P.O. Box 4241, Station A
Toronto, ON M5W 5R3
Telephone: 1-800-846-5970
ivari.ca

Notice of Disclosures

LEAVE THIS PAGE WITH THE OWNER

Thank you for your business.

For the purposes of the Notice of Disclosures (the "Notices"), "you" refers to the Owner(s) and "Insured" refers to the Proposed Insured (when applying for new insurance coverage) or existing Insured (if you modify an existing policy with ivari). Please make sure you read this application carefully and that you understand all of it.

Once we receive your application, we will assess the eligibility of each Insured.

We base this eligibility on the information you provide in this application, and any other declaration made in connection to this application, and information previously submitted by you in relation to the insurance you already have or have had with ivari. When underwriting is required, eligibility is also based on additional information from other sources which may include, and not limited to, medical history, physical condition, occupation, lifestyle, and financial situation.

When completing this application, you are required to provide ivari with true and complete information about you and the Insured. Do not disclose any genetic tests taken or plan to take. A genetic test is a type of medical test which analyzes DNA, RNA, or chromosomes. You must, however, provide information about all other types of medical tests. Once we have determined the degree of risk for the Insured, we will let you know if the insurance you applied for or the change requested can be issued.

If you are applying for a new ivari insurance policy or submitting a change to your existing ivari policy or requesting to convert your existing policy where either require underwriting, **please refer to Sections 1 to 4.**

If you are submitting an application to convert your existing ivari policy where no new underwriting is required, **please refer to Sections 1, 2a), 2c) and 3.**

1. Notice regarding investigative consumer and credit reports

When required, as part of our evaluation of your application and claim analysis, we may request an investigative consumer report or credit report be completed. These reports, if requested, will be obtained from an investigative or consumer reporting agency or from a credit bureau.

Personal information collected may include information about your character, general reputation, personal characteristics, finances, credit, and lifestyle. A representative who is employed to make such reports may contact you in person or by telephone in connection with this investigation. For more details about these reports, you may write to us at the Client Services department address noted on the following page.

2. Notice regarding collection, use and disclosure of personal information

a) ivari collects, uses, and discloses your personal information as described in the "Notices", "Acknowledgement and authorization" and "Declaration" in addition, we collect personal information about you from this application.

We collect your Social Insurance Number (SIN) for tax reporting purposes only and in accordance with tax legislation. Certain transactions requested under a universal life policy may require you to provide your SIN before processing. Your banking information will be disclosed to the financial institution(s) processing your pre-authorized debit payments. Your personal information may also be shared with your beneficiaries in relation to a claim.

b) We may also collect such information from supplementary forms and questionnaires as described in the above sections, and when required from the following external sources:

- Physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities, MIB, LLC and other insurers and reinsurers; investigation, consumer and credit reporting agencies; motor vehicle and driver record authorities in any relevant jurisdictions; your independent insurance advisors, including the independent insurance advisor's report section of your application.

The information collected from these sources is used for the following **purposes**:

- Evaluating your insurance application, servicing your policy, and investigation and claim analysis.

  Your personal information may be shared with your independent insurance advisor and the managing general agencies, distributors and market intermediaries and their employees with which your advisor is associated for purposes identified here.

c) **Third-Party Administrators and Third-Party Service Providers:**

ivari retains the services of a third-party administrator to assist in administering ivari insurance policies. The "Third-Party Administrator" will only use your personal information for the purposes of providing services to ivari and no other purposes and is obligated to maintain the confidentiality of personal information consistent with ivari's privacy and security practices, in accordance with applicable laws and in a manner consistent with the use for which it was collected.

We may also retain other "Third-Party Service Providers" who would communicate with you regarding your insurance policy or provide you with other products and services. If we rely on a Third-Party Service Provider, we will only disclose your name, contact information and current insurance coverage, but not your health or financial information. All Third-Party Service Providers are obligated to maintain the confidentiality of personal information consistent with ivari's privacy and security practices, in accordance with applicable laws and in a manner consistent with the use for which it was collected.

Your personal information may be securely used, stored, or accessed in other countries and may be subject to the laws of those countries. For example, personal information may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in these countries.

Upon receiving your application, a file will be established and maintained which will be accessible to you at any time. Your file will be accessible to only those employees and authorized representatives of ivari responsible for administering your file, ivari's reinsurers and other persons authorized by you or by law.

We have safeguards to protect your personal information; however, in the event of an unauthorized access, disclosure or use of your personal information, there is a possibility that you may experience identity theft, negative effects on a credit record, financial loss, embarrassment or damage to your reputation. If ivari believes that you face a real risk of significant harm, ivari's Privacy Office will notify you of the data breach and suggest steps to reduce your risk of harm.

Notice of Disclosures *(continued)*

LEAVE THIS PAGE WITH THE OWNER

Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Office, ivari, 200-5000 Yonge Street, Toronto, Ontario M2N 7E9. To review our privacy policy, visit **ivari.ca**.

By signing and submitting this application on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this application.

3. Disclosure of compensation

This application deals with an insurance product supplied, underwritten, and issued by ivari, a company licensed to offer insurance products in all provinces and territories in Canada.

The independent insurance advisor/distributor soliciting this insurance application is a licensed insurance advisor representing ivari and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with ivari, the advisor/distributor or any other person or entity as a condition of this application.

4. Notice regarding MIB, LLC

Information regarding your insurability will be treated as confidential. ivari or its reinsurers may, however, make a brief report thereon to MIB, LLC, a not-for- profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

Personal information disclosed to MIB, LLC may include your name, birth jurisdiction, occupation and any other information used to determine your insurability. 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 about you in its file.

MIB receives personal information about Canadian consumers, and the collection, use and disclosure of such information is governed by the *Personal Information Protection and Electronic Documents Act* (PIPEDA) and provincial laws. If a brief report is made to MIB by a company, then it will be stored and safeguarded for such period as may be allowed by law.

MIB has agreed to protect such information in a manner that is substantially similar to the privacy and security practices of MIB's Canadian member companies, and in accordance with applicable laws. As a U.S. based company, MIB. is bound by, and such personal information may be disclosed in accordance, with applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations; provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws. **To review MIB's Consumer Privacy Policy, please visit: (https://www.mib.com/privacy_policy.html").**

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB by emailing **Canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal *Fair Credit Reporting Act*. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

ivari, and its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

Questions?

Please contact your independent insurance advisor or write to us at

Client Services Department, ivari, P.O. Box 4241, Station A, Toronto, ON M5W 5R3.

P.O. Box 4241, Station A
Toronto, ON M5W 5R3
Telephone: 1-800-846-5970
ivari.ca

Insurance Application

General information

Policy no. _____

1 a) I/We request the insurance contract and related documents be in? ○ English ○ Français

b) What type of policy are you applying for?
○ Individual insured ○ Joint First-to-Die ○ Joint Last-to-Die ○ Multiple insureds (for term & critical illness protection only)

c) Names of all Insureds to be covered under this policy: _____

_____

2 **Main purpose of insurance:** **MANDATORY FOR UNIVERSAL LIFE POLICIES**

☐ Estate planning ☐ Key person insurance ☐ Retirement planning ☐ Life protection ☐ Partnership

Insured *("Insured" refers to "Proposed Insured" when applying for new insurance coverage)* **PLEASE PRINT IN BLOCK LETTERS**

3 ○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Other _____

First name	Middle initial	Last name

MANDATORY FOR UNIVERSAL LIFE POLICY

Identification document†	Identification document number†	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

†Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority, Permanent Resident Card, Provincial and Territorial Photo Card

4 Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female

Former/Maiden name: _____ SIN: _____ *(Optional)*

5 Current residential address: *(P.O. Boxes and General Delivery not accepted as residential address)*

Number and street name: _____ Apt./Suite: _____

City: _____ Province: _____ Postal code: _____

Home phone: _____ Mobile phone: _____ Business phone: _____

6 Is your country of birth Canada? ○ Yes ○ No If ***"yes"***, provide province of birth: _____

If ***"no"***, a) provide country of birth: _____

b) have you lived in Canada for a minimum of 3 years? ○ Yes ○ No

If ***"no"***, i) how long have you been in Canada: _____ Years _____ Months

ii) What is the Insured's residency status?

○ Canadian citizen

○ Landed immigrant/Permanent resident

○ Contract worker *(other than seasonal worker, provide copy of work permit)*

○ Student permit *(provide copy of student permit)*

○ Officially accepted under Convention refugee *(provide a copy of your document)*

○ Other _____ *(provide a copy of your status document)*

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Insured *(continued)*

7 Is the Insured currently: ○ Employed ○ Not working ○ Juvenile *(under the age of 16)* ○ Student *(16 years and older)*

If "Employed":

a) Name of employer: _____ Number of years: _____ months: _____

b) Employer's address: _____

c) Occupation: _____ In what industry are you employed?* _____

d) Duties: _____

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

If "Not working":

a) Provide reason: _____

b) Are you financially dependent on a spouse or a partner or parents? ○ Yes ○ No

i) If ***"yes",*** what is the annual Canadian earned Income of your dependent? _____

If ***"no",*** what is the amount of your financial support _____ and source _____

ii) If ***"yes",*** is there insurance coverage on your dependent (spouse, partner, or parents)? ○ Yes ○ No

If ***"yes",*** what is the amount of insurance in force or applied for? _____

If a "Juvenile": *(under the age of 16):*

a) If the Insured is less than 2 years old, was the child born prematurely? ○ Yes ○ No ○ N/A

If ***"yes",*** provide details: _____

b) Who does the child live with?

○ Parent ○ Legal guardian ○ Grandparent ○ Other (provide details): _____

c) Is there any insurance coverage in force or pending on the owner(s)? ○ Yes ○ No

If ***"yes",*** owner 1 Life $ _____ CI $ _____

owner 2 Life $ _____ CI $ _____

If ***"no",*** explain why: _____

d) Who is answering the medical questions for this child?

