Application for Insurance

securian CANADA

Policy number 051504

In this application *you* and *your* refer to the person applying for insurance. *We, us, our* and *the Company* refer to Canadian Premier Life Insurance Company ("Securian Canada").

Please PRINT clearly.

Clear

1. General information

Information about you

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
Name of association you are affiliated with	☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.	
Residence address (street number and name)			Apartment or suite
City		Province	Postal code
Telephone number (home)		Telephone number (office)	
Fax		Email address	

Information about your spouse (if applying for coverage)

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
Occupation		Amount of annual earned income $	
☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		

2. Coverage applied for

Long term disability (LTD) insurance

Amount of insurance **applied for at this time** in units of $250:

Members – 30 Day Elimination Period
– minimum $500 to maximum $5,000 $

Employees – 120 Day Elimination Period
– minimum $500 to maximum $2,500 $

Basic life insurance

For members and employees only ☐ Option A ($25,000)

2. Coverage applied for (continued)

Optional life insurance

(Minimum $25,000 - Maximum $250,000 in units of $25,000)

Amount of insurance **applied for at this time** $	Beneficiary last name	Beneficiary first name
Relationship to proposed insured		Beneficiary designation to be* ☐ Revocable ☐ Irrevocable

Spousal life insurance

(Minimum $25,000 - Maximum $250,000 in units of $25,000. Amount cannot exceed member coverage)**

Amount of insurance **applied for at this time** $	Beneficiary last name	Beneficiary first name
Relationship to proposed insured		Beneficiary designation to be* ☐ Revocable ☐ Irrevocable

Dependent child life insurance

($10,000 per dependent child)** ☐ Yes ☐ No

Critical illness (CI) insurance

(Minimum $50,000 - Maximum $300,000 in units of $10,000)
Amount of insurance **applied for at this time**: $

Spousal critical illness (CI) insurance

(Minimum $50,000 - Maximum $300,000 in units of $10,000)
Amount of insurance **applied for at this time**: $

Basic Accidental Death and Dismemberment insurance

($50,000) - For Members and Employees only ☐ Yes ☐ No

Optional Accidental Death and Dismemberment insurance

(Minimum $25,000 - Maximum $250,000 in units of $25,000 - cannot exceed the amount of Life Coverage)

Amount of insurance **applied for at this time** $	Beneficiary last name	Beneficiary first name
Relationship to proposed insured		Beneficiary designation to be* ☐ Revocable ☐ Irrevocable

Spousal Optional Accidental Death and Dismemberment insurance

(Minimum $25,000 - Maximum $250,000 in units of $25,000 - cannot exceed the amount of Life Coverage)

Amount of insurance **applied for at this time** $	Beneficiary last name	Beneficiary first name
Relationship to proposed insured		Beneficiary designation to be* ☐ Revocable ☐ Irrevocable

The same choice must be made for both Extended Health Care and Dental Insurance.

Extended Health Care insurance (includes emergency travel)

☐ Single ☐ Family

Dental insurance (must have EHC to be eligible for Dental)

☐ Single ☐ Family

Office Overhead Expense (OOE) insurance - for Association members only

30 day Elimination Period. Minimum $500 to a maximum $6,000; in units of $100

a) Total Monthly Office Overhead Expense Insurance applied for at this time. $

b) Number of people sharing your office expenses

c) Your share %

2. Coverage applied for (continued)

d) The maximum monthly coverage you may apply for is based on the following information.
(Use your share of actual average monthly expenses):

Wages of employee	$
Utilities (telephone, heat, etc.)	$
Rent or mortgage interest & real estate taxes (applicable to office expenses only)	$
Business taxes, loan interest and business insurance payments	$
Equipment depreciation or rental	$
Other, briefly describe	$
Total (Amount applied for must not exceed this figure.)	$

* You must check *revocable* or *irrevocable* for this application to be considered complete. Where Quebec law applies, a spouse is *irrevocable* unless you make the designation *revocable*. If the beneficiary designation is *revocable*, the Applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary is *irrevocable*, the beneficiary's written consent is required in order for the Applicant to make any change to the beneficiary or the coverage.

** The Applicant is automatically the beneficiary for the spouse and dependent child life coverage.

3. Insurance information - Complete if applying for Life, CI, LTD or OOE insurance

Do you and/or your spouse have any Life, CI, LTD or OOE insurance in-force or pending with any insurer, either as an individual policy, as a group benefit, or as part of an employment contract/partnership agreement?

☐ Yes ☐ No If *yes*, please provide details below.

