RBC Insurance®

Life Insurance Application

89604 (08/2008)

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

- information establishing your identity (for example, name, address, phone number, date of birth, etc.) and your personal background;
- information related to or arising from your relationship with and through us;
- information you provide through the application and claim process for any of our insurance products and services; and
- information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using your personal information

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; and
- as required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

We may also use this information and share it with RBC® companies (i) to manage our risks and operations and those of RBC companies, (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests, and (iii) to let RBC companies know your choices under "Other uses of your personal information" for the sole purpose of honouring your choices.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Please note that this paragraph is not applicable if this form is submitted by an independent representative or a representative that is attached to a firm other than RBC Insurance®.

Other uses of your personal information

- We may use this information to promote our products and services, and promote products and services of third parties we select, which may be of interest to you. We may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided.
- We may also, where not prohibited by law, share this information with RBC companies for the purpose of referring you to them or promoting to you products and services which may be of interest to you. We and RBC companies may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. You acknowledge that as a result of such sharing they may advise us of those products or services provided.
- If you also deal with RBC companies, we may, where not prohibited by law, consolidate this information with information they have about you to allow us and any of them to manage your relationship with RBC companies and our business.

You understand that we and RBC companies are separate, affiliated corporations. RBC companies include our affiliates which are engaged in the business of providing any one or more of the following services to the public: deposits, loans and other personal financial services; credit, charge and payment card services; trust and custodial services; securities and brokerage services; and insurance services.

You may choose not to have this information shared or used for any of these "Other uses" by contacting us as set out below, and in this event, you will not be refused insurance products or services just for that reason. We will never use or share your health information for these purposes. We will respect your choices and, as mentioned above, we may share your choices with RBC companies for the sole purpose of honouring your choices regarding "Other uses of your personal information".

Your right to access your personal information

You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information, to ask questions about our privacy policies or to request that the information not be used for any or all of the purposes outlined in "Other uses of your personal information" you may do so now or at any time in the future by contacting us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: 1-800-663-0417
Facsimile: (905) 813-4816

Our privacy policies

You may obtain more information about our privacy policies by asking for a copy of our "Straight Talk®" brochure about privacy, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacy

Guidelines for Completion of Application

- **Print legibly in blue or black ink.**
- **Do not make erasures or use liquid paper. Do not use ditto marks. Stroke out an error and have the applicant initial it. The application is a legal document forming part of the policy contract.**
- **Ensure the latest version of the MAX illustration software is used as a reference.**
- **This application is for life insurance and available benefits and riders only. Depending on the product, a critical illness, long term care and disability rider may be added to the life component.**
- **If the Proposed Life Insured is not fluent in English, a Statement of Understanding, available on MAX, in the Proposed Life Insured's language of choice must be submitted with the application and is an underwriting requirement.**

Other Standalone Products

- For standalone disability and/or critical illness insurance, complete the Disability and Critical Illness Insurance Application #83530.
- For standalone long term care, complete the Long Term Care Application #89606.

TRIAL Applications

- Identify TRIAL on the cover of the application. Do not give out a Temporary Life Insurance Agreement (TIA) or order any underwriting requirements.

Lives Insured

- Two lives and up to 4 children may be written on this application. In a joint situation, should privacy be an issue, please complete separate applications cross referencing them in the Representative's Report.

Separate Quebec applications

- If this application is being written in Quebec or if the insured or applicant lives in Quebec, ensure you are using the correct application, #81642 for Quebec English, #81643 for the Quebec French version.

Social Insurance Number

- This information is required for tax purposes. It need not be collected for Term policies.

Policy Ownership

- Minimum legal age is 16 years except in Quebec where it is 18 years.
- Joint ownership will be set up with right of survivorship. This will ensure that upon the death of a joint owner, ownership will pass to the surviving owner(s).

Minor Beneficiaries

- If the beneficiary is a minor, we recommend that a trustee be appointed by completing the Appointment of Trustee form available on MAX. This will avoid having to pay any proceeds into court.

Revocable/Irrevocable Beneficiaries

- All beneficiaries are revocable unless the irrevocable box has been checked. Naming a minor as an irrevocable beneficiary should be avoided as the authorization of an irrevocable beneficiary is required for any change which impacts the value of the policy and a minor cannot give that authorization.

Payor Waiver Benefit

- Complete the following sections under Proposed Life Insured B or in a separate application if this is to be a joint policy: Proposed Life Insured #s 1 – 4; Personal Information; Financial Information; Tobacco Usage; Medical History and Authorization.

Replacements

- If this new policy will result in the termination, modification or reduction in benefits of an existing policy within six months of this application, the Comparison Disclosure Statement must be submitted with the application and is an underwriting requirement.

Travel

- In the Personal Information section, if the Proposed Life Insured has travelled within the last 2 years or has plans to travel outside Canada or the United States, the Travel Questionnaire must be completed. This can be printed from MAX software. Given the mobility of today's population, it is a good idea to carry this form with you.

Temporary Life Insurance Agreement (TIA) Limits

- Temporary Life Insurance is only available up to $1,000,000 coverage. If applying for coverage over $1,000,000 and the applicant would like temporary insurance, a life insurance application for $1,000,000 must be submitted plus a separate, optional life insurance application for the higher amount with no money and no TIA. TIA is not available on TRIAL applications.
- TIA is only available if the Proposed Life Insured is at least 15 days old and not older than 65 years as of last birthday.