○ Parent ○ Legal guardian ○ Grandparent ○ Other (provide details): _____

e) Who is signing for this child?

○ Parent ○ Legal guardian ○ Grandparent ○ Other (provide details): _____

First name: _____ Last name: _____

f) Does this juvenile have any siblings? ○ Yes ○ No

If ***"yes",*** do any of the siblings have any life or critical illness insurance in force or pending? ○ Yes ○ No

If ***"yes",*** provide details of life or critical illness insurance in force or pending:

NAME OF SIBLING	COMPANY	TYPE OF INSURANCE PLAN	AMOUNT	STATUS

If ***"no", insurance***, explain why: _____

If a "Student" (16 years and older): ○ Full time ○ Part time

a) Name of educational institution: _____

b) Field of study: _____

c) Expected date of graduation: _____

d) Are you employed? ○ Yes ○ No If ***"yes",*** name of employer: _____

Occupation: _____ In what industry are you employed?* _____

Duties: _____

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Financial information

INSURED

Name	Date of birth: (DD/MM/YYYY)

Personal financial details:

a) Annual earned Canadian income: $ _____

b) Annual Canadian income from other sources: $ _____

Provide details regarding other sources: _____

_____

c) Approximate Canadian net worth (current assets less current liabilities): $ _____

d) Total of current Canadian assets (such as cash and savings on hand, non-registered savings, registered savings, TFSA (Tax-Free Savings Account) or other investments? $ _____

e) Total of current Canadian liabilities (such as mortgage, personal loan, car loan, line of credit, funeral expense or other expenses)? $ _____

f) In the last 5 years, have you filed for personal or business bankruptcy or have not yet received a discharge or are you currently involved in a bankruptcy proceeding or consumer proposal? ○ Yes ○ No

If ***"yes",*** provide details and if applicable date of discharge:

_____

_____

_____

Policy Owner THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNERS

8 a) Policy ownership applies to all coverages.

The Owner(s) must be at least 16 years of age (at least 18 years of age in the province of Québec).

INDIVIDUAL OWNER 1 *(all fields are required)*

Legal name

Date of birth (DD/MM/YYYY)	Relationship to Insured	SIN (Optional)
Occupation		In what industry are you employed?*
Employment status		Employer name

MANDATORY FOR UNIVERSAL LIFE POLICY

Identification document†	Identification document number†	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

† Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority, Permanent Resident Card, Provincial and Territorial Photo Card.

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? ○ Yes ○ No

If ***"no"***, provide details of current status: _____

Owner 1 address

Current residential address *(number and street name) (P.O. Boxes and General Delivery not accepted as residential address)*		Apt./Suite
City	Province	Postal code
Home phone	Mobile phone	Business phone

INDIVIDUAL OWNER 2 *(all fields are required)*

Legal name

Date of birth (DD/MM/YYYY)	Relationship to Insured	SIN (Optional)
Occupation		In what industry are you employed?*
Employment status		Employer name

MANDATORY FOR UNIVERSAL LIFE POLICY

Identification document†	Identification document number†	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

† Please refer to an original, non-expired government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority, Permanent Resident Card, Provincial and Territorial Photo Card.

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? ○ Yes ○ No

If ***"no"***, provide details of current status: _____

Owner 2 address

Current residential address *(number and street name) (P.O. Boxes and General Delivery not accepted as residential address)*		Apt./Suite
City	Province	Postal code
Home phone	Mobile phone	Business phone

Policy Owner *(continued)*

Business financial information (if Corporation/entity owner)

- For entity/corporation owned policies complete ***Confidential Business Financial Questionnaire (UW-BFINQ361)*** or provide financial statements.
- Corporation, non-corporate entity or trust – must complete CORPORATION/ENTITY OWNER section below and when applying for Universal Life the ***Policy Ownership for Corporate & Non-corporate Entities or Trusts form (IP-LP1747)***

CORPORATION/ENTITY OWNER

Legal company/Entity name

Corporation/Entity relationship to Insured

Name of signing officer	Title of signing officer
Name of signing officer	Title of signing officer

Corporation/entity Owner's address

Current address (number and street name) *(P.O. Boxes and General Delivery not accepted)*	Apt./Suite

City	Province	Postal code

Business phone

b) **Mailing address** (All notices and statements will be mailed to the address of the Owner 1 unless another address is indicated.)

Number and street name	Apt./Suite	City	Province	Postal code

c) **Politically exposed persons and head of international organizations** **MANDATORY FOR UNIVERSAL LIFE POLICIES**

Is a premium and/or lump sum payment equal to or greater than $100,000 being made or to be made? ○ Yes ○ No

If the answer is ***"yes",*** each Owner must complete the ***Politically Exposed Persons and Head of International Organization form (IP-LP1165)*** and submit it along with the application.

d) **Multiple owners**

Canadian provinces (excluding Québec) – The policy will be issued to all Owners with Right of Survivorship: Should an Owner die while the policy is in effect, the deceased Owner's interest automatically transfers to the surviving Owner(s) unless the Tenants in Common option is selected below.

☐ Tenants in Common (undivided co-ownership) – Should an Owner die while the policy is in effect, the deceased Owner's interest will transfer to his/her estate unless a Contingent Owner has been named for such Owner.

Province of Québec only – Ownership must be Tenants in Common. Tenants in Common (undivided co-ownership) means that should an Owner die while the policy is in effect, the deceased Owner's interest will transfer to his/her estate. Please name one another as Contingent Owners if Right of Survivorship is desired.

Policy Owner *(continued)*

e) **Contingent owner**

- **For a life policy or a life policy with a Critical Illness Insurance Rider**, if you wish to have your ownership interest transferred to another person in the event of your death, complete this section. If no Contingent Owner is named, upon death of the Policy Owner, ownership will be transferred to the Policy Owner's estate.
- **For a Critical Illness Protection policy**, a Contingent Owner may only be designated if the legislation in your province allows it.

CONTINGENT OWNER FOR INDIVIDUAL OWNER 1

Name of Owner	Name of Contingent Owner *(First and last name)*	Relationship to Owner

Current address of Contingent Owner *(P.O. Boxes and General Delivery not accepted as residential address)*

CONTINGENT OWNER FOR INDIVIDUAL OWNER 2

Name of Owner	Name of Contingent Owner *(First and last name)*	Relationship to Owner

Current address of Contingent Owner *(P.O. Boxes and General Delivery not accepted as residential address)*

Financial information

INDIVIDUAL OWNER 1 *(if other than the insured)*

Name	Date of birth: (DD/MM/YYYY)

Personal financial details:

a) Annual earned Canadian income: $ _____

b) Annual Canadian income from other sources: $ _____

Provide details regarding other sources: _____

_____

c) Approximate Canadian net worth (current assets less current liabilities): $ _____

d) Total of current Canadian assets (such as cash and savings on hand, non-registered savings, registered savings, TFSA (Tax-Free Savings Account) or other investments? $ _____

e) Total of current Canadian liabilities (such as mortgage, personal loan, car loan, line of credit, funeral expense or other expenses)? $ _____

f) In the last 5 years, have you filed for personal or business bankruptcy or have not yet received a discharge or are you currently involved in a bankruptcy proceeding or consumer proposal? ○ Yes ○ No

If ***"yes",*** provide details and if applicable date of discharge:

_____

_____

_____

INDIVIDUAL OWNER 2 *(if other than the insured)*

Name	Date of birth: (DD/MM/YYYY)

Personal financial details:

a) Annual earned Canadian income: $ _____

b) Annual Canadian income from other sources: $ _____

Provide details regarding other sources: _____

_____

c) Approximate Canadian net worth (current assets less current liabilities): $ _____

d) Total of current Canadian assets (such as cash and savings on hand, non-registered savings, registered savings, TFSA (Tax-Free Savings Account) or other investments? $ _____

e) Total of current Canadian liabilities (such as mortgage, personal loan, car loan, line of credit, funeral expense or other expenses)? $ _____

f) In the last 5 years, have you filed for personal or business bankruptcy or have not yet received a discharge or are you currently involved in a bankruptcy proceeding or consumer proposal? ○ Yes ○ No

If ***"yes",*** provide details and if applicable date of discharge:

_____

_____

_____

Declaration of tax residency MANDATORY FOR UNIVERSAL LIFE POLICIES

INDIVIDUAL OWNER 1

Name	Date of birth: (DD/MM/YYYY)

Please answer the following three statements.

Depending on your situation, you may answer ***"yes",*** to more than one.

a) **I am a tax resident of Canada.** ..... ○ Yes ○ No

b) **I am a tax resident or a citizen of the United States.** ..... ○ Yes ○ No

Please provide your taxpayer identification number (TIN) from the United States: _____

If you do not have a TIN from the United States, have you applied for one? ..... ○ Yes ○ No

c) **I am a tax resident in a country other than Canada or the United States.** ..... ○ Yes ○ No

If ***"yes",*** provide your country of tax residence and taxpayer identification numbers (TIN).

If you do not have a TIN for a specific country, give the reason using one of these choices:

Reason 1: I will apply or have applied for a TIN but have not yet received it.

Reason 2: My country of residence does not issue TINs to its residents.

Reason 3: Other reason, provide details.

COUNTRY OF TAX RESIDENCE	TAXPAYER IDENTIFICATION NUMBER (TIN)	IF NO TIN, PROVIDE REASON (SELECT REASON 1, 2 OR 3)	DETAILS FOR REASON 3

INDIVIDUAL OWNER 2

Name	Date of birth: (DD/MM/YYYY)

Please answer the following three statements.

