APPLICATION FOR CHANGE

(WHEN EVIDENCE OF INSURABILITY IS REQUIRED)

This form is to be completed by hand. We do not accept electronically completed forms.

INSURED: _____ POLICY NUMBER: _____

DATE OF BIRTH: _____ (MM/DD/YYYY)

CHANGE(S) REQUESTED (Check all that apply)

- ❒ Occupation class change ..... complete sections 1, 2 and 4.
- ❒ Reconsideration of rating ..... complete sections 1, 2 and 4.
- ❒ Reconsideration of exclusion rider ..... complete sections 1, 2 and 4.
- ❒ Reinstatement ..... complete sections 1, 2, 3 and 4.
- ❒ Tobacco rates to non-tobacco rates ..... complete sections 2, 3 and 4.

SECTION 1 OCCUPATION AND INSURANCE INFORMATION

a. Current occupation _____

b. At current occupation since _____

c. At current occupational duties since _____

d. Annual earned income $ _____

e. Current Duties: Admin/Office _____ % Sales _____ %
Supervision _____ % Manual/Physical _____ %

f. Number of full time employees _____

g. Do you have any intention of changing your occupation within the next 12 months? ❒ Yes ❒ No
If "Yes", provide details _____

h. Are you eligible for: Workers Compensation? ❒ Yes ❒ No
Employment Insurance? ❒ Yes ❒ No

i. Have you applied for, or are you covered, under any plan which provides income benefits in the event of disability?
❒ Yes ❒ No If "Yes", provide details below:

Company	Date of Issue Month Year	Monthly Benefit Amount	Benefit Period	Elimination Period	Taxable Benefit Yes	Taxable Benefit No
					❒	❒
					❒	❒
					❒	❒

SECTION 2 PERSONAL INFORMATION

a. Since this policy was originally applied for, have you:

i. had any company decline to issue or reinstate, rate, modify, postpone, rescind or cancel any life, disability or critical illness insurance? ❒ Yes ❒ No
If "Yes", provide details _____

ii. applied for life or critical illness with another company? ❒ Yes ❒ No
If "Yes", indicate type, amount and name of company _____

iii. ever applied for or received a pension, disability benefit or compensation for any accident or sickness, or had any premiums waived under any insurance contract? ❒ Yes ❒ No
If "Yes", provide details _____

b. Within the last 2 years, have you or any person covered under this policy:

i. engaged in flying (as a pilot or crew member), motorized vehicle racing, parachuting, hang gliding, scuba diving, or other hazardous activities or intend to do so? ❒ Yes ❒ No
If "Yes", complete the appropriate questionnaire.

ii. travelled or resided outside of North America, or intend to do so, excluding vacations? ❒ Yes ❒ No
If "Yes", state location, frequency and reason. _____

iii. had a driver's license suspended or had two or more moving violations? ❒ Yes ❒ No
If "Yes", indicate driver's license number and issuing province _____
If infractions occurred in another province, indicate province _____

iv. been charged with a criminal offence? ❒ Yes ❒ No
If "Yes", provide details _____

SECTION 3 TOBACCO / NICOTINE USE

a. Date of last use of ANY form of tobacco product _____ (mm/dd/yyyy)

b. Within the last 12 months, have you or any person covered under this policy:

i. used ANY form of tobacco including cigarettes, cigarillos, cigars, pipes, chewing tobacco or others? ❒ Yes ❒ No

If "Yes", circle product and advise amount and frequency _____

ii. smoked marijuana or used hashish? ❒ Yes ❒ No

If "Yes", advise amount and frequency _____

iii. used any smoking cessation products such as Nicorette gum or nicotine patches? ❒ Yes ❒ No

c. Have you been advised to quit smoking by your attending physician because of any symptoms regarding your health? ❒ Yes ❒ No

If "Yes", date and reason for quitting _____

NON-TOBACCO USER DECLARATION **(TO BE SIGNED BY NON-TOBACCO USERS ONLY)**

I hereby declare that I have not used any form of tobacco and/or marijuana and/or smoking cessation products in the last 12 months. I understand this is an application for Life and/or Disability and/or Critical Illness Insurance change/reinstatement with Non-Tobacco User Premium Rates. I understand and agree that a false Non-Tobacco User Declaration will constitute fraudulent misrepresentation. I understand and agree that there will be no liability, claim or benefits payable from any Life and/or Disability and/or Critical Illness Insurance that is issued by Western Life Assurance Company taking into consideration a false Non-Tobacco User Declaration.

