Equitable Life of Canada®

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APPLICATION FOR CHANGE - G3

Change Request for Policy #: _____ Owner(s): _____

Insured(s): _____ Owners Address: _____

Insured(s) date of birth (dd/mmm/yyyy): _____

Owners Phone #: _____

Owners email: _____

Owners Country of Birth: _____

SIGN UP FOR CLIENT ACCESS!

View your account information online 24/7. Provide an email address and Equitable Life will send the owner of the policy a link to sign up for our secure Client Access website.

PURPOSE OF POLICY (Mandatory for all policy changes)

Indicate the purpose of the policy:

- ☐ Short Term Savings
- ☐ Income Creation
- ☐ Gift
- ☐ Other _____
- ☐ Retirement / Long Term Savings
- ☐ Income / Family Protection
- ☐ Mortgage / Debt Insurance
- ☐ Business / Key Person Protection / Buy Sell Agreement
- ☐ Legacy / Inheritance / Estate Protection
- ☐ Education Purposes

REQUESTED CHANGE - Please indicate the requested change and complete the required sections for that change.

Note. No charges apply for change processing. A $50 charge will apply to reverse the change. The reversal is only available within 21 calendar days from the date the change was processed.

Requirements may vary, based on actual change requested. Refer to online administration guide on Equitable's Website EQUINET: www.equitable.ca/advisorhome for sections required

- ☐ **Addition (A) –** Term riders only allowed for single life plans on same life for Equimax, Universal Life and Equiliving plans. Benefit Riders are also available.
- ☐ **Addition of Children's Protection Rider – (CPR)** $_____ (minimum $10,000, maximum $30,000).
- ☐ **Addition of Critical Illness Rider (CI):** ☐ 10 Year Renewable Term ☐ Level to 75 or ☐ Level to 100
- ☐ **Deletion / Decrease (D) –** riders, benefits, lives:
- ☐ **Smoker to Non Smoker Status (S)**
- ☐ **Exchange Option (E) –** for 10 year Term plan issued after July 15, 2008 to 20 year Term plan (Coverage must be in effect for at least 1 year and no more than 5 years).
- ☐ **Excelerator Deposit Option (EDO) –** Addition of Increase
- ☐ **Rating Reconsideration (R) –** removal or reduction
- ☐ **Change Privilege for Critical Illness (CP): –** 10 Year Renewable Term to "Level to Age 75" or "Level to 100"
- ☐ **Change to Dividend Option (DIV) –** Paid Up Additions
- ☐ **Death Benefit Option (DBO) – change Account Value Protector or Level only**
- ☐ **Cost of Insurance (COI) change to Level or Yearly Renewable Term (at attained age and original rates)**
- ☐ **Separate Policy Option (SPO) or Option to Elect Individual Policies (OTE)**
- ☐ **Other –**

APPLICATION FOR CHANGE - G3

Type of Change:	Complete the following Sections on this Form 374G3										
		1	2	3	4	5	6	7	8	9	Other:
A	If insured is over the Exact Age of 16	X	X	X	X	X	X		X	X	**see notes below for underwriting requirements**
	If insured is under the Exact Age of 16	X	X	X	X	X	X	X	X	X	**see notes below for underwriting requirements**
CPR		X						X	X	X	
CI		X	X	X	X	X	X		X	X	Before completing please review Pre Qualifying Questions on form 347
D		X							X	X	
S		X	X	X	X	X	X		X	X	Urine
E		X							X	X	
EDO	In first year	X							X	X	
		X	X	X	X	X	X		X	X	Policy is more than one year old; or there is no One Year Term Insurance in force under the Enhanced Protection Option; or when adding, increasing, making a single payment or reinstating the EDO
R		X	X	X	X	X	X		X	X	
CP		X							X	X	
DIV	Age 15 & Under	X				X	X	X	X	X	
	Age 16 & Over	X	X	X	X	X	X		X	X	
DBO		X							X	X	
COI	Level	X							X	X	
	YRT	X	X	X	X	X	X		X	X	
SPO		X							X	X	Form 671NOC, 671BCF, Form 378, Void Cheque – Illustration for UL plans only

Type of Change:	Complete the Following Sections on Form 350													
		1	2	3	4	5	6	7	9	10	11	17	19	Other
OTE	Term	X	X	X				X	X	X	X	X	X	Form - 671NOC
	Equimax	X	X	X	X				X	X	X	X	X	Form - 671NOC Signed Illustration
	Equation Generation IV	X	X	X		X	X		X	X	X	X	X	Form - 671NOC Signed Illustration

**refer to Evidence of Insurability Schedule Form 1343 for underwriting requirements for additions based on current age and total insurance within a 6 month period.

