

Individual life insurance application for policy change

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Instructions for completing this form

- When you return this form, send only the pages you have completed. If you are applying for a policy with 2 or more adult insureds, use the appropriate sections from a separate application form to provide personal and health information on the additional insureds.
- If you are requesting the pre-authorized debit plan, also complete **section 10**.
- If requesting a policy change requiring underwriting on a rated policy, also complete **section 8**.

Application for:	Complete sections:
<input type="checkbox"/> Increase in face amount (not allowed for policies issued before 2017) <input type="checkbox"/> Up to \$25,000 <input type="checkbox"/> Over \$25,000	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 6, 7, 11, 12, 13 and TIA <input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 7, 8, 11, 12, 13 and TIA
<input type="checkbox"/> Decrease in face amount	<input type="checkbox"/> 1 (1.1, 1.2), 2 (2.1), 11 and 13
<input type="checkbox"/> Additional rider(s) (not allowed for policies issued before 2017) <input type="checkbox"/> Up to \$25,000 <input type="checkbox"/> Over \$25,000	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 6, 7, 11, 12, 13 and TIA <input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 7, 8, 11, 12, 13 and TIA
<input type="checkbox"/> Child's life insurance rider (not allowed for policies issued before 2017)	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1, 2.5), 5, 9, 11, 12 and 13
<input type="checkbox"/> Cancel rider / benefit	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1) 11 and 13
<input type="checkbox"/> Change to non-smoker rates	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 6, 7, 11, 12 and 13
<input type="checkbox"/> Reconsideration of rating / exclusion	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 7, 8, 11, 12 and 13
<input type="checkbox"/> Reinstatement (if policy lapsed between 61 days and 6 months)	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 6, 7, 11, 12 and 13
<input type="checkbox"/> Reinstatement (if policy lapsed over 6 months)	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 7, 8, 11, 12 and 13
<input type="checkbox"/> Date of birth / sex correction	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 11, 13 and provide proof of birth / sex
<input type="checkbox"/> Change existing and future dividends to paid-up additions <input type="checkbox"/> Up to \$25,000 <input type="checkbox"/> Over \$25,000 (not allowed for policies issued before 2017)	<input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 6, 7, 8 (if rated) 11, 12 (if underwriting is required) and 13 <input type="checkbox"/> 1 (1.1, 1.2, 1.3), 2 (2.1), 5, 7, 8, 11, 12 and 13
<input type="checkbox"/> Change to cost of insurance type	<input type="checkbox"/> 1 (1.1, 1.2), 2 (2.1), 11 and 13
<input type="checkbox"/> Change to coverage plus death benefit <input type="checkbox"/> With underwriting (not allowed for policies issued before 2017) <input type="checkbox"/> Without underwriting	<input type="checkbox"/> 1, 2, 5, 7, 8, 11, 12, 13 and TIA <input type="checkbox"/> 1, 2, 11 and 13
<input type="checkbox"/> Change to level death benefit	<input type="checkbox"/> 1 (1.1, 1.2), 2 (2.1), 11 and 13
<input type="checkbox"/> Exercise guaranteed insurability rider / guaranteed increase option / policy purchase option to increase an existing policy (not allowed for policies issued before 2017) <input type="checkbox"/> If exercising a guaranteed insurability rider / guaranteed increase option / policy purchase option, and applying for a new policy, complete the <i>Simplified conversion application</i> (form 17-8345)	<input type="checkbox"/> 1 (1.1, 1.2), 3, 11, 13, TIA and Interest option supplement or illustration
<input type="checkbox"/> Conversions / exchanges	<input type="checkbox"/> 1, 4, 10, 11, 12, 13, TIA and Interest option supplement or illustration (if UL) and signed illustration

Note: For any premium of \$100,000 or more, you must also submit a *Politically exposed person (PEP) determination* (form 17-8294) for each owner and any person paying for this policy.

1. General information

In this application, *you* and *your* refer to the owner, and *we* and *us* to The Canada Life Assurance Company (Canada Life), except where the context indicates otherwise.

1.1 Policy number(s): _____

Note: Where this application is to result in a new policy, ownership is to be as under the prior policy. If you wish otherwise, you must complete the *Title change* (form 584 CAN) to indicate desired ownership.

1.2 Who is the insured in this application?

Name (first, middle, last)			
Home address* (street number and name)		City	Province
Postal code			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd/mmm/yyyy)	Province (otherwise state or country) of: Residence:	Birth:
Telephone numbers:	Home: ()	Business: ()	Best time to call if a customer interview is required? <input type="checkbox"/> Day <input type="checkbox"/> Evening

Financial information

The following questions are required if an increase in insurance amount is requested for that life:

Approximate annual earned income \$	Approximate annual income from other sources (list sources) \$	Approximate net worth \$
In the past 5 years have you declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give details below including any date of discharge.	

1.3 If this is a joint policy, who is the second insured in this application?

Name (first, middle, last)			
Home address* (street number and name)		City	Province
Postal code			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd/mmm/yyyy)	Province (otherwise state or country) of: Residence:	Birth:
Telephone numbers:	Home: ()	Business: ()	Best time to call if a customer interview is required? <input type="checkbox"/> Day <input type="checkbox"/> Evening

Financial information

The following questions are required if an increase in insurance amount is requested for that life:

Approximate annual earned income \$	Approximate annual income from other sources (list sources) \$	Approximate net worth \$
In the past 5 years have you declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give details below including any date of discharge.	

*If mailing address is a P.O. Box, RR# or general delivery anywhere in this application, record civic address/physical location in 13.15.

1.4 Important: Ownership, beneficiary, trustee for the changed policy (title matters)

Note: To be completed by the owner **only** if changing to or applying for participating or universal life insurance.

- If existing owner is an individual, complete the question below.
- If existing owner is an entity, complete the *International tax classification for an entity* (form 17-8945).

Tax status

Are you a United States citizen or a U.S. resident for U.S. tax purposes?

First owner <input type="checkbox"/> Yes – provide details below <input type="checkbox"/> No U.S. taxpayer identification number (TIN): _____	Second owner <input type="checkbox"/> Yes – provide details below <input type="checkbox"/> No U.S. taxpayer identification number (TIN): _____
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(continued on the next page)

2. Changes (continued)

- 2.2 Any beneficiary designation as shown in this application is revocable **except** a designation where:
- **Title change (form 584 CAN)** is completed to designate the irrevocable beneficiary, **or**
 - The **Civil Code of Quebec** applies and the beneficiary is the owner's **spouse** (such designation is irrevocable, unless otherwise stipulated; *to stipulate revocability, see below*).

I reserve the right to revoke any and all revocable beneficiary designations.

Where Quebec law applies, the designation of an owner's spouse (married or civil union) as beneficiary is irrevocable unless the owner specifies the designation to be revocable by checking the following box:

I specify that any designation of my spouse, made in this form, is **revocable**.

Where a beneficiary designation is irrevocable and while that beneficiary is living, the owner may not, without the consent of the beneficiary (who must be of legal age to give consent), alter or revoke the designation. Dealings with the contract will be subject to the rights of the irrevocable beneficiary.

2.3 Multiple lives benefit

The policy already includes multiple lives benefit, but the death benefit option is now changing to coverage plus (may not be allowed for policies issued **before** 2017).

