# Life and/or Critical Illness Insurance Application

Use this application for Critical Illness and/or RBC *Your*Term™ Life Insurance and available benefits and riders

Insurance

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**DETACH AND GIVE TO PROPOSED INSURED**

# COLLECTION AND USE OF PERSONAL INFORMATION

## Collecting your personal information

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

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

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

## Using your personal information

This information may be used from time to time for the following purposes:

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

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

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

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

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

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

## Other uses of your personal information

We may use this information to promote our products and services, and promote products and services of third parties we select, which may be of interest to you. We may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided.

We may also, where not prohibited by law, share this information with RBC companies for the purpose of referring you to them or promoting to you products and services which may be of interest to you. We and RBC companies may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. You acknowledge that as a result of such sharing they may advise us of those products or services provided.

If you also deal with RBC companies, we may, where not prohibited by law, consolidate this information with information they have about you to allow us and any of them to manage your relationship with RBC companies and our business.

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

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

COLLECTION AND USE OF PERSONAL INFORMATION    CONSUMER FACT SHEET    PERSONAL HISTORY INTERVIEW (PHI)

**DETACH AND GIVE TO PROPOSED INSURED**

# COLLECTION AND USE OF PERSONAL INFORMATION

### Your right to access your personal information

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

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

### Our privacy policies

You may obtain more information about our privacy policies by calling us at the toll free number shown above or by visiting our website at www.rbc.com/privacysecurity.

# CONSUMER FACT SHEET PRE-NOTICE

Information regarding your insurability and claims will be treated as confidential. RBC Life Insurance Company (RBC Life) or its reinsurer(s) may, however, make a brief report thereon to the MIB, LLC, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com, calling 1-866-692-6901 or write to:

MIB, LLC,
50 Braintree Hill Park, Suite 400,
Braintree, MA
USA, 02184-8734
Telephone: 1-866-692-6901
Website: www.mib.com

RBC Life or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

# PERSONAL HISTORY INTERVIEW (PHI)

As part of the underwriting process, you may be asked to respond to a telephone interview. The Personal History Interview (PHI) is conducted by specially trained interviewers. The interview will take approximately 20 minutes.

The questions asked by the interviewer amplify the information on your application for insurance. We also use the PHI process to gather information which may have been omitted or only partially explained in the application. These questions relate to personal, financial and medical aspects of insurability and must be answered truthfully and completely. The answers contained in the Personal History Interview and/or supplementary questionnaire(s) completed by you during a telephone interview will form part of your application for insurance and the contract. Because of the nature of the information obtained, the PHI will only be conducted directly with you.

Any information obtained during the PHI will be kept strictly confidential and will not be released to anyone without your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide you with the best quality underwriting.

# PART 1: PERSONAL AND EMPLOYMENT INFORMATION

(You/Your refers to the Proposed Insured)

## PROPOSED INSURED A

(Check one)
Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other ☐ ______

1. Print name as legally known:
   a. Last ______
   b. First & Middle ______
   c. Birthdate: Day ______ Month ______ Year ______
   d. Birthplace: Country ______
   e. Sex: M ☐ F ☐
   f. Smoker ☐ Non-Smoker ☐
   g. Do You understand English or French? Yes ☐ No ☐

If No, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.

   h. Is a French language Policy requested? Yes ☐ No ☐
   i. Canadian Citizen ☐ Permanent Resident ☐
   Other (Specify) ☐ ______
   If other, have you been residing in Canada for less than 12 months? Yes ☐ No ☐

2. Home Address: a. Number ______
   b. Street ______
   c. City ______
   d. Province ______ e. Postal Code ______
   f. E-mail Address ______
   g. Home Phone No. (    ) ______
   Work Phone No. (    ) ______
   Mobile Phone No. (    ) ______

3. a. Business/Employer Name ______
   b. Business/Employer Address: Suite No. ______
   c. Street ______
   d. Province ______ e. Postal Code ______
   f. City ______
   g. Phone No. (    ) ______
   h. Occupation ______
   i. Describe nature of business ______
   j. Describe duties ______
   k. How long with this employer? ______

## PROPOSED INSURED B

(Check one)
Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other ☐ ______

4. Print name as legally known:
   a. Last ______
   b. First & Middle ______
   c. Birthdate: Day ______ Month ______ Year ______
   d. Birthplace: Country ______
   e. Sex: M ☐ F ☐
   f. Smoker ☐ Non-Smoker ☐
   g. Do You understand English or French? Yes ☐ No ☐
   h. Canadian Citizen ☐ Permanent Resident ☐
   Other (Specify) ☐ ______
   If other, have you been residing in Canada for less than 12 months? Yes ☐ No ☐

5. Home Address: **Same as Proposed Insured A** ☐

   **OR** a. Number ______
   b. Street ______
   c. City ______
   d. Province ______ e. Postal Code ______

   f. E-mail Address ______
   g. Home Phone No. (    ) ______
   Work Phone No. (    ) ______
   Mobile Phone No. (    ) ______

6. a. Business/Employer Name ______
   b. Business/Employer Address: Suite No. ______
   c. Street ______
   d. Province ______ e. Postal Code ______
   f. City ______
   g. Phone No. (    ) ______
   h. Occupation ______
   i. Describe nature of business ______
   j. Describe duties ______
   k. How long with this employer? ______

MAIN PURPOSE

COVERAGE APPLIED FOR

## MAIN PURPOSE OF INSURANCE

7. a. Personal ☐
   Income Replacement ☐
   Estate Conservation ☐
   Other ☐
   Please explain

b. Business ☐
   Protect key personnel ☐
   Fund buy-sell agreement ☐
   Other ☐
   Please explain

## TERM LIFE COVERAGE APPLIED FOR

Joint plans with more than 2 lives to be insured are available by special quote only. If more than 2 joint lives, please submit a separate Application form for each Proposed Insured not covered by this Application and cross reference them to each other.

8. **Amount of Life Insurance Coverage on the Base Plan** $

9. **Insurance Plan and Coverage Option for the Base Plan:**

| | Term Length | Single Life | JFTD |
|---|---|---|---|
| RBC *Your*Term® | (10 to 40) | ☐ | ☐ |

| 10. **Name(s) of Person(s) To Be Insured Under the Base Plan** | Total Disability Waiver | Accidental Death Benefit |
|---|---|---|
| a. | Yes ☐ No ☐ | $ |
| b. | Yes ☐ No ☐ | $ |
| c. | Yes ☐ No ☐ | $ |
| d. | Yes ☐ No ☐ | $ |
| e. | Yes ☐ No ☐ | $ |

11. **Term Rider 1:**

| | Term Length | Single Life | JFTD | Face Amount $ |
|---|---|---|---|---|
| RBC *Your*Term® | (10 to 40) | ☐ | ☐ | |

| **Name(s) of Person(s) To Be Insured Under This Term Rider Coverage** | **Application No.** |
|---|---|
| a. | |
| b. | |
| c. | |
| d. | |

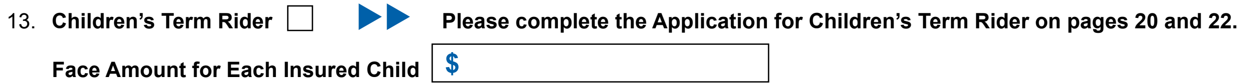
**Term Rider 2:**

| | Term Length | Single Life | JFTD | Face Amount $ |
|---|---|---|---|---|
| RBC *Your*Term® | (10 to 40) | ☐ | ☐ | |

| **Name(s) of Person(s) To Be Insured Under This Term Rider Coverage** | **Application No.** |
|---|---|
| a. | |
| b. | |
| c. | |
| d. | |