SECTION 1 - PLAN SPECIFICATIONS ONCE CHANGE COMPLETED

Insured(s) Name	Plan Description	Amount	Premium
		Mode: ☐ Annual ☐ Monthly	**Total:**

SECTION 2 - SMOKING DECLARATION - for "Yes" answers, specify types and date last used

	LIFE 1	LIFE 2
Have you smoked any cigarettes or used any form of marijuana within the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
Have you used any other tobacco or nicotine based products within the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

(If YES, specify types, frequency of use and date last used.) _____

Any misrepresentation or misstatement in the answers to these questions shall render any insurance issued in connection with this application voidable by Equitable Life of Canada®.

SECTION 3 - FINANCIAL INFORMATION

(Complete for all coverage amounts) Note: Owner to complete Personal Section if insurance is for any child(ren)

LIFE 1 - PERSONAL	
Annual earned income	$
Other income: Amount	$
Other income: Source	
Net Worth	$
Purpose of Insurance Coverage	$

LIFE 2 - PERSONAL	
Annual earned income	$
Other income: Amount	$
Other income: Source	
Net Worth	$
Purpose of Insurance Coverage	$

LIFE 1 - BUSINESS	
Percentage of Ownership	%
Annual Sales (Current Year)	$
Annual Sales (Previous Year)	$
Net Profit	$
Fair Market Value	$
Outstanding Loans/Liabilities	$

LIFE 2 - BUSINESS	
Percentage of Ownership	%
Annual Sales (Current Year)	$
Annual Sales (Previous Year)	$
Net Profit	$
Fair Market Value	$
Outstanding Loans/Liabilities	$

To Follow: ☐ Financial Statement ☐ Letter of Explanation

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL

QUESTIONS TO BE ANSWERED BY THE PERSON(S) TO BE INSURED, EXACT AGE 16 AND OVER OR PARENT OR LEGAL GUARDIAN OF CHILDREN UNDER EXACT AGE 16. (Completion of this section is not required if a paramedical or medical Part II is required.)

PERSON TO BE INSURED - LIFE 1

Given: _____

Last Name: _____

Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lbs ☐ kg

Weight changes past year? ☐ Yes ☐ No

Gain: _____ ☐ lbs ☐ kg Loss: _____ ☐ lbs ☐ kg

Reason for weight change: _____

Name & address of your usual medical advisor:
(IF NONE, STATE LAST CONSULT)

_____

_____

Date last consulted (dd/mmm/yyyy): _____

Reason/Symptoms: _____

Any Diagnosis and Treament? ☐ Yes ☐ No
(If "YES" provide details)

_____

Duration of Illness: _____

Any follow-up advised? (e.g. tests, surgery, hospitalization)
☐ Yes ☐ No (If "Yes", provide details)

_____

PERSON TO BE INSURED - LIFE 2

Given: _____

Last Name: _____

Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lbs ☐ kg

Weight changes past year? ☐ Yes ☐ No

Gain: _____ ☐ lbs ☐ kg Loss: _____ ☐ lbs ☐ kg

Reason for weight change: _____

Name & address of your usual medical advisor:
(IF NONE, STATE LAST CONSULT)

_____

_____

Date last consulted (dd/mmm/yyyy): _____

Reason/Symptoms: _____

Any Diagnosis and Treament? ☐ Yes ☐ No
(If "YES" provide details)

_____

Duration of Illness: _____

Any follow-up advised? (e.g. tests, surgery, hospitalization)
☐ Yes ☐ No (If "Yes", provide details)

_____

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL (CONTINUED)