If, further to this application, a universal life insurance policy is to have **both** a multiple life benefit **and** a coverage plus death benefit, **which of the following optional amounts should be added**, in accordance with the policy provisions, to the benefit payable on the applicable insured's death? (Any added amount will be paid to the beneficiary for that insured, unless you indicate otherwise; see policy for details on coverage plus options and total account value payments on death.)

- Pro-rated portion of the total account value payable on the death of the primary and each additional insured.
- _____% of the total account value payable on the death of the primary and each additional insured (minimum 25% and maximum 100%). This excludes 12 times the current monthly deduction. **If you don't indicate a percentage, we will pay 25%.**
- Total account value payable on the death of the last to die of the primary and all additional insureds. **This option will be used unless you indicate otherwise.**

2.4 Child's life insurance rider (not allowed for policies issued **before** 2017)

How much? \$ _____ (subject to contractual maximums)

Children must be under age 18 when this rider is added and be the natural, adopted or step children of the first insured person. **Complete sections 5 and 9 (listing all the children) and the information below.**

Who will be the beneficiary? Please appoint only one beneficiary for all children. **Note:** For Quebec, see 2.2.

Name (first, middle, last)	Relationship of the beneficiary to the owner

3. Exercising guaranteed insurability rider / guaranteed increase option / policy purchase option to increase an existing universal life policy

This option is not allowed if the policy being increased was issued before 2017.

3.1 Specify which option is being exercised to increase an existing universal life coverage.

- Guaranteed insurability rider Guaranteed increase option Policy purchase option

3.2 What is the guaranteed insurability or policy purchase option date?

- Regular option date
- Alternative option date (dd/mmm/yyyy): _____

Why are you using an alternative option date?

- The insured got married The insured adopted a child The insured had a child
- Other (specify): _____

3.3 a) If increasing an existing universal life policy, provide the following information:

Policy number: _____

Increase scheduled premium amount to: \$ _____

Note: If the policy has automatic payment benefit, the automatic payment benefit amount will be increased accordingly (for Canada Life universal life plans only).

b) Cost of insurance:

- Annually Increasing Level (death benefit option must be coverage plus) 10-pay 15-pay 20-pay

Note: For 10, 15 and 20-pay options, death benefit option must be coverage plus.

4. Conversions / exchanges (continued)

4.6 Indicate if questions 4.7 and 4.8 are being answered, or the illustration is being used:

Request the product type and additional benefits/riders indicated in questions 4.7 and 4.8

or

Request the product type, additional benefits/riders and, if applicable universal life insurance interest options used in the accompanying illustration dated (dd/mmm/yyyy): _____

For universal life insurance policies, also complete the following questions in this application:

- Indicate the beneficiary for the *Total account value* benefit in question 4.7 b) v).
- Indicate the beneficiary for a children's term insurance benefit in question 2.4.

Note: If both the illustration is selected above **and** questions 4.7 and 4.8 are completed, the illustration will be the default.

4.7 Coverage details

a) Name of new product: _____

If applying for participating life insurance indicate: **Premiums:** Payable to age 100 or Max 20 (payable for 20 years)

Single life Joint first-to-die Joint last-to-die (if applying for participating life insurance indicate: **Premiums** payable to: First death Last death)

b) Face amount of basic policy: \$ _____

If converting or exchanging to a universal life insurance policy, complete the following:

i) Complete and submit the *Supplement to the application for universal life insurance interest option* (form 17-8139 or 17-8116IG)

ii) Basic policy specified amount of life insurance at issue: \$ _____

iii) Cost of insurance type: Annually increasing Level 10-pay 15-pay 20-pay

iv) Death benefit option: Coverage plus death benefit
 Level death benefit (cost of insurance option must be annually increasing)

v) Include a benefit payable on first death on a joint last-to-die (coverage plus death benefit only) _____% of total account value to be paid on first death (minimum 25% and maximum 100%). This excludes 12 times the current monthly deduction (default is 25%).

Beneficiary on first death:

Survivor of joint insureds

Other (provide information below):

Name: _____ Relationship to owner: _____

Contingent beneficiary: _____ Relationship to owner: _____

Note: For Quebec and beneficiaries, see 2.2.

vi) Value maximizer (**evidence of insurability is required to add this benefit any time “automatic increases” are selected except for a term conversion with no increase in amount or addition of benefits**)
The Value maximizer allows adjustments to the insurance amount that permit optimal tax treatment. For any decrease to the insurance amount, you must give written consent at the time of each decrease.

Note: If Value maximizer is not selected, no increases and no decreases will be made. Adding Value maximizer to a policy issued **before** 2017 may have tax consequences.

For adjustments to the insurance amount:

Allow: Automatic increases only with a cost of insurance option of:

Annually increasing Level 10-pay 15-pay 20-pay

If no cost of insurance option is selected, annually increasing will be chosen for you.

Optimal decreases only with annually increasing cost of insurance

Both automatic increases and optimal decreases with annually increasing cost of insurance

c) If the policy is eligible for dividends, choose one of the following: (not applicable to universal life insurance)

Paid-up additions (**default**)

Paid out in cash

Enhanced coverage option (if applicable): \$ _____

10 year guarantee Lifetime guarantee

d) Premium frequency: Monthly pre-authorized debit

Annual

4. Conversions / exchanges (continued)

4.8 Benefits and riders (may be subject to underwriting): New Carried over

Renewable and convertible term rider (not allowed on joint policies):
 Amount \$ _____ 10-year term 20-year term

To appoint or change a beneficiary for benefits payable under this rider, complete the *Title change* (form 584 CAN), section D. *Change of beneficiary*.

Death by accidental means rider: Amount \$ _____

Disability waiver of premium: On disability of life insured On disability of waiver-life On death of waiver-life

Note: Unless stated otherwise in the existing policy's waiver of premium on total disability provision, this benefit is not available for the converted insurance if a waiver claim is in effect on the existing policy.

Automatic payment benefit: Amount \$ _____

Check one: On disability of life insured On disability of waiver-life On death of waiver-life

Waiver-life:

Name	Relationship to insured	Sex	Date of birth (dd/mmm/yyyy)	Province/country of birth
		<input type="checkbox"/> Male <input type="checkbox"/> Female		

Additional deposit option (only available on participating life insurance and may be subject to underwriting):

Amount \$ _____

Scheduled premium: Annual premium Pre-authorized debit plan (must match premium mode)

Single premium (premium mode must be annual)

Business growth protection rider – business owners only

10-year 15-year – Option amount: \$ _____ (rider maximum amount is 4 times the option amount)

5. Insurance history

Complete questions 5.1 – 5.3 for adults only (answer both set of questions if a joint policy).

Complete questions 5.4 – 5.8 if the child is under age 18.

Adults only

First insured Second insured

5.1 Do you have any individual life, critical illness or disability income insurance in effect?

Yes No Yes No

If yes, complete the table in 5.2.

5.2 Is the insurance applied for in this application intended to replace or significantly change any life, critical illness insurance or disability income insurance?

Yes No Yes No

If yes, complete the table below and submit the provincial disclosure forms as required.

