HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

APPLICATION

Creditor, Life and Critical Illness Insurance

Instructions for the Advisor

1. Write legibly in blue or black ink.
2. This application may be used to apply for a single policy or for multiple policies for the following products:
   - Term Life 10
   - Term Life 15
   - Term Life 20
   - Term Life 25
   - Term Life 30
   - Term Life 80
   - Term Critical Illness T10
   - Term Critical Illness T15
   - Term Critical Illness T20
   - Term Critical Illness T25
   - Term Critical Illness T30
   - Term Critical Illness T75
   - Survie 2000 – T100
   - Assure-Debt
   - Prodige
3. **An administration fee rebate shall apply for as long as the jointly submitted and issued policy remains in force (Please refer to the Advisors' Guide for full details).**
   - Complete **part 5 - Multi-Policy / Family Rebate**.
   - Complete **part 14 - Pre-Authorized Debit Agreement (PDA)**.
4. If the application is for Survie 2000 only and the amount is for less than $50,000, complete a declaration of insurability. For amounts of $50,000 or more, please order a teleunderwriting interview and all other age amount requirements.
5. If the application is for Assure-Debt (2,000$ maximum, personnal or commercial), Prodige, Term Critical Illness or Term Life please attached the appropriate illustration.
   - The application must be signed by the person to be insured and the policyowner if other than the person to be insured.
   - The application must be dated the day it is signed by the person to be insured.
   - For replacements, you must include with this application the appropriate replacement forms, completed and signed.
   - If the mode of payment is by pre-authorized debit, be sure to complete **part 14 - Pre-Authorized Debit Agreement (PDA)** and attach a **SAMPLE VOID CHEQUE**.
   - This application is subject to a teleunderwriting interview for the completion of the insurability questionnaire. Be sure to inform the person to be insured of the teleunderwriting process.
   - Detach **pages 21 and 22** of this application and leave it with the person to be insured.

PART 1 - The Person to be Insured

N°: _____

Name:

First Name: Sex: M F

Middle Name:

Social Insurance Number: Date of Birth:
day / month / year

Place of Birth:
(province/state/country)

Address:
(number and street) (apt.)

City:

Province: Postal Code:

Home phone number: Business phone number:

Is the person to be insured a permanent resident of Canada? Yes No **If no, please do not proceed.**

Your previous country of residence:

Does the person to be insured speak or read English or French? Yes No **If no, please do not proceed**

In what language would you like your policy issued? In English In French

PART 2 - The Person to be Insured

Please indicate the best time for the teleunderwriting interview:

1st choice: Day:

Hour:

Tel. No.:

2nd choice: Day:

Hour:

Tel. No.:

Please indicate the requested underwritting requirements.

Date	Provider	U/W Requirements	Référence Nº

Note: Please advise your clients that they will be contacted for a phone interview. Questions regarding their medical or family history could be asked. An appointment with a nurse could also be required.

PART 3 - The Policyowner (if other than the person to be insured)

Name of Policyowner:

First Name of Policyowner:

Date of Birth:

day / month / year

If owned by a business:

Name of the Company:

Number:

Date of Constitution:

Relation to Person to be Insured:

Mailing Address:

(number and street) (apt./suite)

City:

Province: Postal Code:

4100-056-en
2021/07

PART 4 - Beneficiary Designation

In the province of Quebec, unless specified below, the beneficiary is irrevocable in the case of a spouse related by marriage or civil union and revocable in all other cases.

In Quebec, any amount to be paid to a minor child as beneficiary will automatically be paid in his name to the parent(s) or to its legal tutor.

A. Death Benefit

All death benefits are payable to the Policyowner, or to the estate of the Policyowner, unless otherwise specified below. If the Insured is under age 18, the beneficiary will be the Policyowner, unless otherwise specified below.

If the Policyowner is a company or corporation, any return of premium amount is payable solely to the Policyowner.

Complete Name:	Date of Birth:	Relationship to Insured:	% share:	Revocable / Irrevocable
Complete Name:	Date of Birth:	Relationship to Insured:	% share:	Revocable / Irrevocable

B. Critical Illness Insurance

Critical illness benefits are payable to the Principal Insured, unless otherwise specified below.

If the Insured is under age 18, critical illness benefits are payable to the Policyowner, unless otherwise specified below.

Complete Name:	Date of Birth:	Relationship to Insured:	% share:	Revocable / Irrevocable
Complete Name:	Date of Birth:	Relationship to Insured:	% share:	Revocable / Irrevocable

C. Premium refund

All return of premium amounts are payable to the Policyowner, unless otherwise specified below.

Complete Name:	Date of Birth:	Relationship to Insured:	% share:	Revocable / Irrevocable

D. Other Benefits

All benefits in case of disability, dismemberment or loss or use, hospitalization, fracture or reimbursement of medical fees are payable solely to the Principal Insured.

If the Principal Insured is under age 18, benefits are payable to the Policyowner.