FAMILY HISTORY

LIFE 1	LIFE 2
☐ Yes ☐ No	☐ Yes ☐ No

Has any family member (whether living or deceased) ever suffered from, or is suffering from:

- Alzheimer's disease
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer (specify type)
- Diabetes (specify type)
- Heart Disease
- High Blood Pressure
- Huntington's Chorea
- Kidney Disease
- Mental Illness
- Motor Neuron Disease
- Multiple Sclerosis
- Parkinson's Disease
- Stroke
- any other hereditary disease

If "Yes", please complete the chart below:

Life #	Family member: Father, Mother, Sisters, Brothers	Disease	Age at diagnosis	Actual Age if Alive	Age at Death	Cause of Death

PERSONAL HISTORY

Have you ever had symptoms of, been treated for, or been advised to receive treatment for, or had or been advised to have any investigations or examinations with respect to questions 1 to 9 below?:

	LIFE 1		LIFE 2	
	Yes	No	Yes	No
1. Heart attack, angina, chest pain, rheumatic fever, stroke, TIA, elevated blood pressure (last reading and date), or cholesterol, murmur, or other heart or blood vessel disease or disorder?	☐	☐	☐	☐
2. Asthma, respiratory, sleep apnea or other lung disorder? (If "YES", complete respiratory questionnaire.) (If "YES", complete respiratory questionnaire.)	☐	☐	☐	☐
3. Hearing or visual impairments?	☐	☐	☐	☐
4. Diabetes, colitis, bowel disorder, hepatitis, or hepatitis carrier state, kidney, bladder, prostate, gout, or urinary disorder, blood or endocrine abnormality?	☐	☐	☐	☐
5. Thyroid or glandular disorder, lupus, MS, ALS, epilepsy, muscle or bone disorder?	☐	☐	☐	☐
6. Cancer, tumour, cyst, polyp, mole, lump or other growth, breast disorder or abnormal ultrasound?	☐	☐	☐	☐
7. Anxiety, depression, fatigue, stress, attempted suicide, nervous breakdown, eating disorder, or other nervous system disorder? (If "YES", complete nervous disorder questionnaire)	☐	☐	☐	☐
8. Optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?	☐	☐	☐	☐
9. The skin, muscles, bones and joints, e.g. arthritis, back or neck pain, paralysis, deformity, unusual skin lesions, unexplained infections, or major organ transplantation?	☐	☐	☐	☐
10. a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	☐	☐	☐	☐
b) Have you ever had a positive test result indicating exposure to the AIDS virus?	☐	☐	☐	☐
c) Within the past 5 years, have you had any indication of a sexually transmitted disease?	☐	☐	☐	☐
11. Have you ever had any: (If "YES", advise type(s), date(s), reason(s), result(s).) a) Electrocardiograms	☐	☐	☐	☐
b) X-Rays	☐	☐	☐	☐
c) Other Diagnostic Tests	☐	☐	☐	☐

SECTION 4 – STATEMENT OF HEALTH: NON-MEDICAL (CONTINUED)

	LIFE 1		LIFE 2	
	Yes	No	Yes	No
12. Have you ever had:				
a) symptoms, illness, injury, surgery, treatment, examination or investigation	☐	☐	☐	☐
b) or been advised to receive surgery, treatment, examination or investigation;	☐	☐	☐	☐
c) surgery, treatment, examination or investigation for which results are not yet known to you, which have not been disclosed in questions 1 to 11 above?	☐	☐	☐	☐
13. Do you regularly take any medication? (If "Yes", specify type, dosage, when and by whom prescribed.)	☐	☐	☐	☐
14. Have you been absent from work as a result of illness or injury for 5 or more consecutive days within the past 5 years?	☐	☐	☐	☐
15. Have you consulted any physician within the past 5 years for anything not covered in the above questions or in this Application? (If "Yes", give particulars)	☐	☐	☐	☐
16. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐	☐	☐	☐
17. Have you been advised to have surgery, treatment or testing, which has not been completed?	☐	☐	☐	☐
18. a) Do you drink alcoholic beverages? (If "Yes", specify type and ounces per week.)	☐	☐	☐	☐
b) Have you ever received advice, treatment or counselling pertaining to your use of alcohol?	☐	☐	☐	☐
c) Have you ever used marijuana, cocaine or any illegal or addictive drugs?	☐	☐	☐	☐
d) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs?	☐	☐	☐	☐
(If "Yes", to 18(b), (c), or (d) complete Alcohol or Drug Use questionnaire.)				

