization we require valid proof of the business existence. Choose one of the following most accessible documents listed and send us a copy.

Owner 2	First & Last Name (and Company Name if applicable)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)	
	Driver's License Number	Province of Issue	Expiry Date	
Place of Birth: Province		Country		
I don't have a driver's license, I have indicated another document below:				
<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Record of Landing <input type="checkbox"/> Provincial Medical Card (except if issued in ON, MB, NB and PEI) <input type="checkbox"/> Permanent Resident card				
Province of Issue (if applicable)		Document #		
Business/Non Business Organization				
<input type="checkbox"/> Certificate of Corporate Status <input type="checkbox"/> Any record that confirms the existence of a Business <input type="checkbox"/> Articles of Association <input type="checkbox"/> Articles/Letter or Incorporation <input type="checkbox"/> Partnership Agreement				
The legal Name of the Organization		Province of registration		
Address		Incorporation Number		

The *Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations* require that we obtain additional identification information in the case where the owner is a corporation or an entity, or is a charitable organization. Complete form PC 6330 (*Client Identification Supplementary Information*) if the owner is a corporation or entity or charitable organization.

For additional owners, provide the same information in section A5.

Owner 3	First & Last Name (and Company Name if applicable)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)	
	Driver's License Number	Province of Issue	Expiry Date	
Place of Birth: Province		Country		
I don't have a driver's license, I have indicated another document below:				
<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Record of Landing <input type="checkbox"/> Provincial Medical Card (except if issued in ON, MB, NB and PEI) <input type="checkbox"/> Permanent Resident card				
Province of Issue (if applicable)		Document #		
Business/Non Business Organization				
<input type="checkbox"/> Certificate of Corporate Status <input type="checkbox"/> Any record that confirms the existence of a Business <input type="checkbox"/> Articles of Association <input type="checkbox"/> Articles/Letter or Incorporation <input type="checkbox"/> Partnership Agreement				
The legal Name of the Organization		Province of registration		
Address		Incorporation Number		

B4• Contingent Owner

Complete this section if you want another person to be the owner, if the owner dies.

If all owners predecease the life insured, the life insured will become the owner.

<input type="checkbox"/> Proposed Insured 1 (Go to C) <input type="checkbox"/> Proposed Insured 2 (Go to C) <input type="checkbox"/> Jointly Proposed Insured 1 and 2 (Tell us which one will deal with Standard Life below) (Go to C) <input type="checkbox"/> Corporate Ownership (Complete this section) <input type="checkbox"/> Other (Complete this section)				
First & Last Name (and Company Name if applicable)		Incorporation Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)
Relationship to insured	SIN	Tel - Res.	Tel - Bus.	
		-	-	

C – Premium Payment

C1 • Premium payment	Selected/Initial Premium <input type="text" value="Amount \$"/>	Perspecta Additional Deposit at Issue <input type="text" value="Amount \$"/>
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How will the first premium be paid?

Cheque attached
 Withdraw from bank account C.O.D. (Attach specimen cheque)

How will future premiums be paid?

Annual Direct Billing Semi-annual Direct Billing
 Pre-authorized debit agreement: Annual Semi-annual Quarterly Monthly (PAD – attach specimen cheque)
 Add to existing PAD agreement:

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.

What draw day do you want?

Draw Day on Issue Date OR Specify Date: Draw days cannot be after the issue date or the 29th, 30th, or 31st of any month.

Who is paying the premium?

Bill to Proposed Insured 1 (Go to D) Bill to Proposed Insured 2 (Go to D) Bill to Owner (Go to D)
 Bill to Other (Complete this section)

Complete this section only if the premium payer is not the owner or one of the insured(s) and sign on page 7.

Indicate Billing Address if not owner or insured(s).

First & Last Name or Company Name		Date of Birth (DD/MM/YYYY)	
Billing Address		Unit/Suite	
City	Province	Postal Code	
Occupation	Relationship to Owner	If Business: Registration Number	Place of Registration

Premium Payer ID verification

(See section B3 for types of ID documents accepted)

Type of Document	Document #
Province of Issue (if applicable)	Expiry Date

D – Information Regarding Proposed Insured(s) and Owner

D1 • Insurance history questions

To be completed by all applicants who are Proposed Insureds on this application including any owner who is applying for waiver benefits.

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.

For all Proposed Insureds, this is the first time Life or Critical Illness Insurance has been applied for (excluding group benefits) (go to D2).
 Other Life or Critical Illness Insurance are pending or in force (complete this section).