Nova-Scotia only

I understand that the effect of my designating a beneficiary irrevocably is that, under the provisions of the Insurance Act, while the beneficiary is living, I may not alter or revoke the designation without the consent of the beneficiary and I may not assign, exercise rights under or in respect of, surrender or otherwise deal with the contract without the consent of the beneficiary.

Signature of Policyowner: _____

Signature of Policyowner: _____

Part 5 - Multi-Policy / Family Rebate

Application N°:

PART 6 - Existing or Pending Insurance

a) Is there any existing life, critical illness or disability insurance in force or **pending** with Humania Assurance or any other company?

Yes No

b) Is this application intended to replace an existing insurance policy or a pending application?

Yes No

c) Please give details below of all **existing and pending** life, critical illness and disability insurance on the insured.

Name of Company	Type of insurance (life/CI/DI)	Date issued	Total amount of coverage	Replacing Yes	Replacing No

PART 7 - Coverage Requested

Smoker Non-smoker

1. Assure-Debt Prodige Term Life Term Critical Illness

Please attach a copy of your illustration for the requested coverage.

An administration fee rebate shall apply for as long as the jointly submitted ans issued policy remains in force.

Please complete Part - 5 if applicable.

Please refer to the Advisors' Guide for full details.

2. Survie 2000

		Annual	Monthly
• Face amount Survie 2000: $	Premium: $		$

For coverage amounts less than $50 000, complete declaration of insurability.

Rider

- Waiver of premium benefit in the event of total disability of:
  - OWP (Policy owner) (The policyowner must complete a declaration of insurability (form: 4100-045-en))
  - IWP (Insured) Premium: $ $
  - OWP25 (Policy Owner/Child) (The policyowner must complete a declaration of insurability (form: 4100-045-en))
- Accidental death and dismemberment – triple benefit:

  Coverage amount: $ Premium: $ $
- Accidental death and dismemberment – double benefit:

  Coverage amount: $ Premium: $ $
- Guaranteed Insurability Benefit (G.I.):

  Coverage amount: $ Premium: $ $
- Child Life Insurance Rider (a declaration of insurability must be completed for each covered child (form: 4100-045-en)):

  Units Premium: $ $
- Total Premium Refund Rider: Premium: $ $

Policy fee: Fee: $ $

Total Premium : $ $

Part 8 - Professional Information

Complete for Assure-Debt

1. Occupation

a) Title, Designation:

Daily Job Duties:

b) How many years have you worked in this occupation:

c) If less than 1 year, what was your previous occupation:

d) How many weeks per year do you work:

e) How many hours per week do you work:

f) Professionnal Category: Reclassification to:

2. Breakdown of hours worked:

Fabrication/Repair: hours per week Sales/Representation: hours per week

Administrative/Office: hours per week Driving/Transport: hours per week

3. Do you work at another job or other occupation: Yes No

a) If yes: Title/Designation:

Daily Job Duties:

b) Name and address of employer:

c) Number of yours worked at this job:

4. Earned Income:

a) Current annual net earned income before taxes: $

b) Annual net income before taxes for last year: $

c) Annual net income before taxes for previous year: $

5. Other Income:

Investment **Income, Rental Income or other sources of income not related to your occupation:**

a) Last year: $

Part 8 continues on next page.

Part 8 - Professional Information (…continued)

Complete for Assure-Debt

b) Previous year: $

c) What source of income do they come from: $

6. Are-you: Salaried Yes No

Name and address of the employer:

How many years have you worked in this occupation:

If less than 1 year, what was your previous occupation:

7. Are-you: Self-Employed Yes No

Business address:

If this is also your home address, home many hours per week do you work outside of the home?

8. Are-you: Business Owner Yes No

a) If yes, percentage ownership (%):

b) Since when:

Name and company address:

If other shareholders, please specify along with % of shares of each:

PART 9 - Financial Information

Complete for Assure-Debt

1. What is your annual net earned income before taxes? $

IMPORTANT: For each debt, indicate the monthly payment, the % share and if commercial or personnal.

2. Existing debts:	Required monthly payment	% share	Commercial or Personal
Residential mortgage:	$	%	
Other mortgages:	$	%	
Bank loan:	$	%	
Line of credit:	$	%	
Credit card:	$	%	
Residential lease:	$	%	
Car lease:	$	%	
Other debt:	$	%	
Other debt:	$	%	
Total:	$	%	

3. For benefit amounts of $1,000 or less, the debt ratio is not considered.
4. For benefit amounts of $1,001 to $2,000 for which the debt ratio is over 55%, the Insurer will offer the lesser of 45% of net income before taxes or $1,500, with a waiting period of 90 days and a maximum benefit period of 5 years.
5. Maximum benefit amount of 2,000$, personnal or commercial.

PART 10 - Identification of Financial Advisor

The signature of the service advisor is mandatory. The application will be returned if this signature is missing.

Complete name of service advisor/representative

Code % Telephone No.

Complete name of other advisor/representative

Code % Telephone No.

Compensation **Level** **Accelerated (if available)** Agency

If no choice is indicate, the accelerated commission shall be paid when this option is available.