Name of insured	Name of insurance company	Type of insurance	Amount of insurance	Year of issue	Amount of accidental death	Purpose of insurance	If replacement, give policy number
		<input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	\$		\$	<input type="checkbox"/> Personal <input type="checkbox"/> Business	
		<input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	\$		\$	<input type="checkbox"/> Personal <input type="checkbox"/> Business	
		<input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	\$		\$	<input type="checkbox"/> Personal <input type="checkbox"/> Business	
		<input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	\$		\$	<input type="checkbox"/> Personal <input type="checkbox"/> Business	
		<input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	\$		\$	<input type="checkbox"/> Personal <input type="checkbox"/> Business	

5.3 At this time, do you have any other applications for life, critical illness or disability income insurance pending? **If yes,** complete the information below:

Yes No Yes No

Name of insured	Name of insurance company	Type of insurance: <input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	Amount of insurance applied for \$	Total amount of new insurance to be put into effect \$
Name of insured	Name of insurance company	Type of insurance: <input type="checkbox"/> Life <input type="checkbox"/> Critical illness <input type="checkbox"/> Disability	Amount of insurance applied for \$	Total amount of new insurance to be put into effect \$

6. Simplified non-medical

The simplified non-medical can be used in the following situations:

- Policy changes with an increase in coverage of up to \$25,000 where age and amount rules allow for a full non-medical.
- Change to non-smoker (A urine specimen is always required for a combined insured amount of \$500,001 or greater for all in-force policies.)
- Reinstatements (for policies that have been lapsed between 61 days and 6 months)
- Change death benefit option to coverage plus (for face amounts up to \$25,000)

Note:

- **If the face amount is \$5 million or greater**, section 8 is required. The underwriter may request additional medical evidence.
- **If the face amount is less than \$5 million**, the underwriter may request additional medical evidence such as a full non-medical or urine specimen.
- **If requesting a policy change requiring underwriting on a rated policy**, also complete section 8.

6.1 Name of insured (print): _____
First name Middle name Last name

6.2 Have you ever suffered from any illness, injury, received medical treatment or consulted a doctor for reasons other than routine examination, childbirth or for minor ailments such as colds or flu? Yes No

6.3 a) Within the **past 5 years**, have you used any tobacco/nicotine product, marijuana or hashish? Yes No

If yes, provide details as indicated below.

Product	Number smoked/used	Frequency of use per	Date last used (dd/mmm/yyyy)
<input type="checkbox"/> Cigarettes/e-cigarettes		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigarillos		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Pipe		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigars		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Marijuana/hashish		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Nicotine patch and/or gum		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Other (specify – e.g., chewing tobacco, snuff, betel nuts, vaping, etc.):			

b) Have you ever used cocaine, marijuana, hashish, narcotics, or other hallucinogenic, habit forming, or illicit drugs? Yes No
If yes, complete *Drug questionnaire* (form B0426A-1).

6.4 Do you currently use alcohol? Yes No
If yes, indicate: **Type:** _____ **Amount per week:** _____

6.5 Have you ever had any problem, received treatment or advice or belonged to an organization because of alcohol use? Yes No
If yes, complete *Alcohol questionnaire* (form B0430B-2).

6.6 **If yes to any questions in 6.2 through 6.5** (except question 6.3 a) and 6.4), provide details below.

Question number	Conditions/symptoms, duration, tests, results and treatment	Date		Name and address of healthcare provider, clinic and/or hospital
		month	year	

7. Personal information

Complete this section for adults only

7.1 Who is the information in this section about?

Name (print): _____
 First name Middle name Last name

Occupation: _____ Nature/type of business: _____

7.2 What is your citizenship? Canadian citizen Landed immigrant for at least 1 year Other (specify): _____

7.3 Within the **past 5 years**, have you used any tobacco/nicotine product, marijuana or hashish? Yes No

If yes, provide details as indicated below.

Product	Number smoked/used	Frequency of use per	Date last used (dd/mmm/yyyy)
<input type="checkbox"/> Cigarettes/e-cigarettes		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigarillos		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Pipe		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Cigars		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Marijuana/hashish		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Nicotine patch and/or gum		<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	
<input type="checkbox"/> Other (specify – e.g., chewing tobacco, snuff, betel nuts, vaping, etc.):			

7.4 Have you operated an aircraft or been a member of an aircrew in the **past 5 years**, or do you intend to do so in the future? Yes No

If yes, complete *Aviation questionnaire* (form 17-8321).

7.5 Within the **past 2 years**, have you engaged in or do you plan to engage in any of the following: scuba diving, mountain climbing, hang gliding, parachute jumping, racing cars, boats or other motorized vehicles, or any other hazardous sport or activity? Yes No

If yes, complete the *Hazardous sports/Avocations questionnaire* (form 17-8322).

7.6 a) In the **past 12 months**, have you travelled, resided or worked outside of North America? Yes No

b) Within the **next 12 months**, do you intend to travel, reside or work outside of North America? Yes No

If yes to **7.6 a) and/or b)**, also complete *Foreign travel/Residence questionnaire* (form B0443A-1).

7.7 Have you ever had an application for life, critical illness or disability income insurance declined or postponed, or been offered insurance with restrictions or rates that were not standard? Yes No

If yes, provide details in question 7.10.

7.8 Provide your driver's licence number and where it was issued in 7.8 a) if:

- Coverage applied for on your life is \$2,000,001 or greater
- If yes, is answered to either 7.8 b) or c)

Note: If you live in British Columbia, Manitoba, Quebec, North West Territories or the Yukon (or any other jurisdiction where the requirement might apply), you must also complete a *Motor Vehicle Report Authorization* form, or equivalent form granting access to your driving record.

a) Driver's licence no.: _____ Issuing jurisdiction: _____

b) Within the **past 3 years**, have you been convicted of, or are you currently charged with, any moving traffic violation(s) or has your driver's licence been under suspension or revoked? Yes No

If yes, give dates and details: _____

c) Within the **past 10 years**, have you been convicted of either impaired driving or refusal to provide a breath sample? Yes No

If yes, date of conviction (dd/mmm/yyyy): _____

7.9 Have you been convicted of any criminal offence in the **past 5 years**, or do you have any criminal charges pending? Yes No

7. Personal information (continued)

7.10 If yes to any questions in 7.1 through 7.9, provide details below.

Question number	Details

7.11 Conditions to qualify for temporary insurance

Temporary insurance is not applicable in these 6 cases:

- To a group conversion
- To the exercise of guaranteed insurability options
- To a reinstatement
- If the total underwriting risk is \$5,000,000 or greater
- For a policy change with no overall increase in the amount of life insurance coverage
- If the *actual* age of the proposed insured is 71 or over.

Refer to the *Date coverage begins* section of the *Temporary insurance agreement* for conditions that have to be met for temporary insurance coverage to come into effect.

Have you:

- a)** Within the **past 12 months**, consulted or been treated by any physician or other practitioner for any known or suspected heart attack, stroke, cancer or the acquired immunodeficiency syndrome (AIDS); or ever tested positive for HIV (the AIDS virus)? Yes No
- b)** Within the **past 30 days**, consulted or been treated by a physician or other practitioner (**for other than** an uncomplicated pregnancy or any minor condition for which no follow-up visit has been arranged or contemplated)? Yes No
- c)** Within the **past 12 months**, been proposed as a life insured under any application for life insurance which was declined or postponed? Yes No

Temporary insurance is not available on any life where a **yes** answer has been given to questions 7.11 a), b) and c). **However**, the application for policy change may still be considered.

Always complete the *Temporary insurance agreement* and give it to the owner.