Details Of "Yes" Answers

Question #	Life #	Provide Details

SECTION 5 – INSURANCE HISTORY

	LIFE 1	LIFE 2
Do you have any other Insurance in force?	☐ Yes ☐ No	☐ Yes ☐ No

If "YES", please complete the following:

Life #	Name of Company	Year Issued	Sum Insured: Personal	Sum Insured: Business	Sum Insured: Critical Illness
			$	$	$
			$	$	$
			$	$	$
			$	$	$

SECTION 6 – GENERAL INFORMATION

(Questions 1 to 12 apply to all lives to be insured)

IF "YES" ANSWER TO 1 OR 2 BELOW, COMPLETE SUPPLEMENTARY AVOCATION QUESTIONNAIRE.

IF "YES" ANSWER TO ANY QUESTIONS BELOW IN 3-12, COMPLETE "DETAILS" BELOW.

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
1. Have you made any flights (within the last 2 years) or do you intend to make any flights other than as a fare-paying passenger on a scheduled airline? (If "YES", complete Aviation Questionnaire.)	☐	☐	☐	☐
2. Have you engaged (within the last 2 years) or do you intend to engage in any hazardous sport or hobby e.g. scuba diving, hang-gliding, skydiving, etc? (If "YES", complete Avocation Questionnaire.)	☐	☐	☐	☐
3. Have you been convicted of, have pending charges for, or pleaded guilty to driving under the influence of alcohol and/or drugs, or refused a breathalyzer sample in the last 10 years? (If "YES", provide Driver's License No. below)	☐	☐	☐	☐
4. Have you been convicted of, have pending charges for, or pleaded guilty to any other driving offences (excluding parking tickets) in the last 3 years? (If "YES", provide Driver's Licence No. below)	☐	☐	☐	☐
5. In the last 10 years have you been charged with or convicted of or pleaded guilty to any criminal offence, or are any criminal charges pending?	☐	☐	☐	☐
6. Have you been a resident of Canada for less than 24 months? (If "YES", give previous country of residence, current immigration status and date of arrival)	☐	☐	☐	☐
7. Do you intend to travel outside of North America for longer than a total of 6 weeks , or change your Country of residence, in the next 12 months? (If YES, complete Travel Questionnaire.)	☐	☐	☐	☐
8. Have you ever had any application for LIFE, DISABILITY, GROUP or CRITICAL ILLNESS insurance on your life postponed, declined, rated or modified in any way?	☐	☐	☐	☐
9. Do you have an application for LIFE, DISABILITY, GROUP or CRITICAL ILLNESS insurance now pending with any other company?	☐	☐	☐	☐
10. Will this contract, if issued, replace a Life Contract now in force, with this or any other company? (If "YES", specify in "Details" section and forward completed Disclosure Statement(s)) If replacing Equitable Life Policy, indicate policy number in "Details" section.	☐	☐	☐	☐
11. Have you lapsed or cancelled a Life Contract within the past 6 months? (If "YES", specify in "Details" section and forward Completed Disclosure Statement(s))	☐	☐	☐	☐
12. Have you ever declared bankruptcy, personal or business, whether discharged or not? (If "YES", advise whether personal or business, date declared and date discharged)	☐	☐	☐	☐

Details Of "YES" Answers

Question #	Life #	Provide Details

SECTION 7 – CHILDREN'S STATEMENT OF HEALTH - NON MEDICAL

CHILDREN TO BE INSURED NON-MEDICAL AND COVERAGE INFORMATION

Complete for: a) All children to be insured under Children's Protection Rider
b) LIFE 1 or LIFE 2 under the exact age of 16 (Section 4 also required for all ages when applying for Juvenile Critical Illness)
c) Signature of all children who have attained age 16, 18 in Quebec, is required in Section 8