Depending on your situation, you may answer ***"yes",*** to more than one.

a) **I am a tax resident of Canada.** ..... ○ Yes ○ No

b) **I am a tax resident or a citizen of the United States.** ..... ○ Yes ○ No

Please provide your taxpayer identification number (TIN) from the United States: _____

If you do not have a TIN from the United States, have you applied for one? ..... ○ Yes ○ No

c) **I am a tax resident in a country other than Canada or the United States.** ..... ○ Yes ○ No

If ***"yes",*** provide your country of tax residence and taxpayer identification numbers (TIN).

If you do not have a TIN for a specific country, give the reason using one of these choices:

Reason 1: I will apply or have applied for a TIN but have not yet received it.

Reason 2: My country of residence does not issue TINs to its residents.

Reason 3: Other reason, provide details.

COUNTRY OF TAX RESIDENCE	TAXPAYER IDENTIFICATION NUMBER (TIN)	IF NO TIN, PROVIDE REASON (SELECT REASON 1, 2 OR 3)	DETAILS FOR REASON 3

Beneficiary information

INSURED

Name	Date of birth: (DD/MM/YYYY)

If more than one Primary Beneficiary is named, then the proceeds are to be equally shared unless otherwise specified; the same applies to Contingent Beneficiaries. Any breakdown of proceeds **MUST** be stated in percentages rather than dollar amounts. The total percentage of shares for all of the Primary and all of the Contingent Beneficiaries must equal 100%.

Primary/Contingent Beneficiaries:

- All Beneficiaries are deemed primary unless otherwise specified.
- If all Primary Beneficiaries predecease the Insured, the proceeds are payable to the Contingent Beneficiaries, if any, otherwise to the Owner or the Owner's estate.

Irrevocable/Revocable Beneficiaries:

- For applications signed in Québec, the designation of spouse (married or civil union) of the Owner as beneficiary is irrevocable unless otherwise specified.
- All other beneficiary designations in Québec and all beneficiary designations for policies issued elsewhere in Canada are revocable unless otherwise specified.
- By naming an Irrevocable Beneficiary, you are giving up substantial control over your policy. Once an Irrevocable Beneficiary has been designated, his/her consent will be required for future dealings with the policy (some exceptions apply in Québec).
- If naming a minor or person under a legal disability as Irrevocable Beneficiary, please note that consent cannot be given.

Minor or Disabled Beneficiaries

Where a minor or person under a legal disability is designated as a beneficiary, it is recommended that a trustee be appointed to void a payment into court (not applicable in Québec).

9 a) **BENEFICIARY – Life insurance**

If no beneficiary is designated, then the proceeds are payable to the Owner, if living, or the Owner's estate, if deceased.

FIRST NAME, LAST NAME OR ENTITY NAME	DATE OF BIRTH (DD/MM/YYYY)	PRIMARY/ CONTINGENT*	REVOCABLE/ IRREVOCABLE	SHARE %	RELATIONSHIP TO INSURED (IN QUÉBEC TO OWNER)
		◯ Primary ◯ Contingent*	◯ Revocable ◯ Irrevocable		
		◯ Primary ◯ Contingent*	◯ Revocable ◯ Irrevocable		
		◯ Primary ◯ Contingent*	◯ Revocable ◯ Irrevocable		
		◯ Primary ◯ Contingent*	◯ Revocable ◯ Irrevocable		

*A Contingent Beneficiary is always revocable.

If a minor or person under a legal disability is designated, indicate trustee name and relationship to Insured (not applicable in Québec):

b) **BENEFICIARY – Critical illness**

Critical Illness Protection policy or a Critical Illness Protection Rider on a life policy

- ***The beneficiary will be the Insured unless otherwise stated below.***
- ***If the Insured is a minor or person under a legal disability, the beneficiary is the Owner(s), if living, or the Owner's estate, if deceased.***

Note: For a Critical Illness Protection policy, you may only designate a Beneficiary if the legislation in your province allows you to name a beneficiary for the Critical Illness Benefit and/or Early Detection Benefit:

First name, last name	Date of birth (DD/MM/YYYY)

Relationship to Insured (in Québec to Owner)

◯ Revocable ◯ Irrevocable

Indicate trustee name and relationship to Insured, if applicable (not applicable in Québec)

Critical Illness Benefit – Return of Premium on Death:

The proceeds are payable to the Owner(s), if living, or the Owner's estate, if deceased.

Insurance history

INSURED

Name	Date of birth: (DD/MM/YYYY)

10 a) Do you have any insurance in force or pending: life insurance, critical illness, disability, long-term care with ivari or any other company? If ***"yes",*** complete the table below. . . . . ○ Yes ○ No

COMPANY	AMOUNT OF INSURANCE	TYPE OF INSURANCE PLAN				PERSONAL/ BUSINESS		ISSUE YEAR	IN FORCE	PENDING	REPLACING	NAME OF NEW REPLACING COMPANY
		LIFE	CI	DI	LTC	P	B					
	$	○	○	○	○	○	○		○	○	□	
	$	○	○	○	○	○	○		○	○	□	
	$	○	○	○	○	○	○		○	○	□	
	$	○	○	○	○	○	○		○	○	□	
	$	○	○	○	○	○	○		○	○	□	

NOTE: If replacing an ivari policy attach a completed Life Insurance Replacement Disclosure (LIRD), where applicable, or Replacement/Comparison Disclosure form.

b) Is the insurance applied for in this application replacing an existing ivari policy/coverage? . . . . . ○ Yes ○ No

If ***"yes",*** provide policy number(s) _____

Does the Owner instruct ivari to cancel the above stated policy/coverage only when the new policy being applied for is in force? . . . . . ○ Yes ○ No

(The premium under the existing policy is required until this new policy is in force. Failure to do so may result in a lapse/termination of insurance coverage and may result in the inability to offer a reinstatement.)

c) Has any application, reinstatement, modification for life, critical illness, long-term care, or disability insurance ever been rated, declined, postponed, cancelled, rescinded or modified in any way? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

COMPANY	DATE (MM/YYYY)	DETAILS

Plan coverage

INSURANCE APPLIED FOR INSURED

Name	Date of birth: (DD/MM/YYYY)

11 **Complete this section only when applying for a universal life policy (Leave remainder of the page blank):**

☐ **UNIVERSAL LIFE INSURANCE**

SUBMIT AN ILLUSTRATION AND THE SUPPLEMENT TO THE INSURANCE APPLICATION UNIVERSAL LIFE.

Complete this section when applying for a term insurance policy:

☐ **TERM LIFE INSURANCE**

Face amount: $ _____ ○ 10 year ○ 20 year ○ 30 year with *Select*OPTIONS

Term riders	Face amount	**Additional benefits**	Face Amount
☐ 10 Year Rider	$ _____	☐ Children's Insurance	$ _____
☐ 20 Year Rider	$ _____	☐ Accidental Death & Dismemberment	$ _____
☐ 30 Year Rider (Available only on a Term 30 policy)	$ _____	○ Waiver of Premium	
		○ Payor Waiver of Premium*	

*Name of parent or legal guardian. In addition complete, questions 10 and 14 to 17:

_____

Critical Illness Protection Rider*	Benefit		Benefit
○ Term 10 CI – 4 conditions	$ _____	○ Term 10 CI – 25 conditions	$ _____
○ Term 20 CI – 4 conditions	$ _____	○ Term 20 CI – 25 conditions	$ _____

*The critical illness benefit applied for cannot exceed the total life insurance face amount applied for.

Complete this section when applying for a Critical Illness Protection policy:

☐ **CRITICAL ILLNESS PROTECTION**

Benefit: $ _____

- ○ Term 10 Critical Illness – 4 conditions
- ○ Term 20 Critical Illness – 4 conditions
- ○ Term to age 65 Critical Illness – 4 conditions
- ○ Term 10 Critical Illness – 25 conditions
- ○ Term 20 Critical Illness – 25 conditions
- ○ Term to age 65 Critical Illness – 25 conditions

Additional benefits

- ○ Waiver of Premium
- ○ Payor Waiver of Premium*

*Name of parent or legal guardian. In addition complete, questions 10 and 14 to 17:

_____

Additional coverage	Benefit		Benefit
○ Term 10 CI – 4 conditions	$ _____	○ Term 10 CI – 25 conditions	$ _____
○ Term 20 CI – 4 conditions	$ _____	○ Term 20 CI – 25 conditions	$ _____
○ Term to age 65 CI – 4 conditions	$ _____	○ Term to age 65 CI – 25 conditions	$ _____

Note: Early Detection Benefit and childhood critical illness covered conditions are only available with the 25 conditions Critical Illness Protection products.

Other details

12 Policy issue date:

☐ Current date **(default option)** – Recommended in order to avoid a double withdrawal from the client's account.

☐ Date to save age: Insured _____

Premium payment details

13 a) Premium quoted: $ _____ Payment mode quoted _____

b) Initial premium of $ _____ to be paid by:

◯ Withdraw from bank account immediately upon receipt of this insurance application

◯ Payment upon delivery (temporary insurance is not available with this option)

◯ Cheque made payable to ivari attached

c) Future premiums to be paid by:

◯ **Pre-authorized debit:** ◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Annually

The date of withdrawal will be the same as the policy effective date.

If you wish a different withdrawal date, please indicate preferred date of withdrawal (days 1–28 only) _____

For universal life policies, at time of settlement if the specified draw date is after the policy effective date this will result in a double withdrawal from the client's account. This is to ensure all premiums are paid-to-date prior to the next PAD withdrawal.