8. Health information

Complete this section for adults only

8.1 Who is the information in this section about?

Name (print): _____
First name Middle name Last name

8.2 Who is your regular doctor? (If none, list physicians or clinics consulted in the past 5 years.)

Name (first, last)	Address (street number and name)	City/Province
When was your last visit to the doctor? (dd/mmm/yyyy)		What was the reason for this visit?
What treatment or medication was prescribed, if any?		

8.3

Height	Weight	Within the past 12 months , have you had a weight loss of more than 10 lb. (4.5 kg)?
<input type="checkbox"/> ft./in. _____ <input type="checkbox"/> cm	<input type="checkbox"/> lb. _____ <input type="checkbox"/> kg	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , amount and reason:

8. Health information (continued)

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which you may have had. You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

Questions 8.4 through 8.12 should be completed if you are **not** having a medical or paramedical exam.

- 8.4** Have any of your natural parents, brothers or sisters, ever had any of the following: heart disease, stroke, cancer, diabetes, multiple sclerosis, polycystic kidney disease, ALS, Huntington's chorea, Alzheimer's disease, Parkinson's disease, any other hereditary disorder? Yes No

If **yes**, complete the information below.

Family member	Condition, including type of cancer	Age at onset	Age if living	Age at death

- 8.5** Have you ever had, been treated for, or been advised to receive treatment or have any investigations for any of the following:

- a) Heart attack, angina, chest pain, stroke, TIA, elevated blood pressure or cholesterol, murmur or other heart or blood vessel disease or disorder? Yes No
- b) Asthma, sleep apnea or other respiratory disorder? Yes No
- c) Cancer, tumour, cyst, polyp, mole, lump or other growths, breast disorder or abnormal mammogram? Yes No
- d) Anxiety, depression, fatigue, other nervous disorders, lupus, arthritis, MS, ALS, muscle or back disorder? Yes No
- e) Diabetes, colitis, bowel disorders, hepatitis or hepatitis carrier state, kidney, bladder or prostate disease or disorder, or any sexually transmitted disease? Yes No
- f) AIDS, HIV testing, any HIV-related disease, any blood or lymph gland disease or disorder? Yes No
- g) Any eye, ear or throat disease or disorder? Yes No
- h) Any other physical, mental, or nervous symptoms, disease, impairments, or disorders not listed on this page? Yes No

- 8.6** In the **past 2 years**, have you been off work for **2 consecutive weeks** or more due to illness or injury? Yes No

- 8.7** Other than as declared above, in the **past 10 years**, have you been a patient in a hospital or other medical facility, or have you had an electrocardiogram, X-ray, blood or other diagnostic test (other than a genetic test), biopsy or surgery? Yes No

- 8.8** Other than as declared above, do you have any reason to believe you may not be in good health and free from symptoms, disease, impairment or disorder, or have you been advised to have any tests (other than a genetic test) that have not yet been completed, or for which you do not yet have the results? Yes No

- 8.9** Have you ever or do you now drink alcohol? Yes No
 If **yes**, how much? **Type:** _____ **Amount per week:** _____

- 8.10** Have you ever sought treatment or been advised to seek treatment, or been advised to reduce consumption, or attended an organization, due to alcohol use? Yes No
 If **yes**, also complete *Alcohol questionnaire* (form B0430B-2).

- 8.11** Have you ever used cocaine, marijuana, hashish, narcotics, or other hallucinogenic, habit forming, or illicit drugs? Yes No
 If **yes**, also complete *Drug questionnaire* (form B0426A-1).

8.12 If **yes** to any questions in 8.4 through 8.11, provide details below.

Question number	Conditions/symptoms, duration, tests, results and treatment	Date		Name and address of healthcare provider, clinic and/or hospital
		month	year	

Additional details

Use this section if additional space is required for answers in sections 7, 8 or 9

Question number	Name of insured	Details

9. Information about insured children

Notes:

- Children (under age 18) only
- This section is required if the policy is on a child
- Child riders not allowed for policies issued before 2017

9.1 Child	Child's name (print first, middle, last)	Sex	Date of birth (dd/mmm/yyyy)
1		<input type="checkbox"/> Male <input type="checkbox"/> Female	
2		<input type="checkbox"/> Male <input type="checkbox"/> Female	
3		<input type="checkbox"/> Male <input type="checkbox"/> Female	
4		<input type="checkbox"/> Male <input type="checkbox"/> Female	

9.2 a) Name and address of child(ren)'s personal physician (If none, list physicians or clinics consulted in the **past 5 years**):

Child 1	
Child 2	
Child 3	
Child 4	

b) Provide reason and date (mmm/yyyy) of last visit to the physician(s) above:

Child 1	
Child 2	
Child 3	
Child 4	

9.3 Child	Height	Weight	Within the past 12 months, has the child lost any weight?
1	<input type="checkbox"/> ft./in. <input type="checkbox"/> cm	<input type="checkbox"/> lb. <input type="checkbox"/> kg	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , amount and reason:
2	<input type="checkbox"/> ft./in. <input type="checkbox"/> cm	<input type="checkbox"/> lb. <input type="checkbox"/> kg	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , amount and reason:
3	<input type="checkbox"/> ft./in. <input type="checkbox"/> cm	<input type="checkbox"/> lb. <input type="checkbox"/> kg	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , amount and reason:
4	<input type="checkbox"/> ft./in. <input type="checkbox"/> cm	<input type="checkbox"/> lb. <input type="checkbox"/> kg	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , amount and reason:

9. Information about insured children (continued)

9.4 Has there ever been an application for life or critical illness insurance on any of these children that was declined, postponed, or offered with restrictions or rates that were not standard? Yes No

9.5 a) In the **past 12 months**, have any of these children travelled or resided outside of North America? Yes No
b) Is there any intention for any of these children to live or travel outside of North America in the **next 12 months**? Yes No

9.6 If yes to any questions in 9.1 through 9.5, provide details below.

Question number	Child's name	Details

9.7 Conditions to qualify for temporary insurance

Temporary insurance is not applicable in these 5 cases:

- To a group conversion
- To the exercise of guaranteed insurability options
- To a reinstatement
- If the total underwriting risk is \$5,000,000 or greater
- For a policy change with no overall increase in the amount of life insurance coverage.

Refer to the *Date coverage begins* section of the *Temporary insurance agreement* for conditions that have to be met for temporary insurance coverage to come into effect.

Have any of these children:

- a)** Within the **past 12 months**, consulted or been treated by any physician or other practitioner for any known or suspected heart attack, stroke, cancer or the acquired immunodeficiency syndrome (AIDS); or ever tested positive for HIV (the AIDS virus)? Yes No
- b)** Within the **past 30 days**, consulted or been treated by a physician or other practitioner (**for other than an uncomplicated pregnancy or any minor condition for which no follow-up visit has been arranged or contemplated**)? Yes No
- c)** Within the **past 12 months**, been proposed as a life insured under any application for life insurance which was declined or postponed? Yes No

If yes to any questions in 9.7, indicate name(s) of child to be insured:

Temporary insurance is not available on any life where a **yes** answer has been given to any of questions 9.6 a), b) and c). **However**, the application for policy change may still be considered.

Always complete the *Temporary insurance agreement* and give it to the owner.

The remaining questions in this section should be completed if a medical or paramedical exam is **not** required.

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which the child may have had. You must however, tell us if the child is having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about the child's family history, including all genetic conditions.