12. **Payor Death & Disability Waiver:** ☐ Name of Payor

Date of birth Relationship to Proposed Owner(s)



13. **Children's Term Rider** ☐ **Please complete the Application for Children's Term Rider on pages 20 and 22.**

**Face Amount for Each Insured Child** $

## CRITICAL ILLNESS COVERAGE APPLIED FOR

| Plan | Supplementary Benefits |
| --- | --- |
| ☐ Non-Cancellable 10 Year Term to Age 75<br>Amount | Disability Waiver of Premium Rider ☐<br>Return of Premium on Death Rider ☐ |
| ☐ Guaranteed Renewable to Age 65<br>Amount | Disability Waiver of Premium Rider ☐<br>Return of Premium on Death Rider ☐<br>Scheduled Increase Benefit Rider ☐ |
| ☐ Guaranteed Renewable to Age 75<br>Amount | Disability Waiver of Premium Rider ☐<br>Return of Premium on Death Rider ☐<br>Scheduled Increase Benefit Rider ☐ |
| ☐ Non-Cancellable to Age 75<br>Amount | Disability Waiver of Premium Rider ☐<br>Return of Premium on Death Rider ☐<br>Scheduled Increase Benefit Rider ☐ |

EXISTING AND PENDING COVERAGES

BENEFICIARY AND/OR RECIPIENT

## EXISTING AND PENDING COVERAGES

14. a. Do You have any Life or Critical Illness coverages in force or pending, including any with RBC Life? . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

**If Yes, provide details below. Complete Replacement forms where necessary.**

| Proposed Insured A | Proposed Insured B | Name of Insurance Company | | Amount of Life or CI Insurance (including term riders) | | Year and Month Issued | Is the insurance applied for intended to replace any insurance now in force with any company? |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ Life | | $ | ☐ Personal | | Yes ☐ No ☐ |
| | | ☐ CI | | Policy # | ☐ Business | | |
| ☐ | ☐ | ☐ Life | | $ | ☐ Personal | | Yes ☐ No ☐ |
| | | ☐ CI | | Policy # | ☐ Business | | |
| ☐ | ☐ | ☐ Life | | $ | ☐ Personal | | Yes ☐ No ☐ |
| | | ☐ CI | | Policy # | ☐ Business | | |
| ☐ | ☐ | ☐ Life | | $ | ☐ Personal | | Yes ☐ No ☐ |
| | | ☐ CI | | Policy # | ☐ Business | | |

b. Have You applied for life, critical illness or disability insurance concurrently with this Application or within the past 12 months with any other company?

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

**If Yes, indicate details** ▶▶

| Proposed Insured A | Proposed Insured B | Amount Applied for | Coverage Type | Name of Insurer |
|---|---|---|---|---|
| ☐ | ☐ | $ | ☐ Life ☐ CI ☐ DI | |
| ☐ | ☐ | $ | ☐ Life ☐ CI ☐ DI | |
| ☐ | ☐ | $ | ☐ Life ☐ CI ☐ DI | |

## BENEFICIARY (LIFE) and/or RECIPIENT (CI)

All beneficiaries are revocable unless otherwise stated, except in Quebec where the designation of a legal spouse (by marriage or civil union) of the owner is irrevocable, unless expressly stated to be revocable. If naming an irrevocable beneficiary, you should be aware that the consent of the irrevocable beneficiary is required to change the beneficiary designation and to make any change which impacts the value of the policy. A minor cannot give that consent. In all provinces, except Quebec, if the beneficiary is a minor, a trustee should be named in order to avoid a payment into court. Complete the Appointment of Trustee section on page 8. In Quebec, benefits payable to minors are payable to the surviving parent(s) as tutor(s).

If all beneficiaries predecease the Proposed Insured, the proceeds are payable to the contingent beneficiary if any, otherwise to the Owner or the Owner's Estate.

Ensure total shares of both the Primary and Contingent beneficiaries equal 100% respectively.

15.

| Proposed Insured A | Proposed Insured B | Full Name of Beneficiary (First) (Middle) (Last) | Revocable or Irrevocable | Relationship to Proposed Insured (Proposed Owner in Quebec) | Primary or Contingent | % Share |
|---|---|---|---|---|---|---|
| ☐ | ☐ | | | | | |
| ☐ | ☐ | | | | | |
| ☐ | ☐ | | | | | |
| ☐ | ☐ | | | | | |
| ☐ | ☐ | | | | | |

**The benefit Recipient designation applies only to Critical Illness policies.** Return of Premium benefits are payable to the Proposed Owner. Critical Illness benefits will be paid to the Proposed Insured unless the Proposed Owner designates a different Recipient below.

| Recipient | Equally or Survivors (if any) | Relationship | Birthdate (dd/mm/yyyy) |
|---|---|---|---|
| | | | |

All Recipient designations are revocable except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable by checking the following box: ☐ Revocable.

## PROPOSED OWNER(S)

16. a. Proposed Insured A ☐ Proposed Insured B ☐

Proposed Insureds A and B Jointly* ☐
If selected, what is the relationship between Proposed Insureds A and B?

Other ☐ (Please complete the section below)

b. **(Check one)** Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ c. First or Company Name

d. Middle Name e. Last Name

f. Relationship to Proposed Insureds A and B

g. Mailing Address (for billing and correspondence) Street

h City i. Province j. Postal Code

k. Attention l. E-mail Address

* If jointly owned, ownership is to be with right of survivorship unless otherwise indicated. (In Quebec, please name one another as Contingent Owners if right of survivorship is desired.)

## JOINT PROPOSED OWNER (If different than joint ownership by Proposed Insureds A and B)

17. a. **(Check one)** Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ b. First or Company Name

c. Middle Name d. Last Name

e. Relationship to Proposed Insureds A and B

f. Mailing Address (for billing and correspondence) Street

g. City h. Province i. Postal Code

j. Attention E-mail Address

k. Relationship to Other Joint Owner

Joint ownership is to be with right to survivorship unless otherwise indicated. (In Quebec, please name one another as Contingent Owners if right to survivorship is desired.)

## CONTINGENT OWNER

▶▶ Must be completed if purchasing Children's Term Rider.

If all Owners predecease the Proposed Insured, in the absence of a Contingent Owner, ownership passes to the estate of the last surviving Owner.

18. a. **(Check one)** Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ b. First or Company Name

c. Middle Name d. Last Name

e. Relationship to Proposed Insureds A and B

## APPOINTMENT OF TRUSTEE

▶▶ Complete if the Proposed Owner wishes to name a trustee for a beneficiary and such a trustee has not already been appointed under a written Trust Agreement.

This appointment applies to benefits payable to any beneficiary designated under the policy who, at the time benefits are payable, is a minor or lacks legal capacity to give a valid discharge. Payment of benefits to the trustee discharges RBC Life Insurance Company to the extent of the payment.

I authorize the trustee in his/her or its sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the policy.

The trust for any beneficiary will terminate once that beneficiary both is of the age of majority and has legal capacity to give a valid discharge, and I direct the trustee at that time to deliver to the beneficiary any assets held in trust for that beneficiary. I or my personal representative (in Quebec: my tutor, curator, liquidator or mandatory in the event of incapacity) may in writing appoint a new trustee to replace a former trustee.