◯ Establish a new PAD account using banking information provided below:

Transit Number	Financial Institute Number	Account Number

◯ Use existing PAD account from ivari policy no.: _____

◯ Banking on delivery

◯ **Direct bill:** ◯ Annually ◯ Semi-annually ◯ Quarterly

d) **For universal life policies:** Provide source of premium/deposit? (where is the premium/deposit coming from):

_____

e) If the Payor is **other than** the Insured, Owner, or Beneficiary, complete the third party payor determination information below:

INDIVIDUAL PAYOR

Payor name

Date of birth (DD/MM/YYYY)	Relationship to owner
Occupation	In what industry are you employed?*

Current residential address *(number and street name) (P.O. Boxes and General Delivery not accepted as residential address)*	Apt./Suite

City	Province	Postal code

Home phone	Mobile phone	Business phone

*For a list, click ***Valid industries and occupations form (IP-LP1971)*** to access.

CORPORATION/ENTITY PAYOR

Legal company/Entity name

Relationship to owner	Business/Industry
Incorporation #	Place of registration if third party is a corporate entity

Head office address (number and street name) *(P.O. Boxes and General Delivery not accepted)*	Apt./Suite

City	Province	Postal code

Business phone

Personal history

INSURED

Name	Date of birth: (DD/MM/YYYY)

For Insureds 16 years of age or greater, complete questions 14 a) – f).
If additional space is required, please provide answers in the "Remarks section".

14 a) Have you ever smoked or used cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts, traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe, Pipe, chewing tobacco or any other smoking cessation products, or used tobacco in any other form? ○ Yes ○ No

If ***"yes",*** complete the following.

Have you smoked/used in the last 12 months? ○ Yes ○ No

Have you smoked/used in the last 24 months? ○ Yes ○ No

PRODUCTS	QUANTITY	FREQUENCY	DATE LAST USED (DD/MM/YYYY)
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	

b) Have you ever used marijuana or cannabis/cannabinoids products in any form? ○ Yes ○ No

If ***"yes",*** in what form and on average, what is the quantity you typically consume.

FORM OF CONSUMPTION	FREQUENCY	QUANTITY (MEASUREMENT)	QUANTITY (AMOUNT)	DATE LAST USED (DD/MM/YYYY)
	○ Day ○ Week ○ Month ○ Year ○ Single use			
	○ Day ○ Week ○ Month ○ Year ○ Single use			
	○ Day ○ Week ○ Month ○ Year ○ Single use			

i) Do you mix the marijuana or cannabis with tobacco? ○ Yes ○ No

ii) Is your usage for medicinal purposes? ○ Yes ○ No

If ***"yes",***

What condition is being treated? _____

Is it physician prescribed? ○ Yes ○ No

Name of physician: _____

c) Are you currently or have you ever used any drugs such as amphetamines (ecstasy, speed), cocaine, hallucinogens (acid, LSD), opiates (heroin, morphine) anabolic steroids or any other type not previously mentioned, other than marijuana or cannabis/cannabinoids? ○ Yes ○ No

TYPE	QUANTITY	FREQUENCY	DATE LAST USED (DD/MM/YYYY)
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	
		○ Day ○ Week ○ Month ○ Year ○ Single use	

Have you ever received or been advised to receive, counselling or treatment for drug usage? ○ Yes ○ No

If ***"yes",*** provide date of treatment: (DD/MM/YYYY) _____

Personal history *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

If additional space is required, please provide answers in the "Remarks section".

d) Do you currently consume or ever consumed alcohol such as Beer, Wine or Liquor? . . . . . ○ Yes ○ No

If ***"yes",*** complete questions i), ii) and iii).

i) On average, how many alcoholic drinks do you typically consume? . . . . . ○ Yes ○ No

TYPE	QUANTITY (MEASUREMENT)	QUANTITY (AMOUNT)	FREQUENCY
			○ Day ○ Week ○ Month ○ Year ○ Single use
			○ Day ○ Week ○ Month ○ Year ○ Single use
			○ Day ○ Week ○ Month ○ Year ○ Single use

ii) Have you reduced your alcohol consumption?. . . . . ○ Yes ○ No

If ***"yes",*** provide details and date of reduction

iii) Have you ever received or sought to receive been advised to receive, counselling or treatment for alcohol? ○ Yes ○ No

If ***"yes",*** complete table below.

DATE OF TREATMENT (DD/MM/YYYY)	DURATION OF TREATMENT	FOLLOW-UP NEEDED

DRIVING HISTORY

e) i) In the last 2 years have you had speeding violations more than 30km over speed limit, at fault accident(s), hit and run, impaired driving (Alcohol or Marijuana), driving with a suspended license or reckless driving? ○ Yes ○ No

ii) In the last 2 years have you had more than 2 driving violations such as speeding less than 30km over the speed limit or careless driving such as cell phone use, stop sign violation, improper turn, improper passing, failure to yield, distracted driving, no seatbelt or other violations not mentioned?. . . . . ○ Yes ○ No

If ***"yes",*** to questions i) or ii), complete table below:

VIOLATION	DATE (DD/MM/YYYY)	DETAILS

Personal history *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

OFFENCE HISTORY

f) i) In the last 10 years, have you been charged or convicted of any of the following any criminal offence such as assault, theft, fraud, robbery, financial crime (money laundering, tax evasion, conspiracy), drug possession, forgery, burglary or other offenses? ..... ○ Yes ○ No

ii) Do you have any charges currently pending? ..... ○ Yes ○ No

iii) In the last 10 years, have you had your driver's licence suspended or revoked? ..... ○ Yes ○ No

If ***"yes",*** to questions i), ii) or iii), complete table below:

DATE (DD/MM/YYYY)	STATUS	DURATION	REASON

For Insureds of all ages complete questions g) to i).
If additional space is required, please provide answers in the "Remarks section".

TRAVEL

g) With the exception of travelling 6 months or less per year within North America, the Caribbean or European Union countries, do you have any plans to travel or reside outside of Canada in the next 12 months? ..... ○ Yes ○ No

If ***"yes",*** complete table below.

CITY	COUNTRY	PURPOSE OF TRAVEL	LENGTH OF STAY	# OF TIMES PER YEAR

AVOCATION/SPORTS

h) In the last 12 months, have you piloted an aircraft other than with a commercial/major airline carrier, or do you intend to do so in the next 12 months? ..... ○ Yes ○ No

i) In the last 12 months, have you engaged in any hazardous or extreme sports including, but not limited to, mixed martial arts, combat sports, ski jumping, bungee jumping, base jumping, motorized vehicle racing, cliff diving, scuba diving, sky diving, parachuting, sky surfing, hang-gliding and mountain climbing, out of bound snowmobiling, out of bound skiing, other non-ordinary sports or do you intend to do so in the next 12 months? ..... ○ Yes ○ No

If ***"yes",*** indicate the activity and provide as much details a possible such as start date, end date, if no longer participating, locations, frequency, type and characteristics, accidents, injuries along with any other pertinent information pertaining to the activity otherwise additional questionnaires will be required.

Health history

INSURED

Name	Date of birth: (DD/MM/YYYY)

INSTRUCTIONS: When answering the health questions on this form, **DO NOT** provide information about any genetic tests you have taken or plan to take. A genetic test is a type of medical test which analyses DNA, RNA or chromosomes. You must however, provide information about all other types of medical tests. ENSURE you answer all questions truthfully and as described in the Notice of Disclosures.

For Insureds of all ages. *(Not answering the questions will result in a telephone interview)*
If additional space is required, please provide answers in the "Remarks section".

15 a) Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

In the last 12 months have you lost more than 10 lbs./5kg ..... ○ Yes ○ No
(excluding weight loss following childbirth)

If ***"yes",*** i) Weight loss in: _____ lbs. or _____ kg

ii) Provide reason for weight loss: ○ Diet/Exercise ○ Medical condition

If medical condition, provide details: _____

_____

_____

b) Do you have a family doctor or clinic/health care facility that you use regularly? ..... ○ Yes ○ No

If ***"yes",*** provide the name of the doctor and the name of the clinic or health care facility:

Name of doctor/clinic: _____

Address: _____

Date of last visit with your family doctor or clinic/health care facility ***(If unknown leave blank)***: (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? .... ○ Yes ○ No

If ***"yes",*** provide details: _____

_____

c) Are you using any medications or supplements not previously disclosed? ..... ○ Yes ○ No

If ***"yes",*** complete table below:

MEDICATION	DOSAGE	REASON FOR MEDICATION	PRESCRIBING PHYSICIAN, IF DIFFERENT FROM YOUR FAMILY DOCTOR (NAME/ADDRESS/PHONE)

d) Are you under medical investigation, awaiting test results or advised to undergo a diagnostic test that has not yet been performed or for which you have not yet received the results? ..... ○ Yes ○ No

If ***"yes",*** provide details: _____

_____

_____

Health history *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

If additional space is required, please provide answers in the "Remarks Section".

e) In the past 3 three years (Other than requested by a governmental screening program, including immigration tests), have you undergone any diagnostic test including but not limited to: ultrasound, stress electrocardiogram, CT scan, Magnetic Resonance Imaging (MRI), biopsy, mammogram, colonoscopy, PSA testing, coronary calcium scan or any other diagnostic test? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

DIAGNOSTIC TEST	DATE (DD/MM/YYYY)	AREA/LOCATION (BODY PART SUCH AS STOMACH, KNEE, BRAIN ETC)	DETAILS (SUCH AS DIAGNOSIS, TREATMENT, MEDICATION, COMPLICATION, FOLLOW-UP ETC)

f) Do you have any symptoms/pain or complaints such as or related to abdominal pain, weakness, dizziness, fatigue or unspecified pain for which you have not yet consulted a doctor or sought treatment? . . . . . ○ Yes ○ No

If ***"yes",*** complete table below:

SYMPTOMS	OTHER	DATE OF FIRST OCCURRENCE (DD/MM/YYYY)	DATE OF LAST OCCURRENCE (DD/MM/YYYY)	DETAILS/TREATMENT

g) Do you plan to consult a physician or other health professional or undergo an operation in the near future? . . . ○ Yes ○ No

If ***"yes",*** provide details: _____

_____

_____

Health questions

INSURED

Name	Date of birth: (DD/MM/YYYY)