9.8 Have any of these children ever had, been treated for, or had any known indication of any of the following: heart murmur or other heart disorder, asthma, cancer, leukemia, epilepsy, hepatitis, diabetes, AIDS, or any congenital abnormality, hereditary disorder or developmental problems? Yes No

9.9 Have the natural parents, brothers or sisters, of any of these children ever had any of the following: cancer, diabetes, multiple sclerosis, polycystic kidney disease, Huntington's chorea, hemophilia, or any other hereditary disorder? Yes No

9.10 Other than for reasons already declared in this section, in the **past 5 years**, have any of these children been a patient in a hospital or other medical facility, or had any medical investigations planned or recommended? Yes No

9.11 Other than for the reasons already declared in this section, is there any reason to believe any of these children may not be in good health and free from symptoms, disease, or disorder? Yes No

Temporary insurance agreement – detach and give to the owner

Except as described below, no other insurance coverage is provided by this *Temporary insurance agreement*.

<p>Temporary insurance is not applicable:</p> <ul style="list-style-type: none"> • To a group conversion • To the exercise of guaranteed insurability options • To a reinstatement • If the total underwriting risk is \$5,000,000 or greater • For a policy change with no overall increase in the amount of life insurance coverage • If the <i>actual</i> age of the proposed insured is 71 or over 	<p>This temporary insurance is to provide limited coverage (temporary insurance amount) as described below while your application for policy change, numbered as above, is being processed. Coverage under this temporary insurance does not guarantee approval of your application. Any change in insurability while your application is being processed may also affect whether or not your application is approved.</p> <p>In the event of death, while this temporary insurance is in force, of a life (to be) insured who qualifies for temporary insurance coverage, Canada Life will pay the temporary insurance amount (see next section). Any payment under this agreement will be made in accordance with the beneficiary designation(s) in the application and, in cases of joint lives (to be) insured, the plan for which application has been made.</p>
<p>Temporary insurance amount and maximum limit</p>	<p>The temporary insurance amount (or amounts, where temporary insurance becomes payable with respect to two lives or more) cannot exceed \$1,000,000, in total, whether alone or together with amount(s) provided by temporary insurance in force with Canada Life under other agreement(s). In the event temporary insurance becomes payable with respect to two lives or more (and if the \$1,000,000 limit would otherwise be exceeded), and/or there is(are) amount(s) provided by temporary insurance in force with Canada Life under other agreement(s), there will be a reduction in the temporary insurance amount(s) payable under this agreement, in accordance with the limit and as otherwise equitable, as determined by Canada Life.</p> <p>Subject to the limit and other provisions above, the temporary insurance amount is, with respect to</p> <ul style="list-style-type: none"> • Any life insured, the amount of any increase in overall coverage applied for in this application on that life. • Any life to be insured, the amount applied for on that life in this application. <p>This temporary insurance and the insurance policy being applied for will not be in force at the same time.</p>
<p>Date coverage begins (Conditions)</p>	<p>Under this agreement the temporary insurance coverage comes into effect, with respect to a life (to be) insured who qualifies for temporary insurance coverage, on the date the application is signed, if, on that date, all the following conditions are met:</p> <ol style="list-style-type: none"> The application has been completed; The questions on the <i>Conditions to qualify for temporary insurance</i>, with respect to that life (to be) insured, have been truthfully answered no and none has been left blank; and Payment of the estimated first monthly premium (or at least 1/12 of the estimated annual premium) for the policy being applied for has been received. For cases being submitted for <i>preferred</i> underwriting, the regular <i>standard</i> premium must be collected in order for the temporary insurance to be in effect.
<p>Date coverage ends</p>	<p>Insurance coverage under this agreement will end automatically on the earliest of:</p> <ol style="list-style-type: none"> The date the insurance under the policy change applied for takes effect; The date you request cancellation of the application; 2 days after the date Canada Life cancels or declines the application; and 90 days after the date this agreement is signed. Processing of the application may continue, but this temporary insurance will no longer be in effect. Payment made with the application will be retained during processing, and applied to your policy if issued, or refunded to you if not issued. Any delay in refunding does not extend temporary insurance coverage.
<p>Exclusion</p>	<p>If a life (to be) insured who qualifies for temporary insurance dies by suicide, whether sane or not, Canada Life's liability under this agreement will be limited to returning the amount paid with this application.</p>
<p>Always complete</p> <p>List all lives to be insured:</p> <ul style="list-style-type: none"> • Basic lives • Children 	<p><input type="checkbox"/> The life/lives (to be) insured who qualify for temporary insurance are:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> The life/lives (to be) insured who do not qualify for temporary insurance are:</p> <p>_____</p> <p>_____</p>

No advisor of Canada Life is authorized to modify this agreement.

Signed at (City) _____ (Province) _____ on _____ Date (dd/mmm/yyyy)

Signature of Canada Life's advisor: _____



Receipt

Amount of payment received: \$ _____

This *Receipt* is to be given to the owner when a valid payment is made. The amount received is payable to Canada Life for an application for policy change on the insureds named below.

Name of insured(s): _____

This receipt and the application must be completed on the same date.

Signed at (City) _____ (Province) _____ on _____
 Date (dd/mmm/yyyy)

XSignature of **advisor****Pre-authorized debit agreement (“agreement”)**

In this section, *you* and *your* refer to the account holder (or holders) from whose account the withdrawals will be made. *We* and *us* refer to The Canada Life Assurance Company.

Note: If the account holder is not the owner, the advisor is to make a copy of this agreement and give it to the account holder.

By signing at the bottom of section 11, you understand and agree to the following terms:

Your personal information

- We may collect, store, use and disclose your personal information as needed with regard to this agreement.
- If you're not the owner of the policy, we may share any information about this agreement with the owner, including payment information.

Your authorization for regular withdrawals

- You authorize us and your financial institution you named in 10.1 to withdraw from your account any monthly payments you've agreed to make, including payments that may vary from one withdrawal to the next, and regardless of any change in policy ownership. Withdrawals may increase or decrease as the insurance policy is administered, including as a result of any changes to the policy. **You release us from any requirement to let you know in advance of these increases or decreases.**
- Payments are subject to the provisions of the policy being applied for. If the premium due date in the policy is different than the withdrawal date shown in this agreement, the fact that they're not the same doesn't change the premium due date.
- You agree to review your account information regularly. If you find a transaction made under this agreement doesn't match your records, you have 90 days from the date of the transaction to contact us. After that, we'll consider the transaction to be correct.

If a pre-authorized withdrawal is refused by your financial institution

- If any pre-authorized withdrawal is refused by your financial institution, for example because there are insufficient funds in your account (NSF), we may suspend this agreement. We also have the option of making a second attempt to withdraw the amount, but if we still cannot make the withdrawal, we'll suspend this agreement.
- You'll be responsible for any NSF fees charged by your financial institution if they reject a withdrawal.
- If we suspend this agreement and the owner later wants pre-authorized debit payments to resume, we may require a new pre-authorized debit agreement.

Your rights with respect to unauthorized withdrawals

- You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Account changes

- If your account information changes, you must tell us in writing at least 14 days before the next withdrawal is to be made. However, we may agree to accept verbal instructions from you to change account information.

Cancelling this agreement

- You (or the owner) may cancel this agreement by giving us 30 days' written notice. Or if we decide to cancel the agreement, we'll give you (or the owner) 30 days' written notice. Contact your financial institution or www.cdnpay.ca for a sample cancellation form or for information about cancellation rights.