Print full name of each child to be insured	Gender	Date of birth (dd/mmm/yyyy)	Nearest age	Height	Weight	Name and address of usual medical advisor
	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
	☐ male ☐ female			☐ ft/in ☐ cm	☐ lbs ☐ kg	

		Yes	No
1.	Has any application for Insurance on any child been declined, postponed or modified in any way?	☐	☐
2.	If the child is less than 2 years of age, was the birth premature by more than 4 weeks or is there any indication of failure to thrive or gain weight? (If Yes, provide details).	☐	☐
3.	Do any of the children have any physical or mental impairment or have they had any illness, impairment or injury that has required treatment, surgery, and/or hospitalization?	☐	☐
4.	Are any of the children on medication or has any treatment or diagnostic test been advised that has not been completed?	☐	☐
5.	Is there any Family History of Huntington's Chorea, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease? (If yes provide relationship of family member, disease and age at diagnosis).	☐	☐
6.	Do any of the children to be insured NOT live with the owner? Please state below the relationship to the children, date last seen and frequency of visits.	☐	☐
7.	Are there any existing Life or Critical Illness Insurance policies or pending applications, on the lives of the parents of the child? (If Yes, provide type of insurance and amounts. If No, provide reason.)	☐	☐
8.	Are there any existing Life or Critical Illness Insurance policies or pending applications on the lives of all siblings of the child? (If Yes, provide type of insurance and amounts. If No, provide reason.)	☐	☐

Details Of "Yes" Answers and "No" Answers to #7 and #8.

Question #	Life #	Provide Details

SECTION 8 - LEGAL INFORMATION

A. THE OWNER AND THE PERSON(S) TO BE INSURED DECLARE AND AGREE THAT:

1) The personal information willingly provided by me/us to the independent broker/sales advisor and/or the Equitable Life Insurance Company of Canada (the "Company"), collected on this Application and held in their files, will be used by the Company for the purposes of underwriting, servicing, administration, determining Canadian or foreign tax payor status, claims processing and adjudication related to this Application, any resulting insurance and any supplementary documents. I/We understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by the Company, MIB Inc. as provided for in the MIB Notice, its sales distribution network, participating reinsurer(s), other companies, Canadian or foreign tax authorities and any other person or party whom I/we authorize.
2) The statements and answers in all parts of this Application are true, complete and correctly recorded.
3) The insurance being applied for in this Application or such insurance as approved and issued by the Company shall not take effect unless: a) a policy change is issued by the Company and the policy change is delivered or accepted in the manner specified in 3c; and b) the first policy change premium is paid; and c) there is no change in the insurability of the Person(s) to be Insured between the date this Application was signed by the Person(s) to be Insured and: i) the date of delivery of the Critical Illness policy change to the Owners; or, ii) the date of delivery of the life policy change to the Owners resident in Provinces and Territories other than Quebec; or, iii) the date the Application for a life policy change is accepted by the Company without modification for Owners resident in Quebec.
4) Knowledge of or notice to any person shall not constitute knowledge of or notice to the Company unless disclosed in this Application. No person, other than an Authorized Officer of the Company shall have authority to place the Company under any risk or obligation, or approve insurability.
5) Acceptance of any policy change issued on this Application shall be a ratification of any changes or corrections in or additions to this Application which the Company may make in an Endorsement.
6) If the Application is made by an Owner (other than the Person to be Insured): a) and if a policy (policies) change(s) is (are) issued under this Application, such policy (policies) change(s), including all rights thereunder, shall be under the full control of the Owner, subject to the provisions of such policy (policies). b) the person(s) on whose life (lives) this insurance is applied for consents to the insurance being placed on his/her (their) life (lives).
7) They know of nothing not disclosed herein affecting the insurability of the Person(s) to be Insured.