16 a) **Elevated blood pressure:** Have you ever had, or ever been told you had, or received treatment or advice for elevated blood pressure? ..... ○ Yes ○ No

If ***"yes",*** provide details:

i. Date of diagnosis: (MM/YYYY) _____

ii. Treatment: ○ Diet ○ Exercise

iii. Medication Name(s) and dosage: _____

Has your medication or dosage change in the last year? ..... ○ Yes ○ No

iv. Was your last reading reported as normal? ..... ○ Yes ○ No

v. How often do you see a doctor for your condition? ○ Monthly ○ Annually ○ On Occasion ○ Never

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

b) **Cholesterol:** Have you ever had, or ever been told you had, or received treatment or advice for cholesterol? .. ○ Yes ○ No

If ***"yes",*** provide details:

i. Date of diagnosis: (MM/YYYY) _____

ii. Treatment: ○ Diet ○ Exercise

iii. Medication Name(s) and dosage: _____

Has your medication or dosage change in the last year? ..... ○ Yes ○ No

iv. Was your last reading reported as normal? ..... ○ Yes ○ No

v. How often do you see a doctor for your condition? ○ Monthly ○ Annually ○ On Occasion ○ Never

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

c) **Heart Condition:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for heart attack, angina, coronary heart disease, irregular heartbeat, palpitation, arrhythmia, heart murmur, valve disease, peripheral vascular disease, cerebrovascular disorder, stroke, transient ischemic attack, aneurysm, blood clot, thrombosis, congestive heart failure, inflammatory heart disease, cardiomyopathy, any other disease or disorder of the heart, blood vessels or circulatory system? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Heart attack ☐ Angina ☐ Coronary heart disease ☐ Irregular heartbeat
☐ Arrhythmia ☐ Heart murmur ☐ Valve disease ☐ Peripheral vascular disease
☐ Stroke ☐ Transient ischemic attack ☐ Aneurysm ☐ Blood clot
☐ Congestive heart ☐ Inflammatory heart disease ☐ Cardiomyopathy ☐ Palpitation
☐ Cerebrovascular disorder ☐ Thrombosis
☐ Any other disease or disorder of the heart, blood vessels or circulatory system

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

d) **Cancer, Tumour or Growths:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for your prostate, breast, colon, kidney, lung, liver, ovary, pancreas, skin, thyroid, uterus, bladder, leukemia, melanoma, a mass, benign lesion or growth, tumours, cyst, nodule, Hodgkin or Non-Hodgkin lymphoma, polyp, lesion or any other cancer/tumour/growths? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Prostate	☐ Breast	☐ Colon	☐ Kidney	☐ Lung
☐ Liver	☐ Ovary	☐ Pancreas	☐ Skin	☐ Thyroid
☐ Uterine	☐ Bladder	☐ Leukemia	☐ Melanoma	☐ Mass
☐ Benign lesion or growth	☐ Tumours	☐ Cyst	☐ Nodule	☐ Lesion
☐ Polyp	☐ Hodgkin or non-hodgkin lymphoma			
☐ Any other growth conditions				

BLOOD, GLANDULAR OR ENDOCRINE CONDITIONS

e) **Diabetes:** Have you ever had, or ever been told you had, or received treatment or advice for Type 1 or Type 2 diabetes, diabetes mellitus, impaired glucose tolerance, gestational diabetes, or other types? ..... ○ Yes ○ No

If ***"yes",*** provide details:

i. Which of the following currently represents your condition?
- ○ Type 1 (juvenile or insulin-dependent diabetes)
- ○ Type 2 (adult on-set)
- ○ Impaired glucose intolerance or pre-diabetes
- ○ Unknown/other type of diabetes
- ○ Gestational diabetes: ○ History or ○ Current: Are you currently pregnant?..... ○ Yes ○ No

ii. Date of diagnosis: (MM/YYYY) _____

iii. What is the type of treatment for your diabetes: ○ Diet ○ Oral medication ○ Insulin ○ None

iv. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

v. Do you have symptoms, complication or are you off work/disabled due to your condition?..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

f) **Thyroid Disorder:** Have you ever had, or ever been told you had, or received treatment or advice for thyroid disorder? ..... ○ Yes ○ No

If ***"yes",*** provide details:

i. Do you know which diagnosis was made? ..... ○ Yes ○ No

If ***"yes",*** ○ Hypothyroidism ○ Hyperthyroidism ○ Goiter ○ Other _____

ii. Date of diagnosis: (MM/YYYY) _____

iii. Have you had any treatments, medications, surgery or investigation for your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details such as date, surgery, lesion excised, medication, dosage, duration, frequency, follow-ups or other investigations:

_____

_____

iv. Was Malignancy excluded? ..... ○ Yes ○ No

If ***"no",*** provide details: _____

_____

_____

v. Is the condition under control? ..... ○ Yes ○ No

If ***"yes",*** since when? (MM/YYYY) _____

If ***"no",*** provide details about your condition: _____

_____

_____

vi. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

vii. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

g) **Anemia Disorder:** Have you ever had, or ever been told you had, or received treatment or advice for anemia disorder? ○ Yes ○ No

If ***"yes",*** provide details:

i. Your condition: _____

ii. Date of diagnosis: (MM/YYYY) _____

iii. Have you had any treatments, medications, surgery or investigation for your condition? ○ Yes ○ No

If ***"yes",*** provide details such as date, medication, dosage, duration, frequency, follow-ups or other investigations:

_____

_____

iv. Have you been hospitalized because of this condition? ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

v. Are you fully recovered from this condition? ○ Yes ○ No

If ***"yes",*** since when? (MM/YYYY) _____

If ***"no",*** provide details about your condition: _____

vi. Do you have symptoms, complication or are you off work/disabled due to your condition? ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

_____

_____

OTHER BLOOD, GLANDULAR OR ENDOCRINE CONDITIONS

h) Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Coagulation defect, Pro-coagulant, Thalassemia, Idiopathic thrombocytopenic purpura or any other conditions? ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Coagulation defect ☐ Pro-coagulant ☐ Thalassemia ☐ Idiopathic thrombocytopenic purpura
☐ Any other blood, glandular or endocrine conditions

i) **Mental Health Condition:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for mood disorder, depression, adjustment disorder, stress, psychosis, bipolar, personality disorder, generalized anxiety disorder, eating disorder, schizophrenia, had any suicide attempts, any suicide thoughts or ideas, other mental or mood disorder? ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Mood disorder ☐ Depression ☐ Adjustment disorder
☐ Bipolar ☐ Personality disorder ☐ Generalized anxiety disorder
☐ Psychosis ☐ Schizophrenia ☐ Had any suicide attempts
☐ Stress ☐ Eating disorder ☐ Any suicide thoughts or ideas
☐ Other mental or mood disorder

j) **Attention deficit disorder:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Concentration Disorder or any other Hyperactivity condition? ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Attention deficit disorder (ADD) ☐ Concentration disorder ☐ Attention deficit hyperactivity disorder (ADHD)
☐ Other hyperactivity condition

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

EYES, EARS, NOSE, THROAT, LUNG, RESPIRATORY CONDITION

k) **Asthma:** Have you ever had, or ever been told you had, or received treatment or advice for Asthma? ..... ○ Yes ○ No

i. Date of diagnosis: (MM/YYYY) _____

ii. How many times do you experience symptoms? ○ Daily ○ Weekly ○ Monthly ○ Occasionally

iii. Date of last attack or symptoms: (MM/YYYY) _____

iv. Provide name of medication and dosage: _____

v. Have you had any exams or tests for you condition? ..... ○ Yes ○ No

If ***"yes",*** provide details, such as type of exams/test, results, dates, follow-up and other investigations:

vi. Have you been hospitalized because of this condition? ..... ○ Yes ○ No

If ***"yes",*** when were you last hospitalized: (MM/YYYY) _____

If ***"yes",*** provide duration : _____

vii. Do you have symptoms, complication or are you off work/disabled due to your condition? ..... ○ Yes ○ No

If ***"yes",*** provide details (such as shortness of breath, chronic cough, chronic fatigue, weakness, restriction in mobility, numbness or tingling, loss of speech, memory loss, vision problem, lump/bulge, dizziness, abdominal pain, chest pain or other symptoms): _____

OTHER EYES, EARS, NOSE, THROAT, LUNGS, RESPIRATORY SYSTEM

l) Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for sleep apnea, blindness, deafness, nose, throat, lung, pneumothorax, sarcoidosis, cystic lung disease, abscess of the lung, pulmonary fibrosis, bronchiectasis, Chronic Obstructive Pulmonary Disorder (COPD) or any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Sleep apnea ☐ Blindness ☐ Deafness
☐ Lung ☐ Pneumothorax ☐ Sarcoidosis
☐ Pulmonary fibrosis ☐ Bronchiectasis ☐ Nose
☐ Throat ☐ Abscess of the lung ☐ Cystic lung disease
☐ Chronic obstructive pulmonary disorder (COPD)
☐ Any other disease or disorder of the eyes, ears, nose, throat, lungs or respiratory system

m) **Back, muscles and bones disorders:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for back disorder, lower back injury (partial), herniated disk, arthritis, rheumatoid condition, amputation, any other bones, muscles or back conditions? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Back disorder ☐ Lower back injury (partial) ☐ Arthritis
☐ Amputation ☐ Herniated disk ☐ Rheumatoid condition
☐ Any other bones, muscles or back conditions