Options: a) Proposed Insured 1 in force c) Proposed Insured 2 in force e) Owner in force
 b) Proposed Insured 1 pending d) Proposed Insured 2 pending f) Owner Pending

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
		\$				<input type="checkbox"/> Business <input type="checkbox"/> Personal

Replacement / Change Insurance

Replacement forms are required in all cases. Failure to complete them will result in a delay in your policy being issued.

Will this application replace or cause a change in, or involve a substantial loan under any existing insurance or annuity contract? If so, indicate the contract(s) affected. In addition provincial replacement forms must be submitted immediately with this application in the province of Manitoba; within 5 working days in the province of Quebec; and within 3 working days in all other provinces.

	Proposed Insured 1	Proposed Insured 2	All Proposed Children under this application
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional details

D2 • Purpose of Insurance

Failure to complete this section including the question relating to bankruptcy will result in a delay in your policy being issued.

Have any of the insureds or any companies owned by the insured declared bankruptcy within the past 3 years?

Yes No If Yes, select: Personal Corporate

Please provide details including date of discharge: _____

What is the purpose of Insurance?

Personal Insurance: Income Protection Estate Conservation Other: _____
 Business Insurance: Key Person Buy-Sell Agreement Other: _____

Financial Information for Business Insurance:

Name of the business		Nature of the business		Number of years the business has been active
Total Assets \$	Total Liabilities \$	Fair Market Value \$	Net profit after taxes: Current year \$	Previous year \$
Percentage ownership %	Are all the remaining partners proportionately insured? If not, explain why?			
How was the amount of insurance determined?				

D3 • 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.

	Proposed Insured 1							Proposed Insured 2						
	Details		Qty	Frequency			Date Last Used DD/MM/YYYY	Details		Qty	Frequency			Date Last Used DD/MM/YYYY
	Yes	No		Day	Month	Year		Yes	No		Day	Month	Year	
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"/>	/ /
Water 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"/>	/ /

D4 • Temporary Insurance Agreement (TIA) questions

To be completed for each Insured in all cases.

More medical questions will follow, as non-medical, or Paramedical, or Medilife, or Medilife (internist).

	Proposed Insured 1	Proposed Insured 2	All Proposed Children under this application
1. Have you ever had an application for life, health, critical illness 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you within the past 90 days, other than for 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you in the past 5 years ever had, been told you may have or been advised to have tests for: cancer, drug or alcohol abuse, heart or circulation problems such as stroke, high blood pressure, chest pain, unexplained infections, or have you ever had, been told you may have, been advised to have tests for or received information indicating possible exposure to AIDS (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you any intention to reside or travel outside of North America or Western Europe within the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

D5 • Children's Coverages

Do the children live with the Owner? Yes No
 Life & Critical Illness: are all children being insured equally? Yes No (Tell us why below)
 Indicate the critical illness coverage amount of the parents.

Mother \$	Father \$
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If none, tell us why here:

First & Last Name	Date of Birth (DD/MM/YYYY)	Relationship to Owner
	/ /	
	/ /	
	/ /	

E – Declarations and Authorizations

E1 • 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 representative, 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 be communicated to the representative. 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.
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 under the policy applied for), the policy shall be null and void in respect of the Proposed Insured.
3. 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. 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. 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.
4. Understand and agree that where a Temporary Insurance Agreement (TIA) has been issued relating to Life Insurance, the amount payable under this and all other TIAs with Standard Life on each Proposed Insured is limited to the lesser of one million dollars (\$1,000,000) and the total amount of life insurance applied for (including any Accidental Death Benefits).
5. Understand and agree that where a Conditional Insurance Agreement has been issued relating to Critical Illness Insurance, the amount payable shall be the LESSER of the total amount of Critical Illness Insurance applied for in the application(s), and \$500,000, less any other Critical Illness benefits payable by Standard Life.
6. Acknowledge that if this application is for an adult Critical Illness Insurance, I have 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 I have selected herein is appropriate to my needs at this time.
7. Agree that this Application and the attached Temporary Insurance Agreement for life insurance, and if applicable the Conditional Insurance Agreement for Critical Illness, are governed by the legislation of the Owner's province of domicile.
8. I authorize 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.
9. Authorize Standard Life's agents, distribution and marketing partners, for underwriting and administration of insurance and claims paying purposes only: to gather only that information necessary for the object to the file, from any person or organization that has personal information relating to me, 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 me to these same persons and organizations; and to request a personal investigation report relating to me. 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.
10. I declare that the foregoing statements are true, complete and correctly recorded and shall form part of the application for life insurance or critical illness with Standard Life. For the purpose of evaluating the risk under the application for life insurance which has been made to Standard Life or for any claims purposes, I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, Medical Information Bureau, or other organization, institution or person to give any information regarding me to Standard Life or its reinsurers. A photocopy of this authorization shall be as valid as the original.