B. THE OWNER AND THE PERSON(S) TO BE INSURED FURTHER:

1) Acknowledge receiving the Notice regarding the MIB and authorize the Company to obtain information from the MIB.
2) Consent to the obtaining of a consumer report containing personal and/or credit information.
3) Authorize the Company to perform all tests, including, without limitation, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this Application for insurance. Such tests may include tests to determine the presence of various diseases including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS). The Company may disclose to its reinsurer(s), your attending physician(s), health service providers, and the MIB, the results of all such tests and personal information necessary to fulfill any of the identified purposes in this Application. I/we understand and agree that any positive results for HIV, hepatitis, or any other communicable diseases will be reported to the appropriate Public Health Authority. Your personal information collected by the testing facility may be processed and stored by such facility in Canada and/or the U.S. and, as such, may be subject to disclosure to the Canadian and U.S. Governments and agencies through the laws and treaties of and between Canada and the U.S.
4) Authorize the Motor Vehicle Division in any province requiring such authorization to permit the Company or an investigative agency acting on behalf of the Company, to be given a copy of all driving record information relevant to this Application. A photostatic copy of this authorization shall be as valid as the original.
5) Authorize any physician, practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the MIB or any other organization, institution or person, that has any record or knowledge of the person(s) on whose life (lives) this insurance is applied for, or his/her (them or their) health, to give full particulars of such information, including any prior medical history, to the Company or its reinsurers. A photostatic copy of this authorization shall be as valid as the original.
6) Agree that this Application may be transmitted to the Company electronically and received by the Company as the Owner's original application for insurance.
7) Acknowledge receiving from my/our Advisor, disclosure and an explanation of the companies the Advisor represents, licensing, commission, additional compensation, conflicts of interest, and the MIB Notice.

SECTION 8 - LEGAL INFORMATION (CONTINUED)

8) The Company is authorized to provide my health, medical and lifestyle information obtained during its underwriting process, regardless of the source, to my advisor for the purposes of explaining to me any adverse assessment of my insurablity.
☐ Yes ☐ No

FAILURE TO DISCLOSE EVERY FACT WITHIN THE OWNER(S), PERSONS(S) TO BE INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR, OR MATERIAL TO THE INSURABILITY OF THE PERSON(S) TO BE INSURED, OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS APPLICATION AND ANY WRITTEN STATEMENTS GIVEN AS EVIDENCE OF INSURABILITY, SHALL RENDER ANY INSURANCE ISSUED IN CONNECTION WITH THIS APPLICATION VOIDABLE BY THE COMPANY.

Signed at _____ (city) _____ (province) this _____ (day) of _____ (month) 20 _____ .

***Signature of Person to be Insured**

***Signature of Person to be Insured**

Signature of Witness to all signatures

Assignee signature required if the policy is assigned

Signature of Owner(s) (if other than Person to be Insured)

Signature of Beneficiary (if preferred or irrevocable)

Owner(s) S.I.N.

*Signature required for each Person to be Insured who has attained their **16th, (18th in Quebec)** birthday at the date hereof.
*Signature of parent/legal guardian of children under attained age **16, (18 in Quebec)**

SECTION 9 - ADVISOR'S INFORMATION

ADVISOR'S INFORMATION

MGA Name: _____ MGA No: _____

MGA Phone: _____ MGA Fax: _____ MGA Email: _____

Advisor's Name	Advisor's No	Servicing	Commission %	Advisor's Phone	Advisor's Fax
		☐			
		☐			
		☐			

All correspondence to Advisor in ☐ English ☐ French

Advisor's Email Address:

Supervisor's Email Address:

Advisor's Signature

Supervising Advisor's Signature

Date (dd/mmm/yyyy)

Date (dd/mmm/yyyy)

SECTION 9 - ADVISOR'S INFORMATION (CONTINUED)

UNDERWRITING REQUIREMENTS

Name of Service Provider:

Underwriting Requirements	Life 1	Ordered	Life 2	Ordered	Comments/order number(s)
Non-Medical	☐	☐	☐	☐	
M.D. Medical	☐	☐	☐	☐	
Paramedical	☐	☐	☐	☐	
Electrocardiogram	☐	☐	☐	☐	
Blood Profile	☐	☐	☐	☐	
PSA	☐	☐	☐	☐	
Urine (HIV)	☐	☐	☐	☐	
Saliva (HIV)	☐	☐	☐	☐	
Inspection Report	☐	☐	☐	☐	
Financial Statements	☐	☐	☐	☐	
Avocation Questionnaire	☐	☐	☐	☐	
Health Questionnaire	☐	☐	☐	☐	
Order Shared Evidence	☐	☐	☐	☐	