Collecting the Initial Premium

- Money can only be collected at the time of application completion or upon delivery of the policy. The application, TIA receipt and any payment must all be dated the same.

Illustrations and Investment Allocation Forms

- If the plan is universal life, a signed illustration and an investment allocation form should accompany the application.

RBC Insurance®

Application for Life Insurance to RBC Life Insurance Company

Part 1

Please Print

Proposed Life Insured A

1. First Name | Middle Name | Last Name | Prefix

2. Female ☐ Male ☐ | Country of Birth | Social Insurance Number | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday

3. Canadian Citizen ☐ Permanent Resident ☐ U.S. Citizen ☐ Other (please specify) ☐

4. Home Address

City | Province | Postal Code | Phone Number

5. Employer Name | Employer Address | Phone Number

Nature of Business | How long with this Employer? | Professional Designation/ Degree

Current Occupation | Number of Years at this Occupation | Former Occupation (if at current occupation less than 2 years)

Beneficiary – Proposed Life Insured A

If the Beneficiary is a minor, we strongly advise the appointment of a trustee. Complete the Appointment of Trustee form.
Ensure total shares equal 100%.

6. Primary Beneficiary

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

7. Contingent Beneficiary– If all Beneficiaries predecease the Life Insured(s), the proceeds are payable to the Contingent Beneficiary if any, otherwise to the estate of the Owner.

First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Proposed Life Insured B

8. First Name | Middle Name | Last Name | Prefix

9. Female ☐ Male ☐ | Country of Birth | Social Insurance Number | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday

10. Canadian Citizen ☐ Permanent Resident ☐ U.S. Citizen ☐ Other (please specify) ☐

11. Is the home address the same as Proposed Life Insured A? Yes ☐ No ☐ If no, please complete address section below.
Home Address

City | Province | Postal Code | Phone Number

12. Employer Name | Employer Address | Phone Number

Nature of Business | How long with this Employer? | Professional Designation/ Degree

Current Occupation | Number of Years at this Occupation | Former Occupation (if at current occupation less than 2 years)

Beneficiary – Proposed Life Insured B

If the Beneficiary is a minor, we strongly advise the appointment of a trustee. Complete the Appointment of Trustee form.
Ensure total shares equal 100%.

13. Primary Beneficiary

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

First Name | Middle Name | Last Name | Revocable ☐ Irrevocable ☐

Relationship to Applicant/Owner | % Share

14. Contingent Beneficiary– If all Beneficiaries predecease the Life Insured(s), the proceeds are payable to the Contingent Beneficiary if any, otherwise to the estate of the Owner.

First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Applicant/Owner

15. Proposed Life Insured A ☐ Proposed Life Insured B ☐ Proposed Life Insureds A and B jointly ☐
Other ☐ If other, please complete below.

First or Company Name | Middle Name | Last Name | Prefix

S.I.N or Business Number | Relationship to Proposed Life Insured A and B (if any)

Mailing address (for billings, notices etc.)

City | Province | Postal Code | Attention

Joint Applicant/Owner other than Proposed Life Insured A and B, if any

If Joint Owners, ownership is to be with right of survivorship unless otherwise indicated.

16. First or Company Name | Middle Name | Last Name | Prefix

S.I.N or Business Number | Relationship to Proposed Life Insured A and B (if any)

Contingent Owner

Must be completed if purchasing Child Rider.
If all Owners predecease the Life Insured(s), in the absence of a Contingent Owner, ownership passes to the estate of the last surviving Owner.

17. First Name | Middle Name | Last Name

Relationship to Proposed Life Insured A and B (if any)

Language of Policy

18. English ☐ French ☐

COMPLETE ONLY IF APPLYING FOR A UNIVERSAL LIFE PLAN

Confirmation of Individual Applicant/Owner Identity

19. A minimum of one piece of identification is required, the original of which must be shown to the representative.

Driver's license ☐ Permanent Residence card ☐ Canadian Citizenship card ☐ Place of Issue _____

Birth Certificate ☐ Passport ☐ Document number _____ Country of Issue _____

Confirmation of Joint Applicant/Owner Identity if any

20. A minimum of one piece of identification is required, the original of which must be shown to the representative.

Driver's license ☐ Permanent Residence card ☐ Canadian Citizenship card ☐ Place of Issue _____

Birth Certificate ☐ Passport ☐ Document number _____ Country of Issue _____

Confirmation of Applicant/Owner Identity if Corporation or Entity

21. Please verify the identity of the Applicant/Owner using one of the documents below. For corporations only, ensure the document includes names of the directors or add this information in the attached Representative's Supplementary Report.

Certificate of corporate status ☐ Partnership agreement ☐ Trust document ☐

Articles of association ☐ Other ☐

A photocopy of the document must be submitted with this application.

22. Is any Applicant/Owner applying for this policy on behalf of a third party (i.e. will someone else be paying premiums)?
No ☐ Yes ☐ (If yes, complete Third Party Information)

Third Party Information

Name	Address	Principal Business or Occupation	Relationship to Proposed Life Insured

Insurance applied for - Proposed Life Insured A

23. Plan Single Life ☐ Joint Last–to-Die ☐ Joint First-to-Die ☐ Non-Smoker ☐ Smoker ☐

Face Amount	Insurance Riders/Benefits – include coverage amount
$	

If applying for Payor Waiver Benefit, what is the Payor's relationship to the Applicant/Owner? _____

Complete the required sections or a separate application if this is a joint policy.