You

Type of coverage (Life, LTD, OOE, CI)	Amount of benefits	Insurance company	Date of issue (mm-yyyy)	Benefit period	Taxable	Indicate if any insurance will be discontinued if this coverage is issued
	$				☐ Yes ☐ No	☐ Yes ☐ No
	$				☐ Yes ☐ No	☐ Yes ☐ No

Your spouse

Type of coverage (Life, LTD, OOE, CI)	Amount of benefits	Insurance company	Date of issue (mm-yyyy)	Benefit period	Taxable	Indicate if any insurance will be discontinued if this coverage is issued
	$				☐ Yes ☐ No	☐ Yes ☐ No
	$				☐ Yes ☐ No	☐ Yes ☐ No

4. Occupational information

Occupation/title		Are you self-employed? ☐ Yes ☐ No	
Date employment started at current employer (dd-mm-yyyy)	Number of years in current occupation	Number of hours worked per week	Number of weeks worked per year

Do you have any other occupation or contemplate changing your job duties and/or hours of work?

☐ Yes ☐ No If *yes*, please describe fully.

5. Financial information

Only required if applying for LTD insurance.

	Current year-to-date **from** _____ **to** _____ mm-yyyy mm-yyyy	**Last year 20** _____
Net annual earned income before tax	**$**	**$**
Is any portion of your income from a salaried position? ☐ Yes ☐ No	If *yes*, please provide salary **$**	Provide employer name
Do you have any unearned income? ☐ Yes ☐ No	If *yes*, indicate annual unearned income **$**	Sources of unearned income

Have you ever declared or are you contemplating bankruptcy?
☐ Yes ☐ No If *yes*, date of discharge: (mm-yyyy)

6. Statement of insurability

Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Do not tell us about genetic testing or genetic test results.

6.1 Background information

Information about you

Height ft in | m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ lbs ☐ No change ☐ Gain: ☐ Loss: ☐ kg
Reason for weight change		
Name of physician, date and reason for last consultation with physician (if none, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them.		

Information about your spouse - Please complete if applying for Spousal coverage

Height ft in | m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ lbs ☐ No change ☐ Gain: ☐ Loss: ☐ kg
Reason for weight change		
Name of physician, date and reason for last consultation with physician (if none, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them.		

Information about your dependent(s)* - Please complete if applying for Dependent coverage

First name	Last name	☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Date of birth (dd-mm-yyyy)
First name	Last name	☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Date of birth (dd-mm-yyyy)

* A Dependent child is a child under age 21, or age 21 to 25 (26 in Quebec) if attending school full-time; or any age if physically or mentally infirm.

If you need more space, please complete on separate sheet of paper, and sign and date it.

6. Statement of insurability (continued)

6.2 Family history (do not tell us about genetic testing or genetic testing results).

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had cancer (specify type), heart disease, stroke, diabetes, polycystic or other kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), Muscular Dystrophy, familial polyposis of the bowel, Huntington's Chorea or any other hereditary disease?	You	Your spouse
	☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the chart(s) below.

Your family history

	Which condition	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Your spouse's family history

	Which condition	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

6.3 Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment children (therapy, counselling, etc.) including unfilled prescriptions?	You	Your spouse	Your dependent(s)
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the chart(s) below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time
			$			
			$			

If you need more space, please complete on separate sheet of paper and sign and date it.

6.4 Medical information (do not tell us about genetic testing or genetic testing results).

Have any of the persons to be insured ever:	You	Your spouse	Your dependent(s)
a) had chest pain, angina, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, peripheral vascular disease, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had a stroke, transient ischemic attack (TIA or 'mini stroke'), phlebitis, paralysis, dizziness, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or neurological system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) had diabetes, impaired fasting glucose, sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or abnormal pap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) had disorder of the breast including lumps, cysts, abnormal mammogram findings or biopsy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) had tumours, cancer, polyps, moles or other growth; disorder of the skin or lymph glands; blood or immune disorder, leukemia or any other form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had sleep apnea or chronic lung or respiratory disorder; disease or disorder of the eyes (excluding near or far sightedness), ears, nose or throat or had loss of speech?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) had any disorder of the colon, rectum, intestines (including Crohn's or colitis), ulcer, gallbladder, stomach or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6. Statement of insurability (continued)