Other:

		Yes	No
1.	Does the Owner(s) and the Proposed Life Insured(s) speak and read the language in which this application is written? (If "NO" how was the Application completed? Provide detail in Advisor's notes below).	☐	☐
2.	Has there been prior contact with Head Office regarding the Proposed Life Insured(s)? (If "YES" give dates and reference of last Head Office letter, and person or department contact in Advisor's Notes below.)	☐	☐
3.	Are you the Proposed Life Insured, Owner, payor or beneficiary on this policy?	☐	☐
4.	Are you a related party of the Proposed Life Insured(s) or Owner(s)? A related party includes: a) immediate family members such as a spouse, parent, grandparent, child, grandchild, or in-law b) a corporation where the Advisor or an immediate family member, individually or together own 50% or more of any class of shares of the corporation c) where the Advisor is incorporated, any director, officer, employee or agent of the Advisor, and any parent, subsidiary or affiliated corporation of the Advisor (If "YES" give details in Advisor's Notes below.)	☐	☐
5.	Do you know of: a) Any criticism of the Proposed Life Insured(s) or Owner(s) character, habits, mode of living, or business reputation, past or present? (If "YES", provide details in Advisor's Notes below)	☐	☐
	b) Any additional information which would assist in underwriting this application? (If "YES", provide details in Advisor's Notes below)	☐	☐
6.	Was this sale derived from a financial needs analysis?	☐	☐
7.	I have held and viewed the documentation provided by the Proposed Life Insured(s) and the Owner(s) for verification of their identity, and confirmation of the information provided on this Application	☐	☐
8.	I have made a reasonable effort to determine if the Owner(s) are acting on behalf of a third party.	☐	☐

SECTION 9 - ADVISOR'S INFORMATION (CONTINUED)

	Yes	No
9. I have reviewed and explained the Sales Illustration to the Owner(s)	☐	
10. I confirm that I have disclosed the following to the Owners:	☐	
a) the life or critical illness policy, if issued, is underwritten and managed by Equitable Life of Canada;		
b) the company or companies I represent;		
c) I am an independent broker/advisor representing Equitable Life of Canada;		
d) I am a life agent licensed by the Insurance Council of British Columbia and/or the Financial Services Commission of Ontario, if applicable;		
e) I receive compensation and will continue receiving servicing/renewal commissions, if a policy is issued and comes into effect, and if it remains in force;		
f) I may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business I place with Equitable Life of Canada;		
g) I have disclosed any conflicts of interest I may have regarding this Application.		
11. I have reviewed the information provided in this Application with the proposed Owner(s) and to the best of my knowledge, it is complete and true	☐	

ADVISOR'S NOTES

NOTICE REGARDING THE MIB, INC

Information regarding the insurability of the Person(s) to be Insured will be treated as confidential. We or our reinsurer may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. As a U.S. based company, MIB complies with U.S. privacy laws. MIB protects personal information in a manner similar to Canadian privacy laws.

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 MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590, or privacy@mib.com for privacy questions.

We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured may apply for life, critical illness 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

CONFIRMATION OF ADVISOR/BROKER DISCLOSURE

The Insurance product you are applying for is underwritten and supplied by Equitable Life of Canada, licensed to conduct business in all provinces and territories of Canada. The advisor/broker soliciting this insurance application is a licensed independent broker representing Equitable Life of Canada through an independent agency, and will receive compensation from Equitable Life of Canada if a policy is issued and comes into effect, and will continue receiving ongoing compensation if you continue to keep the policy inforce. The advisor/broker may be eligible for additional compensation, such as bonuses and travel incentives, depending on the volume or persistency of business the advisor/broker places with Equitable Life of Canada during a given time period. You are not obligated to transact any other business with Equitable Life of Canada, the advisor/broker or any other person or entity as a condition of the Application.