I appoint

First Name Middle Name Last Name

as trustee to receive, in trust, benefits under the policy.

Relationship to Proposed Insured

OWNERSHIP

APPOINTMENT OF TRUSTEE

## FINANCIAL INFORMATION

19.

| | Proposed Insured A | Proposed Insured B |
|---|---|---|
| a. What is Your annual earned income from employment in Canadian dollars? | $ | $ |
| b. What is Your estimated net worth in Canadian dollars? | $ | $ |
| c. Amount of mortgage outstanding on personal residence and/or cottage? | $ | $ |
| d. If not self supporting, what is the annual gross amount of the family earned income? | $ | $ |
| e. What is Your annual income in Canadian dollars from other sources? | $ | $ |

Describe "other sources" of income

| A | B | |
|---|---|---|
| ☐ | ☐ | |
| ☐ | ☐ | |

f. Have You within the past 5 years declared personal or corporate bankruptcy? Proposed Insured A: Yes ☐ No ☐ B: Yes ☐ No ☐

▶▶ **If Yes, provide the discharge date and complete details below.**

| A | B | Discharge Date | Complete Details |
|---|---|---|---|
| ☐ | ☐ | | A |
| ☐ | ☐ | | |
| | | | B |

20. **If applying for business insurance, complete the following:**

| | Proposed Insured A | Proposed Insured B |
|---|---|---|
| a. Book Value of Business in Canadian Dollars | $ | $ |
| b. Fair Market Value of Business in Canadian Dollars | $ | $ |
| c. Before Tax Net Annual Income of Business in Canadian Dollars | $ | $ |

d. Please complete the following:

| Name of Principals | % of Business Owned | Amount of Life Insurance in Force or Pending | Insurance Company |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

21. **If applying for Critical Illness Business Loan coverage, please complete the following:**

a. Amount of business loan $ ______ b. Payback term (minimum 5 years required) ______

c. Purpose of loan ______

d. Loan details ______



## ADDITIONAL INFORMATION

22. a. Have You collected Employment Insurance (EI), disability benefits, workers' compensation benefits (WC), CPP or QPP disability benefits, income replacement benefits, maternity/parental leave, or any form of social assistance in the past 12 months? Proposed Insured A: Yes ☐ No ☐ B: Yes ☐ No ☐

▶▶ **If Yes, provide details.**

| A | B | Date Started | Date Ended | EI | WC | Maternity/ parental | Other |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ Describe |
| ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ Describe |
| ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ Describe |

b. Have You within the past 24 months been a student pilot, or piloted a plane, ultra-light or glider, or do You have any intention of doing so in the future? Proposed Insured A: Yes ☐ No ☐ B: Yes ☐ No ☐

▶▶ **If Yes, please complete the Aviation Questionnaire**.

c. Have You within the past 12 months traveled outside Canada or the United States of America, or do You intend to do so within the next 12 months? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

▶▶ **If Yes, provide details.**

| A | B | Dates | Countries/Cities | Length of Stay | Reason |
|---|---|---|---|---|---|
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |

d. Have You within the past 24 months engaged in any hazardous or contact sports or activities, including but not limited to racing, scuba diving deeper than 100ft (30m), skydiving, heli-skiing or back-country skiing, or do You intend to do so? . . . . . . . . . . . . . . . . . . . . . . . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

▶▶ **If Yes, provide details.**

| A | B | Hazardous Sport or Activity Type | Dates, Frequency, Professional/Amateur, Recreational/Commercial |
|---|---|---|---|
| ☐ | ☐ | | |
| ☐ | ☐ | | |
| ☐ | ☐ | | |

e. Have You ever had life, disability or critical illness insurance rated, modified, rejected, rescinded, or have You been denied renewal or reinstatement? . . . . . . . . . . . . . . . . . . . . . . . . . . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

▶▶ **If Yes, provide details.**

| A | B | Indicate Type of Insurance | Rated | Modi-fied | Re-jected | Re-scinded | Denied Renewal or Reinstatement | Insurance Company | Reason |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | | |

f. Have You within the past 10 years been found guilty of a criminal offence, or are criminal charges pending? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

▶▶ **If Yes, provide details.**

| A | B | Date of Incident | Details Including Outcome |
|---|---|---|---|
| ☐ | ☐ | | A |
| ☐ | ☐ | | |
| ☐ | ☐ | | B |
| ☐ | ☐ | | |

g. Have You within the past 10 years been convicted of any driving offences or violations, including impaired driving, and/or have You had a driver's license revoked or suspended, or are any such charges pending?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

| Proposed Insured | | |
|---|---|---|
| A: | Yes ☐ | No ☐ |
| B: | Yes ☐ | No ☐ |

▶▶ **If Yes, provide the driver's license number and complete details below, including dates, offence type, how many km/h over the limit.**

| A | B | Driver's License Number | Details, Dates, Offence Type(s), km/h Over Limit |
|---|---|---|---|
| ☐ | ☐ | | |
| ☐ | ☐ | | |

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blank intentionally.

# PART 2: MEDICAL HISTORY: PROPOSED INSURED A (You/Your refers to the Proposed Insured)

**When answering the questions on this form, DO NOT provide information about any genetic test You have taken or plan to take. A genetic test is a type of medical test that analyzes DNA, RNA or chromosomes. DO provide information about other types of medical tests.**

**Legal Name of Proposed Insured** ______

1. Paramedical requested? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes ☐ No ☐

**If Yes, completing pages 12 and 14-18 for Proposed Insured A is not required.**

2. Current Height ______ ☐ cm ☐ ft/in Current Weight ______ ☐ kg ☐ lb

3. Have You lost 10lb/5kg or more within the past 12 months? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes ☐ No ☐

**If Yes**

| Reason | Amount Lost |
|---|---|
| | ☐ kg ☐ lb |

4. Are You presently under medical observation or investigation, treatment, therapy, counselling, or **taking medication**? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes ☐ No ☐

Details

| Name of Medication | Dose Amount | Frequency Taken | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

5. Have You had any symptoms or complaints regarding Your health for which You have not yet consulted a physician or received treatment? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Yes ☐ No ☐

Details

6. Who is Your family physician or regular healthcare provider or clinic?

______ **(If none, write "None.")**

Provide the full address and phone number.

7. Provide the name of the healthcare provider who has Your most recent health record **if different from Your regular healthcare provider or clinic.**

8. Provide the date and reason for Your last consultation with **ANY** physician or healthcare provider, the name of the provider, and the outcome/results.

9. Was any follow-up, further investigation or referral to another healthcare professional recommended? . . . . . . . . . Yes ☐ No ☐

Details

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

MEDICAL INFORMATION

MEDICAL INFORMATION

## PART 2: MEDICAL HISTORY: PROPOSED INSURED B (You/Your refers to the Proposed Insured)

**When answering the questions on this form, DO NOT provide information about any genetic test You have taken or plan to take. A genetic test is a type of medical test that analyzes DNA, RNA or chromosomes. DO provide information about other types of medical tests.**

**Legal Name of Proposed Insured** ☐

10. Paramedical requested? . . . . . . . . . . Yes ☐ No ☐

**If Yes, completing pages 13-18 for Proposed Insured B is not required.**

11. Current Height ☐ ☐ cm ☐ ft/in Current Weight ☐ ☐ kg ☐ lb

12. Have You lost 10lb/5kg or more within the past 12 months? Yes ☐ No ☐

**If Yes**

| Reason | Amount Lost |
|---|---|
| | ☐ ☐ kg ☐ lb |

13. Are You presently under medical observation or investigation, treatment, therapy, counselling, or **taking medication**? . . . . . . . . . . Yes ☐ No ☐

Details

| Name of Medication | Dose Amount | Frequency Taken | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

14. Have You had any symptoms or complaints regarding Your health for which You have not yet consulted a physician or received treatment? . . . . . . . . . . Yes ☐ No ☐

Details

15. Who is Your family physician or regular healthcare provider or clinic?

☐ **(If none, write "None.")**

Provide the full address and phone number.