For more information about this agreement, contact us at 1-888-252-1847 or write to us at the appropriate address indicated on the next page.

A copy of this agreement is as valid as the original.



11. Agreements and signatures

In this section, *you* and *your* mean each owner and insured person (or parent or guardian of a minor insured person) and assignee/hypothecary creditor, if applicable. In this application, *we*, *us* and *our* mean The Canada Life Assurance Company.

By signing below, you understand and agree to the following:

- This application is the basis of the insurance we issue for you and includes this form, any written statements and answers you provide for this application, and all other information given by you over the telephone to a paramedical company or another authorized person representing or acting for Canada Life and/or during a customer interview conducted for Canada Life as outlined in the *Notice of customer interview program* which are also part of this application. You agree that any recording, transcription or other notation of such information (collectively “recording”) by or on behalf of Canada Life shall be considered to be accurate, complete and binding as if given in writing by you. However, where Canada Life provides you a copy of a recording, you agree to review it immediately and contact Canada Life, without delay, if you question or dispute its accuracy or completeness.
- You have read the statements and answers related to you or your child that are written in this application and confirm they are true and complete.
- If you give any incorrect answer or omit stating any fact in this application, and that answer or omission is important for this insurance, we can void any insurance we provide based on this application.
- If you are a parent or guardian of a minor insured included in this application, by signing below you also give the authorizations and agreement applicable for the minor insured.
- If you and/or your insured children have qualified for temporary insurance, you have received, read and understood the terms and conditions of the *Temporary insurance agreement*.
- Except for any temporary insurance as provided in the *Temporary insurance agreement* that has the same number as this application, there is no insurance under the “new” policy we issue until we’ve received payment of the first premium in full and the policy is delivered to the owner and takes effect while none of the facts stated in this application about the insurability of any insured person have changed since the date this application was signed.
- You acknowledge and agree that if an illustration is to be used to provide information on plan type and additional benefits or riders, as requested in 4.6, then despite anything to the contrary contained in the illustration, this information and only this information from the illustration, shall form part of the application.
- You have received the notices regarding the MIB, Inc. (“MIB”) and the customer interview program.
- If you have chosen monthly pre-authorized payments in section 10, you have received, read and agree to the terms and conditions of the *Pre-authorized debit agreement (“agreement”)* on page 17.
- If this application is being made in exercise of a right in an existing Canada Life policy, such as the right to convert term insurance or the right to buy additional insurance under the Guaranteed insurability option, this application and the new policy applied for will be subject to the terms of that right as set out in the existing policy.
- By accepting delivery of the policy we issue for this application, the owner agrees to the terms of the policy, and to any changes we’ve made to the policy or the application, as described in the policy or in a written notice we send to the owner.
- Any information about you or your child that is known by, or any statement that is made by any advisor or medical examiner will not change the written application or this agreement in any way.
- Any change in the insurability of any insured following the completion of the application and prior to delivery of the policy, if known by you, must be communicated by you to Canada Life.
- You have had the opportunity to read this application before signing it and it has been explained to your satisfaction and declare that all statements and answers on this application are complete and true. You, if signing for an owner, confirm you have the authority to sign this application on behalf of, and to bind, the owner.
- You authorize us to use your social insurance, corporate income tax or other tax identification numbers for tax reporting, identification and record keeping purposes.
- **You authorize a personal interview and/or Canada Life obtaining an investigative consumer report containing personal information and/or credit information, all of which may be requested in connection with this application (only if required).**
- You authorize the performance of any medical tests that Canada Life may require to medically underwrite this application for insurance. The tests may include, but are not limited to, tests for, diabetes, immune disorders, infection by the human immunodeficiency virus (HIV, the AIDS virus) and the presence of drugs, nicotine or their by-products (only if required).
- For underwriting, claim and administration purposes, you **authorize and consent to** any physician, medical practitioner, hospital or other medically related facility, insurance company, MIB, motor vehicle department, or other organization, institution or person that has information concerning you or your health to give Canada Life, reinsurers, and any person or organization acting on their behalf any such information (including record copies), and to the recipients collecting such information (only if required).

11. Agreements and signatures (continued)

- You are aware of the reasons the personal information covered by your authorizations and consents is needed, and of the benefits of, and the risks of not, authorizing/consenting. You authorize and consent to Canada Life's collecting, using, retaining, and disclosing personal information concerning you, including health information, for the purposes above (including those set out in **Notice regarding your personal information** in *Important notices*) and as otherwise identified to or known by you (only if required). This and all authorizations and consents concerning personal information are given in accordance with applicable law. They will begin the date they are given (the date of this application, unless indicated otherwise) and end when no longer required. They may be revoked at any time by either written or electronic notification to Canada Life, subject to legal or contractual considerations.
- You authorize Canada Life and reinsurers making a brief report to MIB and releasing your medical findings and test results to the physician shown in 8.2 (only if required), or to:

First insured

Physician's name	Address (street number and name)	City	Province
------------------	----------------------------------	------	----------

Second insured

Physician's name	Address (street number and name)	City	Province
------------------	----------------------------------	------	----------

- A reproduction of any authorization and consent will be as valid as the original.**

Signed at (City) _____ (Province) _____ on _____ Date (dd/mmm/yyyy)

X

 Signature of **owner** (if owner is a corporation, partnership, trust or not for profit, signature of the person authorized to sign)

X

 If owner is a **corporation, partnership, trust or not for profit, print the name and title of the person authorized to sign**

X

 Signature of **owner** (if owner is a corporation, partnership, trust or not for profit, signature of the person authorized to sign)

X

 Signature of **account holder**, if other than owner (if account holder is a corporation, partnership, trust or not for profit, signature of the person authorized to sign)

X

 Signature of **first insured** if age 16 (18 in Quebec) or over, if other than owner

X

 Signature of **joint account holder**, if other than owner (if joint account holder is a corporation, partnership, trust or not for profit, signature of the person authorized to sign)

X

 Signature of **second insured** if age 16 (18 in Quebec) or over, if other than owner

X

 Signature of **insured for payor benefits**, if other than owner

X

 Signature of **parent(s) or legal guardian** for each minor insured, if other than owner

X

 Signature of **irrevocable beneficiary** and/or **assignee/hypothecary creditor**, as required

X

 Signature of **witness** to all signatures (if other than advisor, print full name)

12. Authorization for Canada Life to obtain information

Complete only if any evidence of insurability is required.

Name of **first** insured (print):

 First name Middle name Last name

Name of **second** or additional insured (print):

 First name Middle name Last name

Name of **child(ren)** insured:

Child	Child's name (print first, middle, last)
1	
2	
3	
4	

For underwriting, claim and administration purposes: I authorize and consent to any physician, medical practitioner, hospital or medically related facility, insurance company, medical information bureau (e.g. MIB, Inc.), motor vehicle department, or other organization, institution or person, that has information concerning me or my health to give Canada Life, reinsurers, and any person or organization acting on their behalf any such information (including record copies), and to the recipients collecting such information.