For Universal Life plans only Level Death Benefit with YRT Cost of Insurance ☐ Increasing Death Benefit with Level Cost of Insurance ☐ Increasing Death Benefit with YRT Cost of Insurance ☐

Are you applying for Long Term Care Benefit? Yes ☐ No ☐ If yes, please complete the Long Term Care Supplement.

Existing Insurance - Proposed Life Insured A

Insurance in force or pending? Yes ☐ No ☐ If yes, complete below. Complete Disclosure forms where necessary.

24.

Year Issued	Company	Amount of Life Insurance including Term Riders			Other types of Insurance e.g. Accidental Death Benefit, CI, Disability	Is the insurance applied for intended to replace any insurance now in force with any company?	
		Personal	Business	Group		Yes	No

25. **Conversion:** Existing policy number _____ Full conversion? ☐ Partial conversion? ☐

Balance of partial conversion Retain? ☐ (must meet plan minimum) Cancel? ☐

Conversion details _____

Insurance applied for - Proposed Life Insured B

26. Plan Single Life ☐ Joint Last–to-Die ☐ Joint First-to-Die ☐ Non-Smoker ☐ Smoker ☐

Face Amount

$

Insurance Riders/Benefits – include coverage amount for each

If applying for Payor Waiver Benefit, what is the Payor's relationship to the Applicant/Owner? _____

Complete the required sections or a separate application if this is a joint policy.

Existing Insurance - Proposed Life Insured B

Insurance in force or pending? Yes ☐ No ☐ If yes, complete below. Complete Disclosure forms where necessary.

27.

Year Issued	Company	Amount of Life Insurance including Term Riders			Other types of Insurance e.g. Accidental Death Benefit, CI, Disability	Is the insurance applied for intended to replace any insurance now in force with any company?	
		Personal	Business	Group		Yes	No

28. **Conversion:** Existing policy number _____ Full conversion? ☐ Partial conversion? ☐

Balance of partial conversion Retain? ☐ (must meet plan minimum) Cancel? ☐

Conversion details _____

Premium Payment

If applying for Universal Life, a signed illustration and a completed Investment Allocation form must be submitted with the application.

29. Initial Scheduled Premium Billing Frequency Annual ☐ Monthly PAC ☐

$

PAC withdrawal date if different from policy date (1st – 28th) _____

Initial premium to be drawn by PAC? Yes ☐ No ☐

Pre-Authorized Chequing (PAC) Agreement

Ensure you read & understand the section "Your Privacy Matters to Us"

30. The Payor(s) named below agrees that:

(a) RBC Life Insurance Company (RBC Insurance) is authorized to make scheduled withdrawals to pay the premium for this policy or policies, including the initial premium and/or the Temporary Insurance Agreement premium if requested in this Application, against the account at the financial institution below, or any other financial institution that the Payor may later designate, in accordance with the rules of the Canadian Payment Association ("CPA").
(b) such withdrawals will be on dates and in amounts in accordance with the premium schedule set out in this policy or policies,
(c) if the amount of withdrawal should vary, pre-notification by RBC Insurance is waived,
(d) the financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Insurance to withdraw from the account indicated below, including a representment or redraw within 30 days should any withdrawal not clear the account,
(e) unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy(ies),
(f) notification of any change to the account information provided below, shall be given to RBC Insurance by the Payor 5 days prior to the next scheduled withdrawal. I/We agree that from time to time I/we may authorize RBC Insurance to deduct such payments from another account upon my/our oral or written instructions,
(g) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Insurance or by the Payor,
(h) A PAC may be disputed by the undersigned under the following conditions:
  i) If the PAC was not drawn in accordance with this Agreement; or
  ii) If this Agreement was revoked.

In the event that either (i) or (ii) applies, the Payor agrees to contact RBC Insurance. If a satisfactory resolution cannot be achieved between the Payor and RBC Insurance, then in accordance with CPA rules, in order to be reimbursed, the undersigned acknowledge(s) that a declaration to the effect that either (i) or (ii) took place, must be completed and presented to the branch holding the account up to and including 90 calendar days in the case of a personal PAC (or up to and including 10 business days in the case of a business PAC), after the date on which the PAC in dispute was posted to the account below.

I/We acknowledge that a claim on the basis that this agreement was revoked, or any other reason, is a matter to be resolved solely between me/us and RBC Insurance when disputing any PAC after the 90 calendar days in the case of a personal PAC (or up to an including 10 business days in the case of a business PAC).
(i) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

(j) Add to existing PAC with policy number(s) _____

(k) Special Requests (withdrawals are limited between the 1st – 28th of the month) _____

Bank Information:

Please attach a specimen cheque marked void (a line of credit account cannot be used).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number

Address _____

City _____ Province _____ Postal Code _____

Dated at _____ (City/Province) this _____ day of _____ (Month/Year)