16. Provide the name of the healthcare provider who has Your most recent health record **if different from Your regular healthcare provider or clinic.**

17. Provide the date and reason for Your last consultation with **ANY** physician or healthcare provider, the name of the provider, and the outcome/results.

18. Was any follow-up, further investigation or referral to another healthcare professional recommended? . . . . . . . . . Yes ☐ No ☐

Details

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

## MEDICAL DETAILS – PROPOSED INSUREDS A AND B

19. **In the past 24 months** have You used cigarettes, e-cigarettes, vaping products, cigars, water pipes, betel nut, smoking cessation products or nicotine or tobacco in any form? . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

| A | B | Product Type (cigars, cigarettes, vaping, etc.) | Quantity and Frequency of Use | Date Last Used | Details of Smoking Cessation Therapy (type, when started/completed) |
|---|---|---|---|---|---|
| ☐ | ☐ | | | | A |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | B |

20. Have You used marijuana and/or hashish **within the past 5 years**? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **If Yes, indicate the type, quantity and frequency of use, and date last used.**

| **A:** |
|---|
| **B:** |

21. Do You consume alcoholic beverages? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **If Yes, provide details.**

**Proposed Insured A:**

| | Amount | | Day | Week | Month | Year |
|---|---|---|---|---|---|---|
| Beer | | cans/bottles | ☐ | ☐ | ☐ | ☐ |
| Wine | | glasses | ☐ | ☐ | ☐ | ☐ |
| Liquor | | ml/oz | ☐ | ☐ | ☐ | ☐ |

**Proposed Insured B:**

| | Amount | | Day | Week | Month | Year |
|---|---|---|---|---|---|---|
| Beer | | cans/bottles | ☐ | ☐ | ☐ | ☐ |
| Wine | | glasses | ☐ | ☐ | ☐ | ☐ |
| Liquor | | ml/oz | ☐ | ☐ | ☐ | ☐ |

22. Have You ever sought or received advice or treatment relating to alcohol use, or used alcohol excessively? . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **If Yes, please complete the Alcohol Use Questionnaire.**

23. Have You ever used cocaine, barbiturates, crack, or any other narcotic drug, or ever sought or received advice or treatment for the use of drugs, prescribed or non-prescribed? . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **If Yes, indicate the type of drug, quantity and frequency of use, and date last used.**

| **A:** |
|---|
| **B:** |

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

**Have You ever had any known indication of or been treated for:**

24. a. Acquired immune deficiency syndrome, AIDS related complex, AIDS related conditions; or have You tested positive for antibodies to the AIDS virus or HIV? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

b. Any disease or disorder of the eyes, ears, nose or throat (including loss of speech)? . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

c. Sleep apnea, chronic insomnia, or any other sleep disorder? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

d. Chest pain, heart attack, angina, abnormal ECG, irregular pulse, heart murmur, high blood pressure, high cholesterol, peripheral vascular disease or any disease or disorder of the heart or circulatory system? . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

e. Stroke, transient ischemic attack (TIA), headaches, cognitive impairment, memory disorder, Parkinson's disease, Alzheimer's disease, motor neuron disease, Huntington's disease, fainting spells, dizziness, seizures, epilepsy, paralysis, multiple sclerosis, muscle weakness, numbness or tingling of the limbs, or any disease or disorder of the brain or nervous system? . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

f. Protein, albumin, blood, or sugar in the urine, abnormal prostate test, kidney stones, or any disease or disorder of the kidneys, urinary tract, bladder, prostate, or reproductive organs? . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

g. Anxiety, depression, nervousness, stress, fatigue, burnout, eating disorder, other emotional disorder, psychiatric disorder, mental disorder or psychosis; or have You ever attempted suicide? . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

**Have You ever had any known indication of or been treated for:**

h. Chronic fatigue, chronic fatigue syndrome, Epstein-Barr virus, fibromyalgia, or chronic pain?. . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

i. Cancer, dysplastic nevi, tumour, cyst, mass, lesion, lump, nodule, polyp or other growth, any disorder of the skin or lymph glands, blood disorder or any form of malignant disease?. . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

j. Diabetes, endocrine disorder, elevated blood sugar, thyroid disease, rheumatism, rheumatic fever, lupus, gout, or syphilis? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

k. Any disease or disorder of the breast, including lumps, cysts or other masses, other physical changes, abnormal mammogram findings or any biopsy? . . . . . . . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

l. Any amputation or deformity, hernia or rupture, deep vein thrombosis or varicose veins? . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

m. Any arthritis, disease or disorder of the muscles, bones, hip, ankle, knee, wrist, elbow, shoulder, hands, feet or any other joint?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

n. Any type of back or spinal trouble (includes neck area) including sprain, strain, or disc disease or disorder? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

MEDICAL INFORMATION

**Have You ever had any known indication of or been treated for:**

o. Any type of shortness of breath, persistent cough, asthma, emphysema, bronchitis, pleurisy, tuberculosis, or any disease or disorder of the chest or lungs? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

p. Any type of peptic ulcer, indigestion, colitis, or any disease or disorder of the stomach, colon or intestines, gall bladder, liver, pancreas; or have You tested positive for hepatitis and/or been told You are a carrier? . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

**Other than the information provided in Part 2, questions 1-24, have You in the past 10 years:**

25. a. Been examined by or consulted a physician, chiropractor, psychologist, physiotherapist, osteopath, homeopath, or other practitioner? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

b. Been under observation or treatment in any hospital or other institution or facility, or been advised to be admitted? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

c. Had an X-ray, ECG, CT scan, MRI, blood or urine test, abnormal PSA (Prostate Specific Antigen) test, or other diagnostic tests? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

d. Had any surgical operation, treatment, special diet, or any illness, ailment, abnormality or injury? . . . . . . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

e. Been advised to have any diagnostic test, be hospitalized, or have surgery which was not completed? . . **A:** Yes ☐ No ☐

**B:** Yes ☐ No ☐

▶▶ **Details**

| **A:** |
|---|
| **B:** |

Details include symptoms, date of onset, diagnosis, treatment, date of full recovery and name of healthcare provider.