_____ _____

Date Signature of Insured

SECTION 4 DECLARATION OF INSURABILITY

1. a. Height: _____ b. Weight _____ c. Weight one year ago: _____

d. Reason for any weight change over 10 lbs. (5kg.): _____

e. Name and address of personal physician: _____

f. Reason last consulted: _____

g. Date last consulted: _____ (mm/dd/yyyy)

	Yes	No	Provide details for all "Yes" answers:
2. Have you: **(Circle items which apply.)** a. ever used drugs (including but not limited to cocaine, amphetamines, barbiturates, hallucinogens, heroin or other derivatives of opium) other than as prescribed by a physician? **If "Yes", complete Drug Usage questionnaire.**	❒	❒	
b. ever received, or been advised to seek, counselling or treatment regarding the use of alcohol, or ever attended Alcoholics Anonymous (AA) meetings? **If "Yes", complete Alcohol Usage questionnaire.**	❒	❒	
c. currently use alcoholic beverages? **If "Yes": Type** _____ **Amount per week** _____	❒	❒	
d. ever had or received medical advice for abnormal blood pressure, chest pain, coronary artery disease or any other disorder or disease of the heart, blood vessels or cardiovascular system?	❒	❒	

SECTION 4 DECLARATION OF INSURABILITY (continued)

	Yes	No	Provide details for all "Yes" answers:
e. ever had or received medical advice for cancer, tumour, or any other growth or malignancy?	❒	❒	
f. ever had or received medical advice for diabetes, thyroid disorder, anemia, hepatitis or hepatitis carrier state, or any other blood or glandular disorder?	❒	❒	
g. ever had or received medical advice for any nose, throat, lung, sleep apnea or any other respiratory disorder?	❒	❒	
h. ever had or received medical advice for any disorder of the stomach, intestines, rectum, liver or pancreas?	❒	❒	
i. ever had or received medical advice for any injury or disease of the bones, muscles, joints, ears, eyes or skin?	❒	❒	
j. ever had or received medical advice for epilepsy, seizures, brain disorder, multiple sclerosis or any other disease or disorder of the nervous system?	❒	❒	
k. ever had or received medical advice for anxiety, depression, chronic fatigue, suicide ideation, or an emotional, behaviour, mental or nervous disorder?	❒	❒	
l. ever had or received medical advice for any disease or disorder of the kidney, bladder, or genital organs or system?	❒	❒	
m. ever had or received medical advice for AIDS (acquired immune deficiency syndrome), positive HIV test or any other immunological disorder?	❒	❒	
3. Other than as stated above, within the past five years, have you:			
a. consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	❒	❒	
b. had any abnormal diagnostic test result?	❒	❒	
c. been aware of any symptoms or complaints for which a physician has not yet been consulted or received treatment?	❒	❒	
d. been advised to have any test, exam or consultation but have not yet done so?	❒	❒	
4. Since this policy was originally issued, have any of your immediate family members (father, mother, siblings) been diagnosed with heart disease, stroke, cancer (specify type), kidney disease, mental illness, alcoholism, Huntington's Chorea, amyotrophic lateral sclerosis (Lou Gehrig's Disease), motor neuron disease, multiple sclerosis, Alzheimers, or any other hereditary disease?	❒	❒	
If "Yes", indicate family member, condition, <u>age at onset</u> and, if applicable, <u>age at death</u>.			

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

MIB PRE-NOTICE

MIB receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at privacy@mib.com.

Information regarding your insurability will be treated as confidential. Western Life Assurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of 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 a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will also arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is:

MIB Information Office
330 University Avenue, Suite 501
Toronto, Ontario, M5G 1R7
Telephone Number: (416) 597-0590

Western Life Assurance Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PRIVACY NOTICE

The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services.

This information, and information in existing files, may be used by and exchanged among Western Life Assurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies, and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force.

Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@westernlife.com or by calling 1-888-647-5433 and asking to speak to the Privacy Officer.

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THIS PAGE MUST ALWAYS BE SIGNED

AGREEMENT AND AUTHORIZATION

AGREEMENT

Each of the undersigned insured and/or policyowners agree that:

1. All statements, agreements, representations and answers made in this application, and any additional declarations or answers which may be made in any personal declaration required in connection with this application, together with all prior applications shall be consideration for the basis of the reinstatement and/or changed policy(ies) requested.

2. The answers to the statements and questions are complete, true and correctly recorded.

3. In order to effect the change, the Company shall have the right either:
   a. to issue a replacement policy if necessary; or
   b. to amend the present policy.

4. Except as changed by this application, any indebtedness under this policy and the rights of any beneficiary, assignee or other persons having interest in the policy shall remain unchanged.

5. The reinstatement and/or change shall not take effect until:
   a. approved by the authorized officers of the company;
   b. all premiums and fees required have been paid and honoured by the financial institution;
   c. the policy is delivered, and no change has taken place during the lifetime and good health of all persons who are or would be insured by this policy subsequent to the completion of this application.

6. The suicide and incontestability periods will apply from the effective date of reinstatement. Surrender charges will be reinstated.

7. The information collected on this Application for Change is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Western Life Assurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies, and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@westernlife.com or by calling 1-888-647-5433 and asking to speak to the Privacy Officer.

AUTHORIZATION

In connection with my application for change, I hereby acknowledge receipt of the MIB Pre-Notice and Privacy Notice.

I authorize Western Life Assurance Company, or its reinsurers to make a brief report of my personal health information to MIB, Inc. (“MIB”).

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. (“MIB”) or other organization, institution or person, that has any records or knowledge of me or my health, to give to Western Life Assurance Company, or its reinsurers, any such information.

The present consent is valid for the purpose of the present contract, its modification, extension or reinstatement. A photocopy of this consent has the same value as the original.

SIGNATURES

Signed at _____ Province _____ Date _____
Day Month Year

_____ _____
Insured (or guardian if under 16) Policyowner, if other than Insured

Name of Insured _____

SUPPLEMENTARY REPORT

Dated _____ Signature of Insured _____