Print Name of Payor (Account Holder) _____

Print Name of Second Payor (Account Holder) (if any) _____

Signature of Payor _____

Signature of Second Payor (if any) _____

Personal Information - Proposed Life Insured A and B

1. Has the Proposed Life Insured:	A Yes	A No	B Yes	B No
(a) had any application for any form of life or health insurance, any change or reinstatement declined, rated, cancelled or modified in any way? If yes, please give details.	☐	☐	☐	☐
(b) applied for or received a pension, including CPP disability, income replacement benefits, compensation, workers compensation benefits of any type or Employment Insurance Disability Benefits? If yes, please give details.	☐	☐	☐	☐
(c) in the last 3 years engaged in any activity or sport, including but not limited to racing, sky diving, ultra-light flying, hang gliding, scuba diving, mountaineering, heli-skiing, CAT or back-country skiing or have plans to do so? If yes, please provide details or complete the appropriate questionnaire.	☐	☐	☐	☐
(d) flown an aircraft as pilot or student pilot or operated as a crew member in the last 3 years or have plans to do so? If yes, please complete the Aviation Questionnaire.	☐	☐	☐	☐
(e) within the last 2 years travelled outside Canada or the United States of America or have plans to do so in the future? If yes, please complete the Foreign Travel Questionnaire.	☐	☐	☐	☐
(f) been found guilty of a driving violation, had a driver's licence revoked or suspended in the last 10 years or are there any such charges pending? If yes, please give details.	☐	☐	☐	☐
Date _____ Type _____				
Date _____ Type _____				
Driver's Licence No. _____ Province of issue of licence _____				
(g) been found guilty of impaired driving or any other alcohol or drug related offence within the last 10 years or are there any such charges pending? If yes, please explain fully.	☐	☐	☐	☐
(h) been found guilty of a criminal offence within the last 10 years or are there any criminal charges pending? If yes, please explain fully.	☐	☐	☐	☐
(i) or the Applicant/Owner declared bankruptcy within the last 10 years? If yes, please explain fully, including dates of discharge if applicable.	☐	☐	☐	☐
(j) ever had a licence to practise any occupation suspended, revoked or under review; been found guilty of any professional misconduct or had disciplinary measures recommended in connection with any licence to practise? If yes, please explain fully.	☐	☐	☐	☐

Additional details of "yes" answers.

Insured A or B	Question #	Details

Financial Information – Proposed Life Insured A

Complete for all applications

1. Main purpose of insurance

   Personal ☐ Income Replacement ☐ Estate Conservation ☐ Investment Credit Facility ☐

   Other:

   Business ☐ Buy/Sell ☐ Key Person ☐ Collateral ☐

2. Source of planned premium _____

3. What is your annual earned income in Canadian dollars from:

   Salary $ _____

   Commissions $ _____

   Bonuses $ _____

   Other $ _____

4. What is your annual income in Canadian dollars from other sources:

   Dividends $ _____

   Interest $ _____

   Other $ _____ Source _____

5. If you are not currently working, what is the source of your income? _____

6. What is your estimated net worth in Canadian dollars? _____

7. What is the amount of mortgage outstanding on your personal residence? _____

Complete if applying for business insurance

1. Book value of business in Canadian dollars $ _____
2. Fair market value of business in Canadian dollars $ _____
3. Net annual before tax income of business in Canadian dollars $ _____
4. Percentage of business owned _____ %
5. Are other partners, owners, executives insured for a similar amount? Yes ☐ No ☐ If no, please explain.

Complete if Proposed Life Insured is under age 16.

1. Amount of insurance on father $ _____ If none, please explain.
2. Amount of insurance on mother $ _____ If none, please explain.
3. Are all other children in the family insured? Yes ☐ No ☐ If no, please explain.
4. Amount of insurance on other siblings $ _____
5. Source of premium. If not from parents, please provide details. _____

Financial Information – Proposed Life Insured B

Complete for all applications

1. Main purpose of insurance

   Personal ☐ Income Replacement ☐ Estate Conservation ☐ Investment Credit Facility ☐

   Other:

   Business ☐ Buy/Sell ☐ Key Person ☐ Collateral ☐

2. Source of planned premium _____

3. What is your annual earned income in Canadian dollars from:

   Salary $ _____

   Commissions $ _____

   Bonuses $ _____

   Other $ _____

4. What is your annual income in Canadian dollars from other sources:

   Dividends $ _____

   Interest $ _____

   Other $ _____ Source _____

5. If you are not currently working, what is the source of your income? _____

6. What is your estimated net worth in Canadian dollars? _____

7. What is the amount of mortgage outstanding on your personal residence? _____

Complete if applying for business insurance

1. Book value of business in Canadian dollars $ _____
2. Fair market value of business in Canadian dollars $ _____
3. Net annual before tax income of business in Canadian dollars $ _____
4. Percentage of business owned _____ %
5. Are other partners, owners, executives insured for a similar amount? Yes ☐ No ☐ If no, please explain.

Complete if Proposed Life Insured is under age 16.

1. Amount of insurance on father $ _____ If none, please explain.
2. Amount of insurance on mother $ _____ If none, please explain.
3. Are all other children in the family insured? Yes ☐ No ☐ If no, please explain.
4. Amount of insurance on other siblings $ _____
5. Source of premium. If not from parents, please provide details. _____

Tobacco Usage

The information listed below is relied upon to establish the policy's premium rate and is material to the insurance risk. Failure to make proper disclosure will entitle RBC Insurance to render the policy null and void.

1. Has the Proposed Life Insured A ever used any of the following:	Yes	No	Quantity/Frequency	Date last used
(a) cigarettes	☐	☐		
(b) cigarillos	☐	☐		
(c) cigars	☐	☐		
(d) chewing tobacco	☐	☐		
(e) pipe	☐	☐		
(f) snuff	☐	☐		
(g) marijuana or hashish	☐	☐		
(h) smoking cessation products such as Zyban, patches or gum	☐	☐		
(i) tobacco substitutes such as betel nuts, betel leaves, supari, paan or gutka? Please specify.	☐	☐		

Additional details of "yes" answers.