26. Have Your natural parents, brothers or sisters, either living or dead, ever suffered from any of the following conditions: heart disease, polycystic kidney disease, high blood pressure, a stroke, diabetes, cancer, multiple sclerosis, Alzheimer's disease, Huntington's disease, Parkinson's disease, motor neuron disease or any form of hereditary disease? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **If Yes, complete the chart below.**

| A | B | Condition | Mother | Age at Onset | Father | Age at Onset | Sister | Age at Onset | Brother | Age at Onset |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | ☐ | | ☐ | | ☐ | | ☐ | |
| ☐ | ☐ | | ☐ | | ☐ | | ☐ | | ☐ | |
| ☐ | ☐ | | ☐ | | ☐ | | ☐ | | ☐ | |
| ☐ | ☐ | | ☐ | | ☐ | | ☐ | | ☐ | |

**Female Applicants Only**

27. Are You currently pregnant? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **If Yes,**

a. What is the due date?

| **A:** |
|---|
| **B:** |

b. Have You experienced any complications with this pregnancy or any past pregnancy? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **A:** Yes ☐ No ☐
**B:** Yes ☐ No ☐

▶▶ **If Yes, provide details.**

| **A:** |
|---|
| **B:** |

**As needed, provide additional details below to any Yes answers from Part 2.**

| Question Number | Conditions, Symptoms, Diagnosis and Treatment | Date of Onset | Name of Healthcare Provider | Date of Recovery |
|---|---|---|---|---|
| | | | | |

# PART 3: PREMIUM AND PAYMENT INFORMATION

**1.** a. Method of Payment: Monthly ☐ Annually ☐

b. Pre-Authorized Debit Plan (PAD) (Complete the PAD Agreement below) ☐ OR Direct Bill ☐

c. Initial deposit collected? Yes ☐ No (Payment On Delivery) ☐

**If initial deposit is collected, it is in exchange for the Receipt(s) and TIAs.**

d. Temporary Life Insurance Agreement (TIA) premium to be withdrawn by PAD? Yes ☐ No ☐

e. TIA premium collected for life insurance? Yes ☐ No ☐ If Yes please indicate amount collected $ ______

f. If TIA has not been applied for, is the initial life insurance premium to be withdrawn by PAD? Yes ☐ No ☐

**2. PRE-AUTHORIZED DEBIT (PAD) AGREEMENT**

Ensure You read and understand the section entitled "Collection and Use of Personal Information."

The Payor(s) named below agrees that:

a. RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals against the account at the financial institution below or any other financial institution that the Payor(s) may later designate to pay the premium in accordance with the premium schedule set out in this policy/these policies, including the initial premium and/or the Temporary Insurance Agreement premium, if requested in this application.

b. **RBC Life is not required to provide notification before the Temporary Insurance Agreement premium and/or the initial premium is debited, or if the amount of the withdrawal should vary.**

c. Unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy/policies.

d. The financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premiums or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account.

e. Notification of any change to the information provided below shall be given to RBC Life by the Payor(s) a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor's oral or written instructions.

f. This Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Payments Canada website at www.payments.ca.

g. In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

   The Payor(s) has certain recourse rights if any debits do not comply with this Agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.payments.ca.

h. The names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

i. Add to existing PAD with policy number(s) ______

j. Special Requests (Withdrawals must be between the 1st – 28th of the month) ______

**Bank Information: Please attach a specimen cheque marked "Void" (a line of credit account cannot be used).**

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

Address ______

City ______ Province ______ Postal Code ______

Signed at ______ (City/Province) this ______ day of ______ (Month/Year)

______ Print Legal Name of Payor (Account Holder)

______ Print Legal Name of Second Payor (Account Holder) (if any)

______ Signature of Payor

______ Signature of Second Payor (if any)

# APPLICATION FOR CHILDREN'S TERM RIDER

Must be the natural or adopted child of a Life Insured named on page 4.
A Contingent Owner must be named in the main Application (see page 8).
All children must be between 14 days and 20 years of age.
Any child age 16 years or over, or age 18 years or over in Quebec, must sign the Application.
The beneficiary of this benefit will be the Proposed Insured or Proposed Joint Insureds under the Policy.

## Children's Names

a. First Name ______ Middle Name ______ Last Name ______

Female ☐ Male ☐ Date of Birth (dd/mm/yyyy) ______

Height ______ ☐ cm ☐ ft/in Weight ______ ☐ kg ☐ lb Relationship to Proposed Insured(s) ______

Relationship to Proposed Owner(s) ______

b. First Name ______ Middle Name ______ Last Name ______

Female ☐ Male ☐ Date of Birth (dd/mm/yyyy) ______

Height ______ ☐ cm ☐ ft/in Weight ______ ☐ kg ☐ lb Relationship to Proposed Insured(s) ______

Relationship to Proposed Owner(s) ______

c. First Name ______ Middle Name ______ Last Name ______

Female ☐ Male ☐ Date of Birth (dd/mm/yyyy) ______

Height ______ ☐ cm ☐ ft/in Weight ______ ☐ kg ☐ lb Relationship to Proposed Insured(s) ______

Relationship to Proposed Owner(s) ______

## Children's Medical History

| | | YES | NO |
|---|---|---|---|
| 1. | Has any insurance application for any child been declined, postponed, or modified in any way? | ☐ | ☐ |
| 2. | Do any of the children have any physical or mental impairment, or have they had any illness, impairment or injury that has required treatment or an operation? | ☐ | ☐ |
| 3. | Are any of the children currently on medication, or has any treatment or diagnostic test been advised that has not been completed? | ☐ | ☐ |
| 4. | Do all of the above children reside with the Proposed Insured? If No, provide details below about who the child lives with and how often the Proposed Insured sees the child. | ☐ | ☐ |

5. What was the reason, the date of, and the result of the child's last visit to a healthcare professional? Please answer below and include the healthcare professional's name, professional designation, address, postal code and phone number.

| Child | Question # | Details |
|---|---|---|
| | | |

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blank intentionally.

## Children's Term Rider Agreement and Authorization

I certify that to the best of my knowledge the answers given are full, complete and true, and agree that they shall form part of my Life Insurance Application to RBC Life Insurance Company.

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me and/or my child (as named on this Application for Children's Term Rider included in the Life Insurance Application). I understand that the Company will create and maintain files that contain personal information concerning me and/or my child. I also understand that access to personal information concerning me and/or my child will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or the persons to whom I have granted access, in writing, or to any other person authorized by law.

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

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

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other healthcare practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of healthcare or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my and/or my child's employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also the MIB, LLC; and also any other person, agency, credit bureau or institution having information, records or data regarding me and/or my child. This Authorization to obtain information is valid until revoked by me in writing. If I choose to revoke this Authorization to obtain information, consequences may include termination of the underwriting process and/or the Policy, if one has been issued.

I understand that any information, records or data received by the Company pursuant to this Authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes, for the purpose of evaluating any claim for benefits, assessing the validity of the Policy as issued, and issuing and delivering the Policy. Only to the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the MIB, LLC; to other insurance companies or any reinsurer; and to my Servicing Advisor, such as my insurance advisor or broker; and to other third parties, who are required to maintain the confidentiality of this information (ex: the managing general agency with which my Servicing Advisor is associated (if applicable)). This Authorization to disclose information as reasonably necessary is valid until revoked by me in writing.

I authorize the Company to release to my and/or my child's healthcare professional any medical information obtained for this insurance Application, including the results of any blood or urine test or urine drug screening tests for the purpose of revealing findings that might require further investigation or treatment or for the purpose of explaining any underwriting decision. This Authorization to disclose medical information is valid until revoked by me in writing. A photocopy of this Authorization, as executed by me, will be as valid as the original. Any alteration of this Authorization will render it null and void.

I authorize the Company to disclose to my Servicing Advisor material information regarding my and/or my child's health and personal history solely for the purpose of explaining underwriting decisions. This disclosure could include history of mental illness, infectious disease, drug and alcohol use, record of criminal activity, or other facts that have a material effect on the Company's decision to insure me and/or my child. This Authorization to disclose information for this purpose is valid until 60 days after the later of the day the Company issues a new or amends the existing Policy; or the day the Company notifies me in writing that my Application has been declined, withdrawn, or filed incomplete.