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

n) **Gastrointestinal conditions:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for ulcerative colitis, Crohn's disease, pancreatitis, liver disorder, hepatitis, fatty liver, alcoholic liver disease, non-alcoholic liver disease, cirrhosis, Barrett's esophagus, intestinal problems or any other gastrointestinal conditions? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Ulcerative colitis ☐ Crohn's disease ☐ Pancreatitis ☐ Liver disorder
☐ Hepatitis ☐ Fatty liver ☐ Alcoholic liver disease ☐ Non-alcoholic liver disease
☐ Cirrhosis ☐ Barrett's esophagus ☐ Intestinal problem
☐ Any other gastrointestinal conditions

o) **Kidney, bladder, and reproductive organs:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for your kidney, renal failure, chronic kidney failure disease, nephritis, kidney stone, urinary track disorder, your bladder, blood in the urine, abnormality in the urine, abnormal protein levels, sexually transmitted disease, female organ problems/disorders, abnormal pap, male genital organ problems/disorders, prostate, abnormal PSA (Prostatic Specific Antigen) levels, any other disease or disorder of the kidney, bladder and reproductive organs? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Kidney ☐ Abnormality in the urine ☐ Nephritis ☐ Chronic kidney failure disease
☐ Kidney stone ☐ Urinary track disorder ☐ Bladder ☐ Sexually transmitted disease
☐ Renal failure ☐ Abnormal protein levels ☐ Blood in the urine ☐ Female organs problem/disorders
☐ Abnormal pap ☐ Male genital organs problem/disorder ☐ Prostate
☐ Abnormal PSA (prostatic specific antigen) levels
☐ Any other disease or disorder of the kidney, bladder and reproductive organs

p) **Neurological condition and brain disorders:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for Alzheimer's Disease, autism spectrum disorder, cerebral palsy, epilepsy, seizure, cognitive or developmental disorder, down syndrome (trisomy 21 syndrome), multiple sclerosis, Parkinson's Disease, chronic headaches, head or brain injuries, muscular dystrophy, meningitis, paralysis, neuritis, neuropathy, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's disease), lesion or any other disease or disorder of the brain or the nervous system? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Alzheimer's disease ☐ Autism spectrum disorder ☐ Cerebral palsy ☐ Epilepsy
☐ Cognitive or developmental disorder ☐ Muscular dystrophy ☐ Multiple sclerosis ☐ Parkinson disease
☐ Head or brain injuries ☐ Motor neuron disease ☐ Meningitis ☐ Paralysis
☐ Neuropathy ☐ Chronic headaches ☐ Lesions ☐ Seizure
☐ Down syndrome (trisomy 21 syndrome) ☐ Neuritis
☐ Amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease)
☐ Any other disease or disorder of the brain or the nervous system

q) **Immune system:** Have you ever had, ever been told you had, been diagnosed, received treatment or medical advice for immune deficiency syndrome, Lupus, AIDS, Scleroderma, test results indicating exposure to the HIV virus, any other disease or disorder of the immune system ? ..... ○ Yes ○ No

If ***"yes",*** select all that apply and complete the ***Supplemental Health Questionnaire (LP-HS2126)*** **for each condition:**

☐ Immune deficiency syndrome ☐ Lupus
☐ Test results indicating exposure to the HIV virus ☐ AIDS
☐ Any other disease or disorder of the immune system ☐ Scleroderma

Health questions *(continued)*

INSURED

Name	Date of birth: (DD/MM/YYYY)

ADDITIONAL MEDICAL HISTORY

r) Have you ever had or ever been told you had, any disease, condition, abnormality or hereditary disorder not already mentioned? ..... ○ Yes ○ No

If ***"yes",*** provide details _____

_____

_____

s) Are you consulting or have to consult any doctor other than already mentioned or your family doctor or clinic/ health care facility previously noted? ..... ○ Yes ○ No

If ***"yes",*** provide details _____

_____

_____

Family history

17 Has any family member (whether living or deceased) ever suffered from, or currently has: polycystic kidney disease, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), heart disease, stroke, cancer (specify type), diabetes, kidney disease, heart attack, multiple sclerosis, Alzheimer's Disease or Parkinson's or any hereditary disorder? ..... ○ Yes ○ No

If ***"yes",*** complete the table below.

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH

Children's Insurance Rider

INSTRUCTIONS ***Complete this section on behalf of a child applying for a Children's Insurance Rider who is between 15 days and up to and including age 18.***

18 a) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

b) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

c) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

d) Child name (First, last): _____ Gender: ○ Male ○ Female

Date of birth: (DD/MM/YYYY) _____ Height: _____ ○ ft./in. / ○ cm Weight: _____ ○ lbs. / ○ kg

Name and address of family doctor: _____

Date of last visit with your family doctor or clinic/health care facility (If unknown leave blank): (MM/YYYY) _____

Reason for visit: _____

Results from visit: _____

Are any follow-ups, investigation or referral to another health care professional/specialist recommended? ○ Yes ○ No

If ***"yes",*** provide details: _____

Children's Insurance Rider *(continued)*

Refer to children named in question 18

If ***"yes,"*** to any question(s), identify the child and provide additional information in the **"Remarks section".**	A YES	A NO	B YES	B NO	C YES	C NO	D YES	D NO
19 Has there ever been an application for life or critical illness insurance on any of these children that was declined, postponed, offered with restrictions or modified with a rating in any way?	○	○	○	○	○	○	○	○
20 Has any child to be insured ever had any illness, impairment or injury that required treatment, surgery or hospitalization?	○	○	○	○	○	○	○	○
21 Was any child to be insured born prematurely? If ***"yes,"*** provide birth weight in the **"Remarks section"**	○	○	○	○	○	○	○	○
22 Has any child to be insured consulted, or been treated by, any physician or other practitioner for any known or suspected heart problem, cancer, mental impairment or acquired immunodeficiency syndrome or ever tested positive for HIV or exhibited any delay in physical or mental development?	○	○	○	○	○	○	○	○
23 Has any child to be insured been prescribed any medication or had or been advised to have any treatment or diagnostic test, whether or not completed?	○	○	○	○	○	○	○	○
24 Is any child to be insured not a legal child or a child of the Insured(s) whose legal adoption has not yet been made final?	○	○	○	○	○	○	○	○
25 Are there any other health issues not described above?	○	○	○	○	○	○	○	○

26 Are there any children on whom coverage is not being requested? ○ Yes ○ No

If ***"yes,"*** provide details.

Remarks section

Details of any ***"yes"*** answers. If applicable, attach the appropriate completed questionnaire(s).

QUESTION #	NAME OF INSURED	DETAILS (Provide dates, diagnosis, results of investigations, names of medical advisors, medfacilities and treatment.)

Acknowledgement and authorization

Acknowledgement of variability of universal life policies

There are many variables that can affect an insurance policy's performance. Interest rates and the performance of the securities markets, in particular, can fluctuate significantly and can have a negative or a positive impact on the policy's non-guaranteed benefits and values.

The benefits and values outlined in the illustration are not guaranteed, as they are based on assumptions that are subject to change. They are neither an estimate nor a guarantee of future policy performance.

Exclusions and limitations for Critical Illness Protection

Any Critical Illness Benefit, if applied for, contains exclusions, a survival period and a moratorium period. Refer to your policy wording for details.

Applicant's acknowledgement

I/We, the applicant(s) and Owner(s) stated in this Insurance Application, have reviewed and discussed with my/our independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my/our satisfaction.

Grouped Policies

INSTRUCTIONS

If you wish to have this policy issued on the same day as another policy or policies for families, partnership or other business reasons, please give the names of the other Insured(s) below:

- **Not applicable to any policy with a Critical Illness Protection Rider or any Critical Illness Protection policy**
- **Policy will not be held from issue beyond 30 days from approval.**

Group with:

_____ _____ or _____
(First name) *(Last name)* *(Policy number)*

_____ _____ or _____
(First name) *(Last name)* *(Policy number)*

Client authorization for Pre-Authorized Debit (PAD) payment program

I/We authorize ivari to make automatic withdrawals from my/our bank account at the financial institution identified in this application, or as otherwise set out in any communication from me/us, for the Temporary Insurance Agreement (if applied for) and insurance premiums which become due on or after the date this authorization is signed. Withdrawals from my account may be for variable amounts, as they may change in accordance with the insurance contract including for renewal and conversion premiums and as required to administer the policy.

I/We waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.

If the bank or financial institution does not honour an automatic premium withdrawal when first presented for payment, ivari may attempt to withdraw that payment again within 5 days. ivari reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1.

I/We or ivari may end this agreement at any time by giving 10 days written notice. I/We understand that canceling this authorization may result in loss of insurance coverage unless ivari receives another form of payment. Any refund of premium made pursuant to this authorization shall be paid to the Policy Owner.

I/We certify that all required signatures for the authorization of the withdrawals are present in this authorization. I/We further authorize such financial institution to deal with these withdrawals as if authorized directly by me/us. I/We understand and agree to the "Terms and conditions of participation in the Pre-Authorized Debit (PAD) payment program", which my advisor has reviewed with me/us.

I hereby direct ivari to proceed as indicated in the Premium Payment Details section of the insurance application.

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

Signature of Payor	Signature of Payor
Payor name shown on bank records	Payor name shown on bank records
Signature of Policy Owner, if not a Payor	Signature of Policy Owner, if not a Payor

Terms and conditions of participation in the Pre-Authorized Debit (PAD) payment program

EFFECTIVE DATE

I/We understand and agree that the fully completed "Client authorization for Pre-Authorized Debit (PAD) payment program" will take effect for the policies applied for, on the latest of the following dates:

a) The date the authorization is received by the Head Office of ivari;

b) The date the full amount of the first premium for the policy is received by ivari's Head Office; and

c) The date when the policy applied for is first placed in full force and effect by ivari.