I am aware of the reasons the information covered by my authorizations and consents is needed, as well as the benefits of, and the risks of not, authorizing/consenting. These authorizations and consents will commence the date this application is signed and will end when no longer required. They may be revoked at any time by either written or electronic notification to Canada Life, subject to legal or contractual restrictions and considerations. **A reproduction of the above authorizations and consents will be as valid as the original.**

Signed at (City) _____ (Province) _____ on _____
 Date (dd/mmm/yyyy)

X _____
 Signature of **first insured** if age 16 (18 in Quebec) or over

X _____
 Signature of **parent(s) or legal guardian** for each minor insured

X _____
 Signature of **second insured** if age 16 (18 in Quebec) or over

X _____
 Signature of **witness** to all signatures
 (if other than advisor, print full name)



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13. Advisor's report (Questions 13.1 through 13.3 are required for universal life insurance policies only)

13.1 Owner(s) identification (universal life insurance) – documentation shown *must* be original and valid.

a) Individual owner(s)

First owner name (print):

First name _____ Middle name _____ Last name _____

Address*: _____
 Street number and name _____ City _____ Province _____ Postal code _____

***If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence below:**

Date of birth (dd/mmm/yyyy): _____

Owner chooses one type of government-issued photo ID:

Driver's licence Passport

Other (specify type): _____
 (excluding health insurance cards)

Document number _____ Jurisdiction of issue _____ Issue date (dd/mmm/yyyy) _____ Expiry date (dd/mmm/yyyy) _____

Second owner name (print):

First name _____ Middle name _____ Last name _____

Address*: _____
 Street number and name _____ City _____ Province _____ Postal code _____

***If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence below:**

Date of birth (dd/mmm/yyyy): _____

Owner chooses one type of government-issued photo ID:

Driver's licence Passport

Other (specify type): _____
 (excluding health insurance cards)

Document number _____ Jurisdiction of issue _____ Issue date (dd/mmm/yyyy) _____ Expiry date (dd/mmm/yyyy) _____

b) Individual owner(s) occupation

First owner:

Detailed occupation/title*: _____

Employer/entity name: _____

Nature/type of business: _____

***If retired or unemployed:** Source of income: _____

Prior occupation: _____

***If homemaker or student:** Source of income: _____

Second owner:

Detailed occupation/title*: _____

Employer/entity name: _____

Nature/type of business: _____

***If retired or unemployed:** Source of income: _____

Prior occupation: _____

***If homemaker or student:** Source of income: _____

c) Incorporated or non-incorporated entity owners (e.g., corporations, partnerships, trusts):

If the owner is an incorporated or non-incorporated entity (including partnerships, trusts and not-for-profit organizations), complete the *Questionnaire for applicants/owners that are entities* (form 17-8295), and the *International tax classification for an entity* (form 17-8945).

Full legal name: _____

Address*: _____
 Street number and name _____ City _____ Province _____ Postal code _____

***If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence below:**

13. Advisor's report (continued)

13.1 c) (continued)

Registration number:

- i) Incorporation number: _____
 Jurisdiction of issue: Federal or Province/territory of: _____
- ii) Other registration number for a non-incorporated entity: _____
 Type of number: _____
 Jurisdiction of issue: Federal or Province/territory of: _____

13.2 Advisor's confirmation

Did you (the advisor) see the original document noted above, was it valid, and did you record the information above in the presence of the owner? Yes No

If no, and the plan is owned by a person, meet with the owner and complete the *Owner and third party identification* (form 17-8341). **If you cannot meet with the owner**, request and complete the *Non-photo owner identification* (form 46-10771).

If it is owned by an incorporated or non-incorporated entity (including partnerships, trusts and not-for-profit organizations), complete the *Questionnaire for applicants/owners that are entities* (form 17-8295).

13.3 Third party determination and identification (universal life insurance)

a) Will another person or entity pay for this policy, have the use of or access to any policy values while the policy is in effect, or is another person or entity directing the owner to apply or signing on behalf of the owner? Yes No

If yes, complete 13.3 b).
If no, skip to 13.4.

b) If there's more than one third party, use a separate page to record the information requested for each additional third party.

Third party's name	Date of birth (dd/mmm/yyyy)	Relationship to owner
Address*:		
Street number and name	City	Province
Postal code		

*If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence below:

If a corporation, provide: incorporation no. and country/province of incorporation (provide similar information for a non-incorporated entity, e.g., partnership).

Third party's role(s): Under a power of attorney/Mandate Payor Trustee Executor
 Collateral assignee/hypothecary creditor Other: _____

Detailed occupation/nature of business of entity (if not working or no longer operating an entity, provide details on third party's previous occupation or principal entity)	Sources of income other than occupation/principal entity
--	--

Employer/entity name	Nature/type of business
----------------------	-------------------------

c) Those signing for an owner (e.g., power of attorney), must be identified by appropriate government-issued photo ID: (excluding health insurance cards)

Name of signer	Type of document	Document no.	Jurisdiction of issue	Issue date (dd/mmm/yyyy)	Expiry date (dd/mmm/yyyy)

If unable to collect the third party information we've requested, explain the reason here:

13. Advisor's report (continued)

13.4 Purpose of insurance - Check all that apply:

a) Personal:

- Income for survivor Insured 1 Insured 2
- Last expenses Insured 1 Insured 2
- Estate conservation Insured 1 Insured 2
- Mortgage/debt cancellation Insured 1 Insured 2
- Savings/retirement fund Insured 1 Insured 2
- Charitable giving Insured 1 Insured 2
- Other(specify): Insured 1: _____
 Insured 2: _____

b) Business continuance insurance:

- Key person protection Insured 1 Insured 2
- Business succession/equity purchase Insured 1 Insured 2
 (Sole proprietor purchase agreement, Share redemption
 Partnership buy/sell, Shareholder cross purchase)
- Business loan protection (provide copy of agreement) Insured 1 Insured 2
- Other(specify): Insured 1: _____
 Insured 2: _____

- c) Child insured:** As part of an overall financial plan
 Preserve the children's insurability
 Family protection
 Other (specify): _____

13.5 Who sold this insurance?

Advisor's name (print first, middle, last)	Advisor code	Regional marketing centre	% share of commission
			%
			%
			%

13.6 Additional information about the insureds:

First insured	Name (print first, middle, last)	Marital status	Name of employer
	If insured is a Canada Life administrative employee, provide employee no.		
Second insured	Name (print first, middle, last)	Marital status	Name of employer
	If insured is a Canada Life administrative employee, provide employee no.		

If an insured is not self-supporting, who are they dependent on?

Name (first, middle, last)	Relationship of this person to the insured	Occupation	How much insurance is there on this person? Life \$

13.7 If the owner is not the insured, complete the following:

Approximate annual earned income \$	Approximate annual income from other sources (list sources) \$	Approximate net worth \$
--	---	-----------------------------

13. Advisor's report (continued)

13.8 Information about business insurance

Complete this question only if the insurance was bought for business purposes.
All questions should be answered relative to the business.

Name of principals (print first, middle, last)	% of business owned	Amount of insurance already in effect	Amount of insurance to be put into effect
	%	\$	\$
	%	\$	\$
	%	\$	\$
Estimated annual sales for the business \$	Estimated annual after tax income for the business \$	Estimated fair market value of the business \$	
How did you calculate how much business insurance was needed?			

13.9 When should the insurance be dated? Unless you indicate otherwise, the insurance will be current dated.

Backdated to age: _____ or Other (specify): _____

13.10 Do you know of any information not disclosed in this application that could impact the insurability of an insured? Yes No
If yes, provide details in 13.15.