	You	Your spouse	Your dependent(s)
i) had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; amputation; fibromyalgia or rheumatic/ arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) had any psychiatric disorder; depression, suicide attempts or ideations; anxiety state or panic attacks; eating disorder; other emotional disorders; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) had a disorder of the liver, tested positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepatitis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) had any other illness, disease, disorder, condition or injury not listed above; had any health dependent(s) symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Are you contemplating any medical treatment or planning to undergo surgery, or are you currently suffering from a disability or fulfilling an elimination period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past five years, have any of the persons to be insured:			
n) consulted a physician, chiropractor, psychologist, physiotherapist, psychiatrist, or any other health care professional, or been admitted to a hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) had any symptoms or adverse findings, or were advised to have further examinations, diagnostic tests, hospitalization or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) submitted to ECGs, blood tests, x-rays, a biopsy or any other diagnostic tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) had any surgical operation, treatment, ailment, abnormality or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
r) received any treatment or are currently taking any medication, over-the-counter medications, including any herbal supplements or remedies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
s) been advised to have any further examinations, diagnostic tests, hospitalization or surgery which has not been completed, or had any symptoms or complaints regarding your health for which a physician has not yet been consulted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 12 months:			
t) have you, your spouse or dependent child(ren) been unable to work for more than five consecutive days or made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6.5 Additional information

You

a) Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes*, please record how much and how often.

Your spouse

Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes*, please record how much and how often.

	You	Your spouse	Your dependent(s)
Within the past 10 years, have any of the persons to be insured:			
b) consumed substantially more alcohol than outlined previously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) been charged with impaired driving or been arrested, due to the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had your driver's license suspended or revoked, or had three or more moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use and/or abuse of non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Statement of insurability (continued)

	You	Your spouse	Your dependent(s)
g) had Life, Critical Illness, or Disability insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years, have any of the persons to be insured:			
h) piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities such as skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do any of the persons to be insured:			
i) expect to change country of residence or expect to travel outside Canada or the USA within the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For female applicants only			
j) Are you pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please indicate expected due date.	(mm-yyyy)	(mm-yyyy)	(mm-yyyy)
k) Have you had any previous complications of pregnancy such as miscarriage, preeclampsia, caesarean section, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details below for any *yes* answers under sections 6.4 and 6.5. Include the results of all physical examinations and check-ups. If you need more space, please complete on separate sheet of paper and sign and date it. Do not tell us about genetic testing or genetic testing results.

Question	Name of the person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results

7. Premium payment method

Pre-authorized debit (PAD) option. ☐ Monthly ☐ Annually

Please attach to this application form a personal blank cheque, marked VOID across the front.

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize Canadian Premier Life Insurance Company (“Securian Canada”) to collect the monthly or annual premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Securian Canada notify you of any payments after the first payment whether the amount of the monthly or annual premium is changed or not. You understand that either the monthly premium is due the first of each month or the annual premium is due every March 1st.** This agreement will be cancelled automatically if Securian Canada is unable to make a withdrawal from your account.

This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting *www.payments.ca*.

Securian Canada may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

7. Premium payment method (continued)

You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit *www.payments.ca.*

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5
Telephone number: 1-877-363-2773

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder **X**	Date (dd-mm-yyyy)
Signature of account holder **X**	Date (dd-mm-yyyy)

Send no money with this application. You will be notified with a premium statement.

8. Payor information

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payor(s) name (first and last) **or** full legal name of corporation/entity			
If applicable, date of birth (dd-mm-yyyy)		Relationship to you	
Address (street number and name)			Apartment or suite
City	Province/state	Country	Postal/zip code

9. Declaration and authorization

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I hereby certify that I have read the Medical Information Bureau (MIB) notice (see section 10), and having read the contents, I have, by the signature(s) below, authorized the MIB to give to Canadian Premier Life Insurance Company (“Securian Canada”), or its reinsurers, any information it may have.

I authorize Securian Canada to share the application information with my Advisor for the purpose of administering and servicing my application. This information includes the type and status of underwriting requirements such as a blood profile, medical questionnaire or attending physicians statement, but excludes the results of any such tests or contents of any completed questionnaires or documents. I understand that I may refuse to give consent to share and I may at any time withdraw this consent by notifying Securian Canada.

I authorize Securian Canada and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original, and shall remain in effect for the duration of my insurance coverage.

Your signature **X**		Your spouse’s signature **X**
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)
Name of advisor (if applicable)	Telephone number	Email address of advisor

Please return your completed application to:
Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

10. Medical Information Bureau notice

In the course of underwriting your application, Securian Canada may disclose information about you or your spouse to its reinsurers. Securian Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you and/or your spouse may apply for life or health insurance or to whom a claim for benefits may be submitted.

Securian Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you and/or your spouse also applies for insurance coverage or submit(s) a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to MIB at:

Medical Information Bureau
330 University Avenue
Toronto, ON M5G 1R7

or call 416-597-0590

11. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. (“MIB”), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *http://www.securiancanada.ca/privacy-statement.*