2. Has the Proposed Life Insured B ever used any of the following:	Yes	No	Quantity/Frequency	Date last used
(a) cigarettes	☐	☐		
(b) cigarillos	☐	☐		
(c) cigars	☐	☐		
(d) chewing tobacco	☐	☐		
(e) pipe	☐	☐		
(f) snuff	☐	☐		
(g) marijuana or hashish	☐	☐		
(h) smoking cessation products such as Zyban, patches or gum	☐	☐		
(i) tobacco substitutes such as betel nuts, betel leaves, supari, paan or gutka? Please specify.	☐	☐		

Additional details of "yes" answers.

Child Term Rider

Must be natural or adopted child of Proposed Life Insured A or B. A Contingent Owner must be appointed. Any child over age 16 must sign the application.

(a) First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Female ☐ Male ☐ | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday | Height cm ☐ ft/in ☐ | Weight kg ☐ lbs ☐

(b) First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Female ☐ Male ☐ | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday | Height cm ☐ ft/in ☐ | Weight kg ☐ lbs ☐

(c) First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Female ☐ Male ☐ | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday | Height cm ☐ ft/in ☐ | Weight kg ☐ lbs ☐

(d) First Name | Middle Name | Last Name

Relationship to Applicant/Owner

Female ☐ Male ☐ | Date of Birth (dd/mmm/yy) | Age as of Nearest Birthday | Height cm ☐ ft/in ☐ | Weight kg ☐ lbs ☐

	Yes	No
1. Has any insurance application on any child been declined, postponed or modified in any way?	☐	☐
2. Do any of the children have any physical or mental impairment or have they had any illness, impairment or injury that has required treatment or an operation?	☐	☐
3. Are any of the children currently on medication or has any treatment or diagnostic test been advised that has not been completed?	☐	☐
4. Do all of the above children reside with either of the Proposed Life Insureds? If no, provide details about who the child lives with and how often the Proposed Life Insured sees the child.	☐	☐
5. What was the reason for, the date of and the result of the child's last visit to the health care professional? Include health care professional's name, professional designation, address, postal code and phone number in the space below.		

Space for additional information to the above questions or names of additional children.

Child	Question	Details

Medical History Proposed Life Insured A

1. Height cms ☐ ft/in ☐ Weight kg ☐ lbs ☐

2. Has your weight changed in the last year? Yes ☐ No ☐ Gained? ☐ Lost? ☐ _____ kg ☐ lbs ☐
   If yes, state reason for change _____

3. (a) Name and address of your personal health care professional/clinic (If none, so state)

   (b) How long have you been a patient there?

   (c) Date and reason last consulted

   (d) What was the diagnosis, treatment given or medication prescribed? (If none, so state)

4. (a) Other than the above, within the past year have you consulted any other health care professional? Yes ☐ No ☐

   (b) If yes, give the date, reason and any treatment given or medication prescribed.

5. Any family history of diabetes mellitus, cancer (specify type), high blood pressure, colon polyps, heart disease, polycystic kidney disease or other kidney disease, stroke, Huntington Disease, hepatitis or Parkinson Disease? Yes ☐ No ☐

	Condition or Cause of Death	Age at Onset	Age if Living	Age at Death		Condition or Cause of Death	Age at Onset	Age if Living	Age at Death
Father					Brothers				
Mother					Sisters				

Additional details

Question #	Details

Medical History Proposed Life Insured B

1. Height cms ☐ ft/in ☐ Weight kg ☐ lbs ☐

2. Has your weight changed in the last year? Yes ☐ No ☐ Gained? ☐ Lost? ☐ _____ kg ☐ lbs ☐
   If yes, state reason for change _____

3. (a) Name and address of your personal health care professional/clinic (If none, so state)

   (b) How long have you been a patient there?

   (c) Date and reason last consulted

   (d) What was the diagnosis, treatment given or medication prescribed? (If none, so state)

4. (a) Other than the above, within the past year have you consulted any other health care professional? Yes ☐ No ☐

   (b) If yes, give the date, reason and any treatment given or medication prescribed.

5. Any family history of diabetes mellitus, cancer (specify type), high blood pressure, colon polyps, heart disease, polycystic kidney disease or other kidney disease, stroke, Huntington Disease, hepatitis or Parkinson Disease? Yes ☐ No ☐

	Condition or Cause of Death	Age at Onset	Age if Living	Age at Death		Condition or Cause of Death	Age at Onset	Age if Living	Age at Death
Father					Brothers				
Mother					Sisters				