I do not agree to the disclosure of health and personal information to the Servicing Advisor ☐

Signed at ____________ (City/Province) this ______ day of ____________ (Month/Year)

| | |
|---|---|
| Signature of Parent/Guardian (tutors* in Quebec) | Signature of Parent/Guardian (tutors* in Quebec) |
| Signature of Any Child Age 16 Years or Over (age 18 Years or Over in Quebec) | Signature of Any Child Age 16 Years or Over (age 18 Years or Over in Quebec) |

* In Quebec, if there is more than one tutor, all tutors must sign unless one tutor has been given the authority in a specific mandate to act unilaterally on the child's behalf.

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# TEMPORARY LIFE AND/OR CRITICAL ILLNESS INSURANCE APPLICATION

**If any of the following questions are answered "Yes," or left blank the Proposed Insured(s) is not eligible to apply for either Life or Critical Illness Temporary Insurance. For Temporary Life Insurance, and/or if any Proposed Insured is under 15 days of age or over 65 years of age, the Proposed Insured(s) is not eligible to apply for Temporary Life Insurance. For Temporary Critical Illness Insurance, if the Proposed Insured is over 64 years of age and/or has a cumulative total of $250,000 or more of Critical Illness coverage in force with RBC Life Insurance Company and/or in force or pending with another company, Temporary Critical Illness Insurance is not available. Do not proceed.**

**When answering the questions on this form, please do so without reference to any genetic tests you may have taken or are planning to take. A genetic test is a type of medical test that analyzes DNA, RNA or chromosomes.**

| Has the Proposed Insured: | Proposed Insured A YES | Proposed Insured A NO | Proposed Insured B YES | Proposed Insured B NO |
|---|---|---|---|---|
| 1. ever been treated for or had any indication of heart or circulatory disease, heart attack, high blood pressure, chest pain, abnormal ECG, stroke, transient ischemic attacks (TIAs), diabetes, chronic kidney, liver or lung disease, cancer or tumour, multiple sclerosis, paralysis, motor neuron disease, Alzheimer's disease, Huntington's disease, Parkinson's disease, AIDS, ARC or HIV infection, loss of speech, blindness or deafness? | ☐ | ☐ | ☐ | ☐ |
| 2. within the past two years, other than normal childbirth, been admitted to a hospital or other medical facility or been advised to do so? | ☐ | ☐ | ☐ | ☐ |
| 3. been advised to have any tests, investigations or surgery not yet done? | ☐ | ☐ | ☐ | ☐ |
| 4. in the past year had any Application for life and/or critical illness insurance, change or reinstatement declined, rated or modified in any way? | ☐ | ☐ | ☐ | ☐ |
| 5. been absent from work for more than 7 days within the past 6 months because of sickness or injury? | ☐ | ☐ | ☐ | ☐ |
| **Is the Proposed Insured:** | | | | |
| 6. aware of any symptoms for which they have not sought treatment or for which treatment is planned or pending? | ☐ | ☐ | ☐ | ☐ |

LEAVE THIS PORTION ATTACHED

## Temporary Life Insurance Receipt (applicable only if Temporary Life Insurance is applied for)

RBC Life Insurance Company (RBC Life) acknowledges receipt of $ ________, which is at least the minimum payment of one monthly premium (1/12 of an annual premium if paying annually) at standard rates for the life insurance Policy applied for under this Temporary Life Insurance Agreement (Life TIA) or authorization has been provided to RBC Life in this Life Insurance Application (Life Application) to withdraw this sum immediately by pre-authorized debit in payment for coverage under the Life TIA on the life (lives) of

Proposed Insured(s) ________

Signed at ________ (City/Province) this ____ day of ________ (Month/Year)

Signature of Advisor ________

The Temporary Life Insurance Application, the Life Application, and the payment by cheque (if applicable) must all be dated the same date or the Temporary Life Insurance Agreement is null and void.

## Temporary Life Insurance Agreement (Life TIA)

RBC Life Insurance Company (RBC Life) agrees to insure the Proposed Insured specified on the Temporary Life Insurance Receipt, who, in this Life TIA, will be referred to as the Proposed Insured, subject to the terms and conditions set out below.

**Coverage**

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

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

a. the amount of life insurance applied for in the Life Application, OR

b. $1,000,000.

If the total amount of life insurance applied for on the Proposed Insured in the Life Application is greater than the maximum payable under this Life TIA and the Proposed Insured dies while covered under this Life TIA, RBC Life will refund the portion of any payment for coverage over the maximum payable under this Life TIA for that Proposed Insured.

IF APPLICABLE, DETACH AND GIVE TO PROPOSED OWNER

LEAVE THIS PORTION ATTACHED

IF APPLICABLE, DETACH AND GIVE TO PROPOSED OWNER

### Termination of Temporary Life Insurance

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

a. 90 days from the date the Life Application is signed, OR

b. the date on which RBC Life mails notice of termination of insurance under this Life TIA, OR

c. the date the Policy RBC Life issues in response to the Life Application takes effect, OR

d. the date the Proposed Owner(s) refuse(s) to accept delivery or otherwise reject(s) the Policy issued in response to the Life Application, OR

e. the date the Proposed Owner(s) ask(s) RBC Life to cancel this Life TIA or otherwise withdraw(s) the Life Application, OR

f. the date of death of the Proposed Insured (if more than one Proposed Insured, the date of death of the first or last to die according to the Life Application).

Except in the case of fraud, payment received by RBC Life will be refunded in the event of termination under a, b, d or e.

### Limitations and Exclusions

a. If there is material misrepresentation or non-disclosure in any part of the Life Application or Life TIA Application, any Application supplement or questionnaire, or any paramedical or medical exam, no Life TIA will take effect and RBC Life shall, except in the case of fraud, refund the payment for this Life TIA.

b. RBC Life shall have no liability if the specified Proposed Insured commits suicide, except RBC Life shall refund the payment for this Life TIA.

c. No accidental death rider, disability/income replacement, critical illness, children's term rider, or return/waiver of premium benefits are provided under this Life TIA.

d. No Life TIA will take effect if any question is answered "Yes" and/or not answered in the Life TIA Application; the Life Application and/or the Life TIA Application is (are) not signed; the Proposed Insured is under 15 days of age or over 65 years of age; the payment for coverage under the Life TIA is not honoured on presentation; and/or the dates of the Life TIA Application, the Life Application and the cheque (if applicable) are not the same date.

e. Life TIA is not available if the Life Application is made under any conversion provision of an existing Policy or the conversion option of a rider to any existing Policy.

## Temporary Critical Illness Insurance Receipt (applicable only if Temporary Critical Illness Insurance is applied for)

RBC Life Insurance Company (RBC Life) acknowledges receipt of $ ____________, which is at least the minimum payment of one monthly premium (1/12 of an annual premium if paying annually) at standard rates for the critical illness insurance policy applied for under this Temporary Critical Illness Insurance Agreement (CI TIA) in payment of the coverage under the CI TIA on the life of

Proposed Insured(s) ____________

Signed at ____________ (City/Province) this ______ day of ____________ (Month/Year)

Signature of Advisor ____________

The Temporary Critical Illness Insurance Application, the Critical Illness Insurance Application and the payment by cheque must all be dated the same date or the Temporary Critical Illness Insurance will be null and void.