13.11 Did you fully record all of the answers to questions in the presence of the owner and the insureds before this application was signed? Yes No

13.12 Did you take payment of at least one month's premium? Do **not** take a payment if the amount of the insurance is \$5,000,000 or greater. **Note:** If the policy is simply preferred, the regular standard premium must be collected. Yes No

13.13 Did you give the owner the *Receipt* and *Temporary insurance agreement*? Yes No

13.14 Is this application intended to replace or significantly change any insurance? Yes No

13.15 Provide any other relevant information here:

Notes: • For any payment of \$100,000 or more on an individually or jointly owned policy, also submit a *Politically exposed person (PEP) determination* (form 17-8294) for each owner and any person paying for this policy.

• For universal life insurance policies only: If 13.3 a) is answered no, provide details in 13.15 if you have reasonable grounds to believe there is a third party.

13.16 By signing below, I confirm that all the information and answers in this application are true and complete to the best of my knowledge. I have provided the following information in writing to the owner:

- a) The company or companies I represent
- b) That I receive compensation (such as commissions) for the sale of life and health insurance products
- c) That I may receive additional compensation in the form of bonuses, conferences, or other incentives
- d) Any actual or potential conflicts of interest I may have with respect to this transaction

Signed at (City) _____ (Province) _____ on _____ Date (dd/mmm/yyyy)

X

Signature of **advisor**

Important notices – detach and give to the owner(s) and those insured under the policy(ies)

Notice regarding your personal information

(in this notice, *you* and *your* also apply to the owner, if not the same as the insured)

Protecting your personal information is important to Canada Life. When an application is submitted to us, we create a confidential file containing your personal information. The file is kept in the offices of Canada Life or third parties we authorize. Directly, or through others, we handle your personal information – i.e., collect, store, use and disclose it – to, as applicable, provide you financial products and services, respond to claims, help you plan for financial objectives, and otherwise as legally required or as you have authorized. We limit access to the information in your file to our staff and others, including your advisor and service providers, who need it to perform their duties. This includes our reinsurers. In some cases, we may engage service providers outside of Canada to assist us with the handling of your personal information. In those cases your personal information will be subject to the laws of other countries.

If you'd like to review and correct your personal information in our file, or if you have further questions about how we handle and protect your personal information and would like a copy of our privacy guidelines, write to us at:

Canada Life's Chief Compliance Officer
255 Dufferin Avenue
London, ON N6A 4K1

Or visit www.canadalife.com.

About our customer interview program

To complete your application, the insured may receive a telephone call from one of our authorized representatives to obtain personal and financial information. The interview normally takes from 30 minutes and will be conducted at a time convenient to the insured. If the insured is not in when the interviewer calls, the interviewer will leave a name and toll-free number to return the call.

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Important notices (continued)

Notice regarding MIB, Inc.

Canada Life treats the information about your insurability as confidential. However, we and our reinsurers may make a brief report to MIB, Inc., a not-for-profit organization of life and health insurance companies operating an information exchange on behalf of its members. If you apply for insurance coverage or submit a claim to another MIB, Inc. member company, MIB, Inc. will, on request, supply that company with the information in its file.

If you apply to another insurance company for life or health insurance, or if you submit a claim to another company, we or our reinsurers may also share information in your file directly with that company.

For more information about MIB, Inc., visit www.mib.com, call 416-597-0590 or write: MIB, Inc., 330 University Avenue, Suite 501, Toronto, ON, M5G 1R7. You may ask to see your personal information on file with MIB, Inc. and correct anything that's inaccurate or incomplete.

Notice about insurance underwriting report

As part of processing your application, we may request an insurance underwriting report to obtain additional credit and personal information about you. If you'd like a more detailed description of the nature of this investigation and the information we receive, write to Individual Insurance, 255 Dufferin Ave, London, ON, N6A 4K1.

About tax treatment

Any tax information we provide is for general information only. It should not be relied on as providing tax or legal advice.

Any person seeking such advice should consult with a tax or legal professional.



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Important notices (continued)

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Variable interest options Index-linked options	Allocation			Allocation	
	Scheduled premium	Additional premium		Scheduled premium	Additional premium
Canadian Equity	_____%	_____%	Sciences and Technology	_____%	_____%
American Equity	_____%	_____%	European Equity	_____%	_____%
Global Equity	_____%	_____%	Japanese Equity	_____%	_____%
Canadian Bond	_____%	_____%	American Small Cap	_____%	_____%
Real Return Bond	_____%	_____%			
Fund-linked variable interest options					
Fixed income-linked options					
Franklin Bissett Bond	_____%	_____%	Mackenzie Corporate Bond	_____%	_____%
Equity fund-linked options					
Canadian Equity					
ABC Fundamental-Value	_____%	_____%	Mackenzie Canadian Resource	_____%	_____%
Trimark Canadian Equity	_____%	_____%	AGF Canadian Equity	_____%	_____%
Franklin Bissett Canadian Equity	_____%	_____%	Mackenzie Canadian Large Cap Growth	_____%	_____%
Mackenzie Canadian Large Cap Dividend	_____%	_____%	CI Harbour	_____%	_____%
Invesco Canadian Premier Growth Class	_____%	_____%	Dynamic Power Canadian Growth	_____%	_____%
U.S. Equity					
ABC American-Value	_____%	_____%	AGF American Equity	_____%	_____%
			Mackenzie U.S. All Cap Growth	_____%	_____%
Global and International Equity Options					
Mackenzie Global	_____%	_____%	Trimark Global Equity	_____%	_____%
Fidelity Global	_____%	_____%	Signature International	_____%	_____%
Templeton International Equity	_____%	_____%	Dynamic Global Value	_____%	_____%
			Fidelity NorthStar®	_____%	_____%
Canadian Balanced Funds					
CI Harbour Growth & Income	_____%	_____%	Fidelity Canadian Asset	_____%	_____%
ABC Fully-Managed	_____%	_____%	Fidelity Monthly Income	_____%	_____%
Profile / Asset allocation accounts					
Conservative Profile	_____%	_____%	Advanced Profile	_____%	_____%
Moderate Profile	_____%	_____%	Aggressive Profile	_____%	_____%
Balanced Profile	_____%	_____%			
Allocation subtotals for page 2	_____%	_____%		_____%	_____%
Allocation subtotals from page 1	_____%	_____%		_____%	_____%
Total allocations must equal 100%	_____%	_____%		_____%	_____%

2. Side account (owned by the owner of the policy and is not part of the policy)

- A side account will be set up automatically.
- Any interest earned in this account is taxable.
- Owner-initiated withdrawals from the five-year compound guaranteed interest option are subject to market value adjustments. Automatic transfers to the policy are not.
- **If no selection is made, allocations will automatically be credited to the five-year compound guaranteed interest option.**

Transfers from the policy to this account are to be allocated to the:

- Daily interest option
 Five-year compound guaranteed interest option

This supplement is being submitted in connection with, and forms part of the application. I request that The Canada Life Assurance Company (Canada Life) allocate my funds as indicated above. To the extent of any inconsistencies between this supplement and the application, the information in this supplement will govern.

Signed at (City) _____ (Province) _____ on _____ Date (dd/mmm/yyyy)

X

 Signature of **owner**
 (if entity, authorized person to sign **and indicate title**)

 If **owner is an entity**, print full legal name of entity

X

 Signature of **owner**, if more than one owner
 (if entity, authorized person to sign **and indicate title**)

X

 Signature of **witness** to all signatures