Additional details

Question #	Details

Medical History continued – Proposed Life Insured A and B

	A		B	
6. Have you ever had, or been told you have or have you ever received treatment or advice for:	**Yes**	**No**	**Yes**	**No**
(a) dizziness, fainting, convulsions, epilepsy, seizures, tremor, Parkinson disease, headache, migraine, speech problems, paralysis, stroke, transient ischemic attack (TIA), memory disorder, Alzheimer disease, numbness, neuropathy, multiple sclerosis or other neurological disorder?	☐	☐	☐	☐
(b) anxiety, depression, chronic fatigue, suicidal thoughts or any other psychiatric, emotional, behavioural, mental or nervous disorder?	☐	☐	☐	☐
(c) disorder of the eyes, ears, nose, mouth or throat?	☐	☐	☐	☐
(d) shortness of breath, wheezing, chronic cough, chronic bronchitis, chronic obstructive lung disease, emphysema, asthma, blood spitting, hoarseness, pleurisy, pneumonia, tuberculosis, sleep apnea or other respiratory or lung disorder?	☐	☐	☐	☐
(e) high blood pressure, elevated cholesterol, abnormal ECG (electrocardiogram), chest pain, angina, heart attack, myocardial infarction, coronary artery disease, coronary angiogram, angioplasty, coronary artery surgery, palpitation, irregular heart rhythm, heart failure, ankle swelling, heart murmur, rheumatic fever, heart valve abnormality, blood clot, thrombophlebitis, pulmonary embolus or other disorder of the heart, blood vessels or circulatory system?	☐	☐	☐	☐
(f) ulcer, stomach or intestinal bleeding, jaundice, hepatitis, hepatitis carrier state, colitis, Crohn disease, chronic diarrhea or other disorder of the stomach, intestines, liver, gallbladder or pancreas?	☐	☐	☐	☐
(g) sugar, protein, blood or pus in the urine, kidney stone, kidney infection, kidney cysts, prostate disorder, abnormal PSA (Prostate Specific Antigen) test, ovarian, uterine or cervical disorder, sexually transmitted disease, complications of pregnancy or any other disorder of the bladder, kidneys or reproductive tract?	☐	☐	☐	☐
(h) AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) or a positive test for antibodies to HIV (Human Immunodeficiency Virus)?	☐	☐	☐	☐
(i) skin cancer, dysplastic nevi, rheumatism, arthritis, gout, lupus, SLE (Systemic Lupus Erythematosus), osteoporosis, amputation, fibromyalgia, chronic pain disorder or any other disorder of the skin, joints, muscles, bones, ligaments, soft tissues, discs, neck, back or spine?	☐	☐	☐	☐
(j) any cancer, tumour, cyst, mass, lesion, lump, nodule or breast disorder?	☐	☐	☐	☐
(k) anemia, bleeding disorder, clotting disorder, allergies, immune disorders, lymphoma, leukemia or any other disorder of the blood or lymph nodes or any serious or unexplained infection?	☐	☐	☐	☐
(l) diabetes mellitus, thyroid or other endocrine or hormonal disorder?	☐	☐	☐	☐

Details of "Yes" answers. Include date, diagnoses, results of tests, duration and names and addresses of all attending health care professionals and medical facilities.

Insured A or B	Question #	Details

Medical History continued – Proposed Life Insured A and B

		A		B	
		Yes	No	Yes	No
7.	(a) Do you currently take any medications, including herbal, naturopathic, homeopathic or other remedies?	☐	☐	☐	☐
	(b) Within the past 12 months have you received chiropractic or acupuncture treatment?	☐	☐	☐	☐
	(c) In the past 5 years have you had any other tests not mentioned above (such as Coronary Calcium Score, CT scan, MRI, etc,)?	☐	☐	☐	☐
	(d) Have you been advised to undergo investigations, have treatment, testing or consultation which has not yet been completed?	☐	☐	☐	☐
	(e) Are you aware of any other symptom or health-related disorder for which you have not yet consulted a health care professional?	☐	☐	☐	☐
	(f) Have you ever received or been advised to seek counselling or treatment regarding the use of alcohol, or ever attended Alcoholics Anonymous (AA) meetings or any other similar organization?	☐	☐	☐	☐
	(g) Do you currently use alcoholic beverages? If yes, state type, amount and frequency.	☐	☐	☐	☐
	(h) Have you ever used sedatives, tranquilizers or hallucinogenic or narcotic drugs including cocaine and marijuana except as prescribed by a health care professional?	☐	☐	☐	☐
	(i) Females only: Are you pregnant?	☐	☐	☐	☐
	If yes, please state your expected delivery date _____				

Details of "Yes" answers. Include date, diagnoses, results of tests, duration and names and addresses of all attending health care professionals and medical facilities.

Insured A or B	Question #	Details

Temporary Life Insurance Application

Only available when the amount of life insurance applied for is $1,000,000 or less. If any of the following questions are answered 'Yes' or if any Proposed Life Insured is under 15 days or over 65 years old, do not proceed.

Has any Proposed Life Insured	A Yes	A No	B Yes	B No
1. ever been treated for or had any indication of heart or blood vessel disease, high blood pressure, chest pain, stroke, transient ischemic attacks (TIA), diabetes mellitus, chronic kidney, liver or lung disease, cancer or tumours, multiple sclerosis, paralysis, Alzheimer or Parkinson disease, AIDS or HIV infection, loss of speech, blindness or deafness?	☐	☐	☐	☐
2. within the last year, other than normal childbirth, been admitted to hospital or other medical facility or been advised to do so?	☐	☐	☐	☐
3. been advised to have any tests, investigations or surgery not yet done?	☐	☐	☐	☐
4. in the last year had any application for life insurance, change or reinstatement declined, rated or modified in any way?	☐	☐	☐	☐

I declare that the above questions have been truthfully answered.

Dated at _____ this _____ day of _____ year _____

Signature of Applicant/Owner (if other than Proposed Life Insured)

Signature of Proposed Life Insured A

Signature of Joint Applicant/Owner (if any)

Signature of Proposed Life Insured B (if any)

Signature of any minor Proposed Life Insured age 16 and over or parent/guardian of minor Proposed Life Insured under age 16

090318113115

Temporary Life Insurance Receipt

RBC Life Insurance Company (RBC Insurance) acknowledges receipt of $_____ (at least the minimum premium at standard rates for the policy applied for under this Agreement or authorization was provided to RBC Insurance in this Application to withdraw this sum immediately by pre-authorized chequing) in payment for coverage under the Temporary Life Insurance Agreement on the life of

Temporary Life Insurance is subject to the conditions, limits of amount and duration as specified on the Temporary Life Insurance Agreement on the reverse of this receipt.