## Temporary Critical Illness Insurance Agreement (CI TIA)

RBC Life Insurance Company (RBC Life) agrees to insure the Proposed Insured specified on the Temporary Critical Illness Insurance Receipt, who, in this CI TIA, will be referred to as the Proposed Insured, subject to the terms and conditions set out below.

**Coverage**

CI TIA commences once the Critical Illness Insurance Application (CI Application) and the Temporary Critical Illness Insurance Application (CI TIA Application) have been signed and the payment for coverage under this CI TIA has been received.

Subject to the terms of this CI TIA, the Critical Illness coverage provided by this CI TIA will be for a single occurrence of the same specifically defined Critical Illnesses (excluding Cancer) that are contained in the standard policy wording used by RBC Life in effect at the time of the CI Application, and which would be issued if the Proposed Owner's CI Application for a policy on the Proposed Insured were to be approved. Subject to meeting the definition of a Critical Illness as defined in the standard policy wording used by RBC Life in effect at the time of CI Application, and subject to a maximum aggregate liability of $250,000, RBC Life will pay to the Proposed Insured (or the Recipient if one is named in the CI Application), the LESSER OF:

(a) the amount of Critical Illness insurance applied for in the CI Application, OR

(b) $250,000 less the amount of Critical Illness coverage already in force with RBC Life and/or any Critical Illness coverage in force or pending with another company.

If the total amount of critical illness insurance applied for on the Proposed Insured in the CI Application is greater than the maximum payable under this CI TIA and the Proposed Insured meets the definition for a Critical Illness while covered under this CI TIA, RBC Life will refund the portion of any payment for coverage over the maximum payable under this CI TIA for that Proposed Insured.

**Termination of Temporary Life Insurance**

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

(a) 90 days from the date the CI Application is signed, OR

(b) the date on which RBC Life mails notice of termination of insurance under this CI TIA, OR

(c) the date the policy RBC Life issues in response to the CI Application takes effect, OR

(d) the date the Proposed Owner(s) refuses to accept delivery or otherwise rejects the policy issued in response to the CI Application, OR

(e) the date the Proposed Owner(s) ask(s) RBC Life to cancel this CI TIA or otherwise withdraws the CI Application, OR

(f) the date of death of the Proposed Insured.

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

**Limitations and Exclusions**

(a) There is no coverage for, and no payment will be made under this CI Agreement for, any type of cancer or any Critical Illness resulting from any type of cancer.

(b) If there is material misrepresentation or non-disclosure in any part of the CI Application or the CI TIA Application, any application supplement or questionnaire, no CI TIA will take effect and RBC Life shall, except in the case of fraud, refund the payment for this CI TIA.

(c) RBC Life shall have no liability, and liability will be limited to a refund of the payment made, if the Proposed Insured suffers a covered Critical Illness as a result of an act of self-destruction. An act of self destruction occurs when the Proposed Insured, whether sane or insane, takes or attempts to take their own life or inflicts injuries on their own person, and the death or injury results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.

(d) No CI TIA will take effect if any question is answered "Yes" and/or not answered in the CI TIA Application, the CI Application and/or the CI TIA Application is (are) not signed, the Proposed Insured is over 64 years of age, the payment for coverage under the CI TIA Application is not honoured on presentation, and/or if the date of the CI TIA Application, the CI Application and the cheque are not dated on the same date, or if the Proposed Insured has a cumulative total of $250,000 or more Critical Illness insurance coverage already in force with RBC Life and/or in force or pending with another company.

(e) CI TIA is not available if the CI Application is made under any conversion provision of an existing policy or the conversion option of a rider to any existing policy.

(f) Insurance under only one CI TIA can be in effect with RBC Life on the Proposed Insured. If more than one CI Application for CI TIA is submitted on the Proposed Insured, effect will be given only to the one with the higher face amount that meets all of the provisions as set forth herein.

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# AGREEMENT

In this Agreement, RBC Life Insurance Company is referred to as the "Company", any policy issued as a result of this application is referred to as the "Policy", and the Proposed Owner and Proposed Insured, if different from the Proposed Owner, are each referred to as "I", "me" and "my".

It is understood and agreed as follows:

1. I have read the statements and answers recorded on this application and any supplemental forms required to support this application. They are true, complete, and correctly recorded. In order to obtain additional evidence of insurability, the Company may arrange a paramedical or medical examination or telephone interview. During the examination or interview, I will answer all questions honestly and completely. I am responsible for verifying the accuracy and completeness of the information provided in this application, any supplemental forms or questionnaires required to support this application, any paramedical or medical examination, and any documented telephone interview. The Company is entitled to rely on that information. I understand that providing inaccurate or incomplete information may compromise eligibility for coverage and/or benefits, and may mean that there will be no coverage.
2. Upon delivery of this Policy, the Proposed Owner will ensure that the Proposed Insured reviews the statements and answers contained in any paramedical or medical examination, documented telephone interview, or other questionnaire and verifies that they were correctly recorded. The Proposed Owner will immediately advise the Company if any of them were not. The Proposed Owner will also immediately advise the Company if, between the date they were provided and the date this Policy is delivered, there have been any changes to the statements and answers in this application, any paramedical or medical examination, documented telephone interview, or other questionnaire (as applicable).
3. The entire Contract of Insurance shall be the Policy, any attached endorsements, exclusions, amendments, addendums or documents, including documented paramedical or medical examinations and documented telephone interviews, and all completed parts of this application, application supplement(s) and questionnaire(s). No statement made to and no information acquired by a representative of the Company, an examiner, or an interviewer shall be attributed to or binding upon the Company unless contained in the Contract of Insurance. No one other than an officer of the Company may a) alter or modify the terms of this Policy or b) waive any rights or requirements of the Company. Acceptance of the Policy will constitute agreement to its terms and to any changes specified by the Company in the Policy.
4. In Quebec, insurance under the Policy shall only take effect when:
   a. the full initial premium has been paid; and
   b. the Company accepts the application without modification.

   In all provinces other than Quebec, and in Quebec if the Company accepts the application with modification, insurance under the Policy shall only take effect when:
   a. the full initial premium has been paid; and
   b. the Policy has been delivered to the Proposed Owner and all conditions for delivery of the Policy have been completely satisfied, including but not limited to the Company's receipt and approval of all amendments, addendums and exclusions required for the Policy to take effect, signed by the Proposed Owner and the Proposed Insured, if different from the Proposed Owner, within the period required by the Company; and
   c. there has been no change in the health or insurability of the Proposed Insured between the time of the application and delivery of the Policy.
5. I have received satisfactory information about the product(s) being applied for.
6. A copy of the "Consumer Fact Sheet Pre-Notice" has been received and read.
7. I have read the section entitled "Collection and Use of Personal Information' appearing in this Application and understand and agree to its terms.

**CRITICAL ILLNESS RECOVERY PLAN™**

8. A failure to disclose existing and pending coverage, including any coverage with the Company, may compromise eligibility for coverage, and may mean that there will be no coverage. If this application indicates that an existing or pending policy will be replaced by this Policy, the Proposed Owner must discontinue that existing or pending policy as soon as this Policy is delivered. The discontinuance of that existing or pending policy is a condition of delivery, and this Policy will not take effect unless that existing or pending policy is discontinued.
9. This Policy will not provide coverage for any critical illness that is due to a) an accidental bodily injury sustained before this Policy is delivered, or b) a disease or sickness that first manifests itself before this Policy is delivered. However, this Policy will provide coverage for such critical illness if the Proposed Insured has, before this Policy is delivered, fully disclosed to the Company, on this application or otherwise in writing, all information known or reasonably available to the Proposed Insured regarding the injury, disease or sickness, including all signs, symptoms or other manifestations, and the Company has chosen not to exclude the injury, sickness or disease.