GENERAL

I/We also understand and agree to all of the following terms and conditions:

a) I/We certify that the information provided with respect to the PAD account is accurate. I/We will provide ivari with a new pre-printed sample cheque if the PAD account is changed.

b) The amount drawn on the PAD account shall be a total of all amounts required to pay the applicable premium payments for all policies identified on the reverse and the policy.

c) The authorization shall apply to all policies listed on the reverse and the policy, including any renewal, conversion or increase in cost of insurance specified in the contract.

d) The authorization and all its terms and conditions are subject to all of the terms and provisions of the applicable policies.

e) If ivari has not received a premium payment within the time required, for example, your PAD is not honoured, we will try to re-draw your payment within 5 business days. If your premium payment is still not honoured, or for any other reason, then the policy will lapse and become null and void, unless it is otherwise stated in the policy.

f) I/We consent to disclosure of any personal information that may be contained on this authorization to ivari's designated financial institution to the extent necessary for the purposes described in the authorization and these terms and conditions.

TERMINATION

The authorization will be terminated only on the earliest of the following dates:

a) Either I/we or ivari provide(s) written notice to the other within 10 days to that effect; ***or***

b) All of the policies to which the authorization applies are no longer in full force and effect.

The revocation of the authorization does not affect your rights under the policies.

Any cancellation of this automatic withdrawal arrangement will not affect the agreement between me/us and ivari whatsoever with respect to any contract for goods or services, so long as payment is provided by an alternate method.

I/We further understand and agree that (a) if the authorization is terminated, a direct modal premium shall become payable for all policies to which the authorization applies; and (b) the amount and frequency of the premium payable under the policies will be specified in the pages entitled "POLICY DATA"/"Schedule of Benefits and Premiums" attached to the policy and may be different than the premium payable under a PAD plan.

I/We may revoke my/our authorization at any time, provided written notice is received no less than 10 days before the next scheduled payment date. To obtain a sample cancellation form, or for more information on my right to cancel a PAD agreement, I/We may contact my financial institution or visit **www.payments.ca**. 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 withdrawal that is not authorized or is inconsistent with this authorization. To obtain a form for a reimbursement claim, or for more information on your recourse rights, you may contact your financial institution or visit **www.payments.ca**. In addition, I/we may contact ivari to make enquiries, obtain information or seek recourse with respect to any PAD issued by ivari, as indicated below.

ivari
P.O. Box 4241, Station A
Toronto, ON M5W 5R3
Telephone: 1-800-846-5970

Email: conversation@ivari.ca

Application for temporary insurance

INSURED

Name	Date of birth: (DD/MM/YYYY)

All of the following questions must be answered by the Insured named below. If this application is made in conjunction with an application for a multiple or joint life policy, then this Temporary Insurance Application applies to each Insured separately, in accordance with the note below.

Note: Temporary insurance is not available for the Insured if:

- **a) He or she is less than 15 days old;**
- **b) He or she is more than 65 years of age;**
- **c) Any question in this application for temporary insurance is left blank or answered *yes*;**
- **d) At the time this application is made, there is already $2,000,000 (CAD) of temporary life insurance in force with ivari on the Insured;**
- **e) At the time this application is made, there is already $500,000 (CAD) of temporary critical illness insurance in force with ivari on the insured;**
- **f) The first payment is postdated and/or is not in good standing; or**
- **g) The insurance coverage applied for is replacing an existing ivari coverage/policy.**

No advisor is authorized to waive, amend or modify any terms or provisions in this application for temporary insurance or in the Temporary Insurance Agreement. No representative of ivari is authorized to provide temporary insurance coverage if any of the above provisions are true.

Has the Insured:

a) Ever been treated or had any indication of Alzheimer's disease, Parkinson's disease, disorder of the heart or the blood vessels, chest pain, stroke, Transient Ischemic Attack (TIA), loss of speech, loss of limbs, severe burns, deafness, blindness, kidney, liver or lung disease, diabetes, multiple sclerosis, paralysis, coma, cancer or tumour, AIDS or HIV infection or any other immunological disorder, congenital heart disease, cerebral palsy, cystic fibrosis, muscular dystrophy, any mental health disorder, sought treatment or been treated for alcohol or drug usage or advised to reduce your consumption/usage? ○ Yes ○ No

b) Within the last 6 months, been unable to perform regular activities for more than 15 consecutive days because of sickness or injury? ○ Yes ○ No

c) Within the last three months, been admitted to a medical facility, been advised to be admitted to a medical facility or had a diagnostic test (excluding any Genetic tests) and/or surgery recommended or performed (other than for normal childbirth)? ○ Yes ○ No

d) Ever had an application for life or critical illness insurance on his or her life declined, postponed and/or received a life or critical illness insurance policy that was rated or modified in any way? ○ Yes ○ No

Declaration

I/We declare that I/we have read all of the questions, answers and statements in this application for temporary insurance and all of the terms and provisions in the Temporary Insurance Agreement and understand their meaning and importance. I/We further declare that the answers given in this application for temporary insurance are true, complete, and correctly recorded to the best of my/our knowledge and belief. I/We understand and agree that this application for temporary insurance and the Temporary Insurance Agreement shall be the basis for any insurance provided thereunder.

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

Signature of **INSURED**
If the Insured is a minor the signature of a parent or legal guardian is required as disclosed on page 2, question 7 e)

Signature of **OWNER**
If not an Insured

Print name of signing officer and title if entity owned

Signature of **OWNER**
If not an Insured

Print name of signing officer and title if entity owned

Declaration

I/We confirm that I/we understand the language in which this application is written, or, if I/we do not, the details of this application have been fully explained to me/us in my/our preferred language and are completely understood by me/us.

I/We have read all the questions and answers in this application, and I/we understand the meaning and importance of them. The statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief.

ACKNOWLEDGEMENT AND AGREEMENT

I/We acknowledge and agree that:

1. This application consists of all preceding pages in the application, any supplement to it (if applicable), and any other declaration made in connection with this application. Together all this information will form the basis for any policy/coverage issued.
2. This application does not include any "Temporary Insurance Agreement".
3. No information acquired by any representative of ivari will be binding on ivari unless set out in writing in this application.
4. Any policy, amendment, or endorsement issued on this application will not take effect unless all the following conditions are satisfied.
   a) The full premium payment amount is received by ivari under the policy as of the date of this application.
   b) The policy is delivered to the owner during the lifetime of the insured(s) under the policy.
   c) All statements and answers given in this application continue to be true and complete on the date of delivery of the policy.
   d) Where underwriting is required, no change has taken place in the insurability of any insured(s) between the time this application is completed and the time the policy is delivered to the owner.
5. Only the president together with a vice-president or corporate secretary of ivari has the authority to bind ivari or to make any change in this application or any policy issued. ivari will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend, or modify any of the terms or provisions in this application or any policy issued. However, ivari may make certain changes to this application as provided for in your policy contract. The owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements, or amendments.
6. If the answer to any question(s) in this application is misstated or omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
7. All premium payments must be made payable to ivari.
8. I/We have received and fully understand the contents of the Disclosure of Compensation, where applicable.
9. Effective January 1, 2017, new tax rules for life insurance policies have taken effect. If a policy was issued prior to 2017, certain changes made to an existing policy may impact its policy's tax status. Ensure you talk to your advisor to fully understand how any changes may affect your existing policy.

PERSONAL INFORMATION AUTHORIZATION

I/We have read and fully understand the contents of the Notices acknowledge and consent to the collection, use and disclosure of my/our personal information by ivari and its affiliates, authorized representatives and reinsurers described in the Notices, including ivari's disclosures to Third-Party Administrators.

1. When underwriting is required, for the purposes of evaluating my/our application, servicing my/our policy, and investigation and claim analysis, I/we authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, LLC or any other organization, institution, association or person identified in the Notices that now has or may in future have any information concerning me/us or my/our health to disclose to ivari, its authorized representatives and its reinsurers, upon the request of ivari, any such information for the purposes identified in the Notices.
2. When underwriting is required, I/we authorize ivari, to make a brief report of my/our personal health information to MIB, LLC.
3. When underwriting is required, I/we further authorize a representative of ivari to perform such tests, examinations, x-rays, electrocardiograms and blood or urine tests as may be required by ivari. I/We understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus and the presence of medications, drugs, nicotine or their metabolites. ivari may release the results of these tests and examinations to my personal physician(s).
4. I/We certify that the information given in this section is correct and complete. I/We agree to immediately notify ivari of any errors, omissions or changes in the information provided in this application. As the policy owner(s), I/we acknowledge that I/we have an obligation under the *Income Tax Act* and other applicable tax legislation to notify ivari of any changes in my/our tax residency status. I/We acknowledge that the information contained in this application and information regarding my/our policy, contract and account may be reported to Canada Revenue Agency (CRA) or other tax authorities.

A copy of this authorization shall be as valid as the original.

Consents

I/We provide consent to ivari to share my/our personal information (which will not include health or financial information) with third-party service providers that are contracted by ivari to provide me/us with optional added-benefit services and may contact me/us to offer more information and/or enroll me/us in such services.

Note: For more information about added-benefit services that are currently available to you, please ask your advisor.

Owner 1: ○ Yes ○ No **Owner 2:** ○ Yes ○ No

By providing my/our email address(es), I/we consent to ivari using my/our email address(es) to grant me/us online access to ivari's client portal where I/we can view information about my/our ivari policy, if issued.

Owner 1: ○ Yes ○ No **Owner 2:** ○ Yes ○ No

Owner 1 email address: _____

Owner 2 email address: _____

I/We consent to receiving promotional messages from ivari by email, text or other electronic means and I/we authorize ivari to share my/our personal information (which will not include health or financial information) with third party service providers.