Dated at _____ this _____ day of _____ year _____

Signature of Representative

090318113115

Temporary Life Insurance Agreement

If the terms, conditions and requirements are met, RBC Life Insurance Company (RBC Insurance) agrees to insure the Proposed Life Insured(s) specified in the Temporary Life Insurance Application subject to limits in the terms and conditions set out below.

Coverage

Temporary life insurance commences once the Life Insurance Application (Application) has been signed and the payment for coverage under this Temporary Life Insurance Agreement has been received.

In the event of the death of the specified Life Insured(s) (if more than one Life Insured, the first or last-to-die according to the contract) while this Agreement is in force and subject to a maximum aggregate liability of $1,000,000 under this and all other Temporary Life Insurance Agreements issued by RBC Insurance, RBC Insurance will pay the LESSER OF:

(a) the amount of life insurance applied for in the Application, OR
(b) $1,000,000.

Should payment for coverage under this Agreement not be honoured, this coverage will be considered null and void from the date of the Application.

Termination of Temporary Life Insurance

Insurance coverage provided by this Agreement will terminate on the earliest of:

(a) 90 days from the date the Application is signed, OR
(b) the date notice is given by RBC Insurance to the Applicant/Owner of termination of insurance under this Agreement (notice by mail shall be deemed to have been received two days following the date of mailing), OR
(c) the date the policy applied for goes in force.

Except in the case of fraud, payment received by RBC Insurance will be refunded in the event of termination under (a) or (b).

Limitations

(a) If there is material misrepresentation or non-disclosure in any part of the Life or Temporary Life Insurance Application, any application supplement or questionnaire, no Temporary Life Insurance will take effect and RBC Insurance shall, except in the case of fraud, refund the payment.
(b) RBC Insurance shall have no liability if the specified Proposed Life Insured(s), while sane or insane, commits suicide.
(c) No accidental death, disability/income replacement, critical illness or return/waiver of premium benefits are provided under this Agreement.
(d) Post dated cheques are not acceptable.

Disclosure Statement for the Province of British Columbia

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by RBC Life Insurance Company, a company licensed to carry on business in British Columbia.

In relation to any application you may make for the acquisition of life insurance, annuities or other financial products:

- I am acting as a licensed insurance representative on behalf of this company;
- I will be entitled to receive commission from the company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or an on-going service commission; and
- There is no condition associated with this transaction requiring that you must transact additional or other business with either myself or the company.

Dated at _____ this _____ day of _____ year _____

_____
Signature of Representative

Dated at _____ this _____ day of _____ year _____

_____
Signature of Representative

090318113115

TO BE LEFT WITH THE PROPOSED LIFE INSURED

Notice regarding the MIB, Inc.

Information regarding your insurability will be treated as confidential. RBC Life Insurance Company or its reinsurers may, however, make a brief report to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such company, the MIB, upon request, will supply such company with the information in its file.
Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction. The address of the MIB information office is: MIB, Inc., 330 University Avenue, Toronto, Ontario, CANADA M5G 1R7 Telephone: (416) 597 - 0590. Web site: http://www.mib.com
RBC Life Insurance Company or its reinsurers may also release information in its 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.

Authorization

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files, which contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or the persons to whom I have granted access, in writing, or to any other person authorized by law.

I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my Application.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income or employment that is relevant to this Application, which they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also MIB, Inc., and also to any other person, agency credit bureau or institution having information, records or data regarding me.

I understand that any information, records or data received by the Company pursuant to this authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the MIB, Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ (Province/City) this _____ day of _____ (Month) year _____

_____
Signature of Witness

_____
Signature of Proposed Life Insured A

_____
Signature of Proposed Life Insured B

_____
Signature of any minor Proposed Life Insured age16 and over or parent/guardian of any minor Proposed Life Insured under age 16

Authorization

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files, which contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or the persons to whom I have granted access, in writing, or to any other person authorized by law.

I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my Application.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income or employment that is relevant to this Application, which they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also MIB, Inc., and also to any other person, agency credit bureau or institution having information, records or data regarding me.

I understand that any information, records or data received by the Company pursuant to this authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the MIB, Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ (Province/City) this _____ day of _____ (Month) year _____

_____
Signature of Witness

_____
Signature of Proposed Life Insured A

_____
Signature of Proposed Life Insured B

_____
Signature of any minor Proposed Life Insured age16 and over or parent/guardian of any minor Proposed Life Insured under age 16

Declarations, Agreements and Consents

The Applicant/Owner and any Proposed Life Insured, if other than the Applicant/Owner, declare to the best of their knowledge that all statements and answers in all parts of this application and in any supplement to this application are full, complete and true and agree that:

1. RBC Life Insurance Company (RBC Insurance) has 90 days to consider and act upon this application from the date the application was signed. If RBC Insurance has not given notice of approval or rejection within that time, this application shall be considered to have been declined,
2. insurance under the policy shall take effect only when (a) a policy tendered for delivery is accepted by the Applicant/Owner, (b) the full initial premium has been paid and (c) provided no change in insurability of any Proposed Life Insured has taken place between the time of application and delivery. If Medical History - Part 2, is submitted prior to completion of the application, the application shall be deemed to have been made as of the time such History was submitted,
3. RBC Insurance may be entitled to render this policy and any Temporary Life Insurance Agreement null and void if there is misrepresentation or non-disclosure in any part of the application for insurance, medical examination or any questionnaire completed in connection with this application that is material to the insurance risk,
4. the entire contract of insurance shall be the policy, any attached endorsements, exclusions, amendments, addendums or documents and all completed parts of this application, application supplement or questionnaire. Acceptance of the policy will constitute agreement to its terms and notification of any changes specified by RBC Insurance in the policy,
5. no statement made to and no information acquired by a representative of RBC Insurance or an examining physician shall be attributed to or binding upon RBC Insurance unless contained in the application or any related declaration of health-related evidence of insurability. No one other than an officer of RBC Insurance may (a) alter or modify the terms of this application or policy or (b) waive any of RBC Insurance's rights or requirements,
6. if the monthly mode of payment has been selected, I agree to the terms of the Pre-Authorized Chequing Agreement,
7. I have read the section entitled "Collection and use of Personal Information" appearing in this application and understand and agree to its terms,
8. a copy of the "Notice regarding the MIB, Inc." has been received and read,
9. unless otherwise requested in the Language of Policy question in this application, the policy and all related documents have been expressly requested to be in the English language. À moins de stipulation contraire à la question relative à la langue du contrat de la présente proposition, il a été expressément demandé que le contrat et tous les documents qui s'y rapportent soient rédigés en anglais.

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Life Insured A
(or Parent/Guardian if child under 16)

Signature of Proposed Life Insured B (if any)
(or Parent/Guardian if child under 16)

Signature of any minor Proposed Life Insured over age 16

Signature of Witness

Signature of Applicant/Owner if other than Proposed Life Insured
(if Corporate Owner, include Title of signing officer;
if Trustee Owner, sign as Trustee and identify the Trust)

Signature of Joint Applicant/Owner (if any)

Representative's Report

1. How long have you known the Proposed Life Insured A? _____ years Proposed Life Insured B? _____ years
2. Have you collected money? Yes ☐ No ☐
   If yes, indicate amount collected $ _____ Date received _____
3. (a) Is the Proposed Life Insured fluent in the English language? Yes ☐ No ☐
   (b) If the Proposed Life Insured is not fluent in English, a Statement of Understanding in the Proposed Life Insured's language of choice must be completed and submitted before underwriting can proceed.
   (c) If the language used to complete the application was not English, what was the language used and who explained the application? _____
4. (a) Were you present at the time of completion of the application? Yes ☐ No ☐
   (b) Who was present at the time of completion of the application? _____

Complete if Joint Lives

5. (a) Number of lives covered ____ (b) Names of other lives _____

Complete if Proposed Life Insured is a Child Under 16 Years

6. (a) With whom is the child living? (b) Are all other children in the family insured? Yes ☐ No ☐
   If not, why has this child been chosen?

(c) Indicate the amount of insurance on:	Father	Mother	Other Siblings
	$	$	$

(d) Is the Owner the child's parent? Yes ☐ No ☐ If no, please provide full details.

7. Back date to save age? Yes ☐ No ☐ Other special date _____
8. Evidence: The following requirements have been ordered

Medical	☐	Blood Profile	☐	Para-Medical	☐
ECG/Ex.ECG	☐	Int. Medical	☐	Para-Medical company used	_____
Urine-HIV	☐	Inspection	☐	Other ☐	_____
Saliva-HIV	☐	MVR	☐		

9. I, the Representative, confirm that the Applicant/Owner has presented original documents to confirm their identity? Yes ☐
10. **Representative's Declaration**

I declare that:

- I have clearly explained the provisions and limitations of the policy being applied for (and the Temporary Life Insurance Agreement, if applicable) to the Proposed Life Insured(s) (and the Applicant/Owner, if applicable),
- all of the questions in the application were clearly asked of, or read by, the Proposed Life Insured(s) (and the Applicant/Owner, if applicable),
- to the best of my knowledge, all of the answers and statements on the application have been fully and accurately recorded,
- I am not aware of any pertinent information about the Proposed Life Insured(s) that has not been disclosed on the application,
- if a policy is issued, I will deliver it to the Applicant/Owner only after obtaining confirmation that all conditions for delivery have been completely satisfied and there has been no change in the insurability of the Proposed Life Insured(s),
- I understand that I cannot modify the application, the Temporary Life Insurance Agreement or the terms of the policy, if issued.
- I have complied with my duties and obligations in regards to Advisor Disclosure including providing an Advisor Disclosure Statement in writing to the Proposed Owner.

Date						
Representative's signature						
Representative's Name						
Representative's Company Name						
Marketing Office						
Share	%	Servicing Representative Code	%	Representative Code	%	Representative Code

Representative's Supplementary Report

Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk. e.g. occupation, aviation, avocation, purpose of insurance, amount, income, health problems, habits, finances, replacement, insurable interest.

Checklist

Use this Checklist BEFORE you submit the application.

Have you detached and given to the applicant:

Disclosure Statement for the Province of B.C. ☐ MIB, Inc. Pre-Notice ☐ TIA receipt (if applicable) ☐

Have you attached to the application:

Supplementary questionnaires (if required) ☐
Payment for the first month ☐
A void cheque with legible banking codes (if using PAC) ☐
Disclosure form (if applicable) ☐
A signed illustration for all Universal Life Plans ☐
An Initial Investment Allocation Form for Universal Life Plans ☐

Application checked by:

Print Name Code _____ Number _____

Signature _____ Telephone _____

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89604 (08/2008)