Minors: A signature is required by all Proposed 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_____


Proposed Insured 1



Proposed Insured 2



Proposed Insured (minor)


Proposed Insured (minor)


Consenting Parent/Guardian (if juvenile Application or any children's Rider)


Owner (only required if different than Proposed Insured 1 or 2)


Owner (only required if different than Proposed Insured 1 or 2)


Owner (only required if different than Proposed Insured 1 or 2)


E2 • Premium Payer Signature

If the Premium Payer is different from Proposed Insured 1 and 2 and Owner, only then do you need to sign here.

I authorize Standard Life to begin deductions as instructed for regular recurring premium payments, regular investment plan payments and/or for one-time or sporadic payments upon my verbal or written request from the financial institution indicated on the attached specimen cheque, or any other account at any financial institution subsequently designated by me. I further authorize such financial institution to deal with these withdrawals as though they were signed by me.

Province of Signature _____ this _____ day of _____, 20____

Premium Payer

E3 • Representative Signature

Proceeds of Crime (Money Laundering) and Terrorist Financing

The *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and *Regulations* require that we obtain additional identification information in the case where the:

- Owner* is a corporation or an entity;
- Owner* is a charitable organization;
- Owner* makes a premium payment of \$100,000 or more.

Does one or more of the above situations apply?

- Yes (*Complete Client Identification Supplementary Information form PC 6330*).
 No

Third Party Determination

I have made a reasonable effort to determine if the owner(s)* is (are) acting on behalf of a third party. Will the owner(s)* be acting on behalf of a third party?

- Yes (*Complete Third Party Determination form PC 5097*)
 I was unable to determine whether the owner(s)* is (are) acting on behalf of a third party, or third parties, but I have reasonable grounds to suspect that this is the case. (*Complete Third Party Determination form PC 5097*)
 No

* (& Additional Owner, if applicable). Identification needs to be provided on a separate sheet of paper.

I have ascertained the identity of the Proposed Insured(s), owner(s) and premium payer in accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and *Regulations* by examining the original and valid identification documents for each of them. Yes No

I have completed the answers to questions in this application in the presence of the owner and the Proposed Insured(s) before this application was signed. Yes No

I have a relationship with the Proposed Insured(s).

- Yes Type of relationship: _____
 How long have you known the Proposed Insured(s): _____ years
 No

I hold a valid license in the jurisdiction where this application was signed. Yes No

I have disclosed the following information to the client(s):

- the company or companies I represent;
- that I receive compensation (such as commissions or a salary) for the sale of life and health insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- any conflicts of interest I may have with respect to this transaction.

I have provided the client(s) with the Product Disclosure document for the product sold.

I have completed the application with the client(s) and 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)
 / /

F – Notice and Agreements

F1 • Conditional Insurance Agreement For Critical Illness

Instructions to representative:

IF ALL proposed insureds are older than 30 days and younger than age 66, then detach this Agreement and give it to the owner.

Regardless of whether any premium has been collected with the application, there is no Conditional Insurance Agreement if all the conditions set out below and on the reverse are not met.

Conditional Insurance Agreement – Critical Illness Insurance

Standard Life provides free temporary CONDITIONAL critical illness insurance in accordance with the terms set out below and on the reverse.

This conditional insurance, subject to the usual terms of the policy applied for, shall take effect:

- on the date on which sufficient evidence of insurability for all the proposed insureds is received (hereafter referred to as the effective date); and
- provided it is determined that all the proposed insureds were standard risks on the effective date in accordance with Standard Life's usual underwriting rules and practices.

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F2 • Temporary Insurance Agreement (TIA) For Life Insurance

Instruction to representative:

IF: • ALL proposed insureds are older than 15 days and younger than age 66; and

- ALL proposed insureds answered "no" to all parts of questions 1 to 4 of the TIA Insurability Questions (D4, page 5); and

- for EACH proposed insured, the total amount of life insurance applied for is less than \$3,000,001; then detach this Agreement and give it to the owner.

Regardless of whether any premium has been collected with the application, there is no Temporary Insurance Agreement if the conditions above are not met.

Temporary Insurance Agreement (TIA) – life insurance

Standard Life provides free temporary life insurance coverage while we are considering your application. This insurance begins on the date you complete and sign your application.

You are entitled to this coverage if:

- all the proposed insureds are older than 15 days and younger than age 66; and
- all the proposed insureds answered "no" to all parts of questions 1 to 4 of the TIA Insurability Questions (D4, page 5) (there is a copy of them on the back of this Agreement); and
- for each proposed insured, the total amount of life insurance applied for is less than \$3,000,001.