**I have read, understand and agree with the terms of the Temporary Life Insurance Receipt and Agreement (applicable only if the minimum payment has been properly made and the Temporary Life Insurance Receipt properly detached from the application).**

**I have read, understood and agree with the terms of the Temporary Critical Illness Insurance Receipt and Agreement (CI TIA) (applicable only if the minimum payment has been properly made and the Temporary Critical Illness Insurance Receipt properly detached from this application).**

Signed at ____________ this ______ day of ____________
(City/Province) (Month/Year)

Signature of Proposed Insured A

Signature of Proposed Insured B

Signature of Proposed Owner (if different than Proposed Insured(s) A and/or B)

Signature of Joint Proposed Owner (If different than Proposed Insured(s) A and/or B)

If Corporate Owner, provide the title of the signing officer.

If Trustee Owner, identify the Trust.

# CONSENT FORM FOR ELECTRONIC DELIVERY OF CONTRACT

This form is **only applicable for New Business**.

**Delivery of Policy:** If you are the proposed policy owner, **you will need to create an Online Insurance Account**. When the policy documents are ready to be delivered, you will receive an email at the email address you provide below. The email will explain how to create an Online Insurance Account so that you can accept electronic delivery of the policy documents.

| **PROPOSED POLICY OWNER NAME** | **PREFERRED EMAIL** *If you have enrolled for Online Insurance, that email address will be used.* | **MOBILE NUMBER** *Used only for verification purposes* |
|---|---|---|
| | | |

☐ I consent to the electronic delivery of my policy contract and any associated documents to my Online Insurance Account.

**SIGNATURE OF PROPOSED OWNER** **DATE (DD/MM/YYYY)**

---

| **PROPOSED JOINT POLICY OWNER NAME** *If any* | **PREFERRED EMAIL** *If you have enrolled for Online Insurance, that email address will be used.* | **MOBILE NUMBER** *Used only for verification purposes* |
|---|---|---|
| | | |

☐ I consent to the electronic delivery of my policy contract and any associated documents to my Online Insurance Account.

**SIGNATURE OF JOINT PROPOSED OWNER** **DATE (DD/MM/YYYY)**

---

**PROPOSED INSURED CONSENT (MUST BE COMPLETED IF THE INSURED AND OWNER ARE DIFFERENT)**

**Authorization:** I understand that the policy owner has selected electronic delivery of the policy and associated documents and will have electronic access to all of the information (including but not limited to health/medical information) that I have provided to RBC Life Insurance Company in the application process. I hereby consent to the owner having access to all of this information.

*If you do not want the policy owner to have access to the information you have provided, please do not sign this form and discuss your concern with the advisor.*

**SIGNATURE OF PROPOSED INSURED A** **SIGNATURE OF PROPOSED INSURED B** **DATE (DD/MM/YYYY)**

Signature of Parents / Guardians (tutors* in Quebec) if Proposed Insured A is under 16 years of age (under 18 in Quebec).

Signature of Parents / Guardians (tutors* in Quebec) if Proposed Insured B is under 16 years of age (under 18 in Quebec).

* In Quebec, if there is more than one tutor, all tutors must sign unless one tutor has been given the authority in a specific mandate to act unilaterally on the child's behalf.

# AUTHORIZATION



Name of Proposed Insured A [ ] Name of Proposed Insured B [ ]

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files that contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or to the persons to whom I have granted access, in writing, or to any other person authorized by law. I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company. I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income or employment that is relevant to this Application that they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other healthcare practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of healthcare or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also the MIB, LLC; and also any other person, agency, credit bureau or institution having information, records or data regarding me. This Authorization to obtain information is valid until revoked by me in writing. If I choose to revoke this Authorization to obtain information, consequences may include termination of the underwriting process and/or the Policy, if one has been issued.

I understand that any information, records or data received by the Company pursuant to this Authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes; for the purpose of evaluating any claim for benefits; assessing the validity of the Policy as issued; and, issuing and delivering the Policy. Only to the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the MIB, LLC; to other insurance companies, or any reinsurer; and, to my Servicing Advisor, such as my insurance advisor or broker ; and to other third parties, who are required to maintain the confidentiality of this information (ex: the managing general agency with which my Servicing Advisor is associated (if applicable)). This Authorization to disclose information as reasonably necessary is valid until revoked by me in writing.

I authorize the Company to release to my healthcare professional any medical information obtained for this insurance Application, including the results of any blood or urine test or urine drug screening tests for the purpose of revealing findings that might require further investigation or treatment or for the purpose of explaining any underwriting decision. This Authorization to disclose medical information is valid until revoked by me in writing. A photocopy of this Authorization, as executed by me, will be as valid as the original. Any alteration of this Authorization will render it null and void.

I authorize the Company to disclose to my Servicing Advisor material information regarding my health and personal history solely for the purpose of explaining underwriting decisions. This disclosure could include history of mental illness, infectious disease, drug and alcohol use, record of criminal activity, or other facts that have a material effect on the Company's decision to insure me. This Authorization to disclose information for this purpose is valid until 60 days after the later of the day the Company issues a new or amends the existing Policy; or the Company notifies me in writing that my Application has been declined, withdrawn, or filed incomplete.

Proposed Insured A does not agree to the disclosure of health and personal information to the Servicing Advisor ☐

Proposed Insured B does not agree to the disclosure of health and personal information to the Servicing Advisor ☐

Signed at [ ] (City/Province) this [ ] day of [ ] (Month/Year)

Signature of Proposed Insured A [ ]

Signature of Proposed Insured B [ ]

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ADVISOR'S REPORT

# ADVISOR'S REPORT

1. Who initiated this request for Insurance? You ☐ Proposed Owner(s) ☐ Proposed Insured(s) ☐
2. Are you (the Advisor) the Owner, Proposed Insured, payor or beneficiary on this policy? Yes ☐ No ☐
3. Are you (the Advisor) related to the Proposed Owner(s) or Proposed Insured(s)? Yes ☐ No ☐

   A related party includes:

   a) immediate family member

   b) a corporation where the Advisor or a family member, individually or together owns 50% or more of any class of shares of the corporation

   c) where the Advisor is incorporated, any director, officer, employee or agent and any parent, subsidiary or affiliated corporation

   If Yes, please provide details

4. Special date required?
5. Evidence: The following requirements have been ordered:

   Blood Profile ☐ ECG/Ex.ECG ☐ Medical ☐ MVR ☐ Paramedical ☐ Urinalysis ☐ Vitals ☐

   Other ☐ Specify

   Para-Medical Company Used ☐ Specify

6. **Advisor's Declaration:**

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

| Date (dd/mm/yyyy) | | | | |
|---|---|---|---|---|
| Advisor's Signature | | | | |
| Advisor's Name | | | | |
| Advisor's Company Name | | | | |
| Marketing Office/MGA | | | | |
| Share of Commission | % | Servicing Advisor Code | % | Advisor Code |

Please use this space for any special instructions or additional information which would be helpful in the underwriting of this risk.

Insurance

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