Owner 1: ○ Yes ○ No **Owner 2:** ○ Yes ○ No

I/We acknowledge that I/we may withdraw any optional consent at any time by contacting ivari:

P.O. Box 4241, Station A
Toronto, ON M5W 5R3
Telephone: 1-800-846-5970 **Email: conversation@ivari.ca**

Insured's Authorization to disclose information to your Advisor and Distributor

When underwriting is required, I understand that ivari may collect my personal information in supplementary forms, phone interviews or other communications with me or a medical professional, for the purpose of evaluating my insurability. This information could include:

- My medical history
- Medical tests and laboratory results obtained from my physician, or performed for insurance purposes
- Employment history, personal finances, substance abuse history, driving record and criminal history
- Any other facts about my life that may affect the assessment of my insurance request

By agreeing to this authorization, I understand that the information collected may be discussed only with the independent insurance advisor indicated below and with their distributor, who may use it to help me with my insurance options. I acknowledge that I may also cancel this authorization at any time by calling ivari at 1-800-846-5970. This authorization will remain in effect for 45 days after ivari issues a policy or sends a letter indicating that my insurance request has been declined.

Advisor's name: _____ Advisor's code: _____

I, as **Insured**, authorize ivari to make this disclosure of information ○ Yes ○ No

- **I/We have reviewed and understood the "Notices" page the "Acknowledgement and authorization" page and this "Declaration" page.**
- **I/We have reviewed and discussed with my/our independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my/our satisfaction.**

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

_____
Signature of **INSURED**
If the Insured is a minor the signature of a parent or legal guardian is required as disclosed on page 2, question 7 e)

_____
Signature of **OWNER 1**, if not an Insured

_____
Print name of signing officer and title, if entity owned

_____
Signature of **OWNER 2**, if not an Insured

_____
Print name of signing officer and title, if entity owned

_____
Advisor's signature

If the Owner is an entity, the signature(s), name(s) and title(s) of the authorized signing officers thereof are required, as stated in the by-laws of the entity.

Independent Insurance Advisor's report

1. Applications must be completed, in person, with the client. Please confirm that you completed the application in the presence of all Insured(s)/Owner(s)? (Video Conferencing is not considered in person).
   Advisor 1: ○ Yes ○ No If ***"no",*** explain why: _____
   Advisor 2: ○ Yes ○ No If ***"no",*** explain why: _____
   Advisor 3: ○ Yes ○ No If ***"no",*** explain why: _____
2. Is any advisor, the Insured, Owner, Beneficiary or Payor on this policy?
   Advisor 1: ○ Yes ○ No
   Advisor 2: ○ Yes ○ No
   Advisor 3: ○ Yes ○ No
3. Does any advisor have a relationship* with any Insured, Owner, Beneficiary or Payor?
   *A "relationship" includes family relationships (by blood, marriage or adoption), friendships, creditor relationships, and relationships involving financial dependency on the advisor, or relationships involving a corporation owned and/or controlled by the advisor and/or an advisor's family member.
   Advisor 1: ○ Yes ○ No If ***"yes",*** provide details: _____
   Advisor 2: ○ Yes ○ No If ***"yes",*** provide details: _____
   Advisor 3: ○ Yes ○ No If ***"yes",*** provide details: _____
4. By signing below, I/we acknowledge that I/we have disclosed, in writing, maintained in the client's file, where applicable, the following items to the Owner(s) of the policy resulting from this application:
   a) The company or companies I/we represent;
   b) That I/we will receive compensation in the form of bonuses *(such as commissions or a salary)*; and
   c) That I/we have disclosed any conflicts of interest that I/we may have with respect to this transaction.
   d) I/We attest that I/we have followed the ivari Code of Ethical Market Conduct in all aspects of this sale of insurance.
   e) That I/we are licensed in the province in which this application was completed.
   f) That I/we have disclosed the nature of relationship with company(ies) represented
   g) That I/we have disclosed that the consumer has the right to ask for more information

Advisor's notes: Do you have any knowledge of each Insured's personal habits, health, avocations, finances, or reputation that might affect the underwriting risk? If so, give details below.

_____

_____

_____

Advisor's email address: _____

I/We hereby declare that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief, and that I am/we are not aware of additional information material to the Insured(s) except as stated in any advisor's notes. When applicable, I/we have verified the identity of the individuals who submitted the application by referring to the original, non-expired documents. I/We confirm that the information recorded was correctly copied from such document(s). Reasonable effort has also been exercised to determine if the Owner(s) is/are acting on behalf of a third party.

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

_____ _____
Signature of advisor Name of advisor

The individual who wrote this application must be listed below as either Advisor 1, 2 or 3 and MUST have his/her own advisor code.

Distributor name : _____ Code: _____

Advisor name (1): _____ Advisor code: _____ Share %: _____

Advisor name (2): _____ Advisor code: _____ Share %: _____

Advisor name (3): _____ Advisor code: _____ Share %: _____

If shared, who is the servicing advisor? ○ **Advisor 1** ○ **Advisor 2** ○ **Advisor 3**

Temporary Insurance Agreement (TIA)

ivari will provide temporary insurance coverage on each Insured named in the application for temporary insurance once all of the following terms and conditions are met. If your application for temporary insurance is made at the same time as an insurance application for a multiple or a joint life policy, this agreement applies to each Insured separately.

TERMS AND CONDITIONS

1. Effective Date

This agreement shall be effective on the date the application for temporary insurance was completed and signed by the Owner and the Insured, providing all of the following conditions are satisfied:

a) All questions in the application for temporary insurance have been answered "no" by the Insured(s); and

b) The application for temporary insurance is completed, signed and dated, and at least the full amount of one monthly modal premium based on the insurance application for life insurance and critical illness coverage has been submitted with the application; and

c) The initial payment has been honoured.

2. Benefit

Subject to all the terms and conditions of this agreement, if the Insured(s) under this agreement dies or becomes critically ill while this agreement is in effect, ivari agrees to pay the applicable Beneficiary named in the insurance application, and upon proof of death or confirmed diagnosis of a critical illness satisfactory to ivari, a death or a Critical Illness Benefit equal to the lesser of:

a) The amount of life or critical illness insurance applied for;

b) $2,000,000 (CAD) for life insurance; and

c) $500,000 (CAD) for critical illness insurance.

If at the time of the insurance application the Insured has temporary insurance with ivari, the dollar amounts listed in (b) and (c) above will be reduced by the amount of temporary life and temporary critical illness insurance already in effect. No temporary insurance is provided on any additional benefit such as Accidental Death, Waiver of Premium Benefit, Children's Insurance Rider or Payor Waiver of Premium Benefit.

3. Limitations

The total amount of temporary insurance that can be in force at one time on the life of a Insured cannot exceed $2,000,000 (CAD) for life insurance and $500,000 (CAD) for critical illness insurance.

This agreement is void if:

a) At the time the application for temporary insurance is made, there is already temporary life insurance in force with ivari on the Insured for $2,000,000 (CAD).

At the time the application for temporary insurance is made, there is already temporary critical illness insurance in force with ivari on the Insured for $500,000 (CAD).

b) For life insurance or critical illness coverage, the Insured(s) is less than 15 days old or more than 65 years old;

c) The death of the Insured(s) results from a suicide attempt or self-inflicted injury while sane or insane;

d) The death or the critical illness of the Insured(s) occurs while committing or attempting to commit a criminal act, including, without limitation, driving a motor vehicle while under the influence of alcohol or drugs, intentionally taking any drug other than as prescribed by a physician, misuse of medication or the use of illegal drugs or intoxicants; or

e) A material fact has not been disclosed or has been misrepresented in the insurance application or any other declaration made in connection to the Insurance Application, or the application for temporary insurance.

No benefit under the critical illness insurance will be paid if the Insured(s) is/are diagnosed with cancer or die(s) within 30 days of diagnosis of a covered condition. Our standard critical illness policy provisions, limitations and exclusions shall govern the critical illness insurance provided under this receipt.

If the Insured does not qualify for temporary insurance under the terms and conditions of this agreement, ivari will apply the premium received with the Insurance Application as payment for the first premium for the policy issued by ivari. If ivari declines to offer a policy, we will return this premium to you.

4. Termination

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

a) Ninety (90) days from the date the insurance application is signed;

b) The date on which ivari electronically communicates or mails a notice to your independent insurance advisor or distributor to advise the Owner and/or Insured(s) that ivari is either (i) terminating this Agreement, or (ii) advising that the insurance application is withdrawn, cancelled, suspended or declined or (iii) making a counteroffer whereby a policy other than the policy applied for is offered;

c) The date on which the Owner requests the withdrawal of the Insurance Application or temporary insurance; or

d) The date that the policy applied for is issued.

Except in the case of fraudulent misrepresentation, we refund in the event of TIA termination under (a), (b)i-ii, and (c). This TIA terminates on the date specified above regardless of whether we have refunded the premium that you paid with the insurance application.

NOTE: NO ADVISOR OR DISTRIBUTOR IS AUTHORIZED TO WAIVE, AMEND OR MODIFY ANY OF THE TERMS OR PROVISIONS IN THE APPLICATION FOR TEMPORARY INSURANCE OR IN THIS AGREEMENT.

Receipt for temporary insurance

DETACH AND LEAVE WITH THE OWNER IF THE TEMPORARY INSURANCE CONDITIONS ARE MET. DO NOT DETACH IF NO TEMPORARY INSURANCE IS BEING APPLIED FOR.

ivari acknowledges receipt of $ _____ which is at least the full amount of one monthly modal premium based on the insurance application dated _____ (DD/MM/YYYY) on the life of ***(full name of Insured)*** _____

Signed at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

_____
Print full name of advisor

_____
Signature of advisor

THIS RECEIPT DOES NOT BIND IVARI TO PROVIDE COVERAGE UNDER THE TEMPORARY INSURANCE AGREEMENT UNTIL ALL OF THE TERMS AND CONDITIONS THEREOF ARE SATISFIED.

Note: If you do not hear from ivari regarding the insurance within ninety (90) days of the date of your Insurance Application, contact your independent insurance advisor or ivari at its Head Office, **P.O. Box 4241, Station A, Toronto, ON M5W 5R3**