If, for a proposed insured, the total amount of life insurance applied for is less than \$1,000,000 then if the proposed insured dies, Standard Life will pay the amount insured to the beneficiaries designated in the application.

If, for a proposed insured, the total amount of life insurance applied for is \$1,000,000 or more then if the proposed insured dies, Standard Life will pay \$1,000,000 to the beneficiaries designated in the application.

If you have chosen joint-first-to-die coverage, then Standard Life will pay when the first proposed insured dies.

If you have chosen joint last-to-die coverage, then Standard Life will pay when the last proposed insured dies.

If one or more of the proposed insureds commits suicide, whether or not they are of sound mind, then the Temporary Insurance Agreement is void and no payment will be made by Standard Life.

5072H-01-2010

F3 • Disclosure Notice MIB (Medical Information Bureau) — To be detached and given to the owner in all cases

Notice to proposed life insureds regarding Medical Information Bureau (MIB)

Information on each of the proposed insureds will be treated as confidential. Standard Life or our reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies that operates an information exchange on behalf of its members. If you apply for life, critical illness or health insurance coverage or submit a claim for benefits to a company, which is a member of the Bureau, the Bureau will, upon request, supply that company with the information in its file.

The Medical Information Bureau will also arrange to release, at your request, any information it may have in your file. If you question the accuracy of the information, you may contact the Bureau and ask for a correction. The address of the Bureau's information office is:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, ON 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.

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Conditional Insurance Agreement For Critical Illness (continued)

The Conditional Insurance Agreement will end on the date the policy applied for comes into force. Under no circumstances will this insurance go beyond 60 days from the effective date.

The amount of Critical Illness Insurance for a proposed insured under this Agreement is limited to the lesser of:

- the total amount of critical illness insurance applied for on the life of the proposed insured; and
- \$500,000 less any other critical illness benefits payable by Standard Life for the proposed insured.

If any of the proposed insureds is diagnosed with cancer, then no payment will be made under this Agreement.

If any of the proposed insureds dies within 30 days of the diagnosis of a defined critical illness, then no payment will be made under this Agreement.

If any of the proposed insureds is younger than 31 days or is older than age 65, then no payment will be made under this Agreement.

Representative Name	Insured's Name	Date	DD/MM/YYYY	Sum Insured
			/ /	\$

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Temporary Insurance Agreement (TIA) For Life Insurance (continued)

Expiry of temporary insurance coverage

If we accept the application as is, then this TIA ends on the effective date of the policy.

If we do not accept the application as is, then the TIA will end on the date your representative is informed that any coverage has been declined or not accepted as applied for.

Under no circumstances will this insurance go beyond 60 days.

1. Have you ever had an application for life, health, critical illness or disability insurance, reinstatement or change either: rated, declined, postponed, modified, or not proceeded with?
2. Have you within the past 90 days, other than for 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?
3. Have you in the past 5 years ever had, been told you may have or been advised to have tests for: cancer, drug or alcohol abuse, heart or circulation problems such as stroke, high blood pressure, chest pain, unexplained infections, or have you ever had, been told you may have, been advised to have tests for or received information indicating possible exposure to AIDS (HIV)?
4. Have you any intention to reside or travel outside of North America or Western Europe within the next year?

Representative Name	Insured's Name	Date	DD/MM/YYYY	Sum Insured
			/ /	\$

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Notice to proposed life insured(s) and policyowner(s) regarding investigative consumer reports

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 proposed insured(s) and you may be contacted in this regard.

Notice to proposed life insured(s) and policyowner(s) regarding files and personal information

To ensure the confidentiality of the personal information held concerning you, Standard Life will establish a file for the owner(s) and each proposed life insured, for the purpose of providing you with insurance and other financial services. This file will contain information concerning your application for insurance as well as information concerning any insurance claim.

Only employees or mandataries who will be responsible for underwriting, administration, investigation, servicing and for claims purposes, or any other person whom you authorize, will have access to this file.

Your file will be kept in the company's offices. You are entitled to consult the personal information contained in this file, and have any inaccuracies rectified by sending a written request to:

Standard Life
 Attn: Manager, Customer Relations and Ombudsman
 1245 Sherbrooke Street West,
 Montréal, Québec H3G 1G3

Notice to proposed life insured(s) and policyowner(s)

The transaction represented by this application is between the applicant(s) and Standard Life. The Agent/Agency soliciting this application is an independent contractor and will receive compensation from Standard Life upon completion of this transaction. As a result of this application, the Agent/Agency may be eligible for non-monetary benefits depending on the volume of business that s/he places with the company during a given time period. The applicant(s) is (are) not obliged to transact any other business with Standard Life as a condition of this transaction.

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