Confirmation of Advisor Disclosure

I hereby confirm that I have provided my client in writing with the necessary information, as outlined in the document entitled "AdvisorDisclosure", namely: (a) the company(ies) I represent; (b) my compensation; (c) bonuses and conference incentives; and (d) any potential conflict of interest.

I certify that I have fully explained to the insured the nature and effect of making an irrevocable designation of beneficiary and such explanation was given to the insured not in the presence of the beneficiary and that the insured indicated that he was aware of the irrevocable nature of the designation so made by him.

Signature of Representative:

PART 11 - Eligibility for Conditional Insurance

Conditional insurance coverage is in effect provided that the person to be insured has truthfully answered no to each of the following questions and that the age of the person to be insured is greater than 1 month and less than 60 years. If a question below is answered yes, no coverage takes effect under the Conditional Insurance Agreement:

	Yes	No
1. Have you ever been treated for, consulted a doctor or other health practioner, or had indication of heart or blood vessel disease, suspected heart attack, chest pain, diabetes, transient ischemic attack, stroke, chronic kidney disease, disease of the liver or lungs, cancer or tumours, multiple sclerosis, paralysis, loss of limb, coma, deafless, blindness, loss of speech, severe burns, AIDS or HIV infection?		
2. In the past 2 years, has any application for life, critical illness or disability insurance been rated, declined or modified in any way or cancelled by an insurer?		
3. In the past 90 days, have you been admitted in a hospital, clinic or other medical facility, or has an admittance been recommended for any reason other than pregnancy?		
4. In the past 90 days, have you consulted a doctor or other health practioner, and been told to have further examination, diagnostic test or surgery which has not been performed or for which the results are not know?		

If you have answered No to all of the above questions you are eligible for the conditional insurance as outlined in the Conditional Insurance Agreement.

PART 12 - Authorizations and Signatures

I, the undersigned, as the Policyowner or the proposed Insured, declare that the statements, answers and information provided in this application and in any documents which by agreement form part of this application are complete and true. I understand that any misrepresentation or omission may result in the cancellation of any insurance coverage obtained through this application. I authorize Humania Assurance Inc., its reinsurers, other insurers and its teleunderwriting agent, to obtain from any organization or person, any physician or practitioner, hospital, clinic or medically related facility, other insurance or reinsurance companies, the Medical Information Bureau, financial institutions, third party investigation agencies, any personal information, medical history on record on me and my health or my insurability for the purpose of underwriting my application and for administering any claim. I relieve these parties or their obligation of confidentiality and further authorize them to release full particulars including prior medical history to Humania Assurance, its reinsurers or other insurance companies. I authorize Humania Assurance, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize Humania Assurance, its reinsurers, other insurance companies and third party investigation agencies hired by Humania Assurance to acquire personal information about me and to include this information in any other files which they currently hold respecting me, or which may be opened in the future. I further authorize Humania Assurance to exchange information about me with its reinsurers and other insurance companies. I also authorize Humania Assurance to refer to any existing files, opened or closed, which they currently hold regarding me. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period.

A photographic copy of this signed consent shall be as valid as the original. The insurer can contest fraudulent declarations beyond the contestable period. **I acknowledge receiving the pre-notice form describing the procedures of the Medical Information Bureau, the Notice concerning Files and Personal Information and the notice regarding the advisor disclosure statement, and I confirm that I have understood the conditionnal insurance receipt.** No financial advisor or representative is authorized to modify this application form, the policy or the conditional insurance receipt. **Insurance is a contract based on trust. Failure to fully disclose facts material to this application form can render the contract void.** Any policy issued on this application takes effect only upon acceptance of this application by the Insurer without modification and then only if the first premium is paid in full and there has been no change in the insurability of the proposed insured subsequent to the completion of this application.

Signed at _____ Province _____ Date _____
(city)

Signature of Representative _____ Signature of Policyowner _____

Signature of Insured or Parent or Legal Guardian _____
(if other than the Policyowner/children 14 and over must also sign)

PART 13 - General Comments

Please provide any information which may assist in underwriting this application or any additional instructions.

PART 14 - Pre-Authorized Debit Agreement (PDA)

THE PRE-AUTHORIZED DEBIT AGREEMENT (PDA)

The Payor named below authorizes Humania Assurance Inc. (Humania Assurance) to make scheduled pre-authorized debits (PDA) on the bank account with the financial institution named below, or any other financial institution that the Payor may later designate, for the purpose of paying the insurance premium in accordance with the premium schedule stipulated in the policy contract, including the initial premium.

THE ACCOUNT

- This Agreement must be signed by all persons whose signature is required to affect withdrawals on the account designated below.
- You must attach a sample cheque marked "VOID". The sample cheque you send to Humania Assurance will serve for all new debits that you may authorize on the account.
- If you wish to change the account on which the PDA is drawn, you must forward a sample cheque for the new account to Humania Assurance.

THE DEBIT

- You must be the designated Policyowner or the Payor of the policy contract and you must be the holder of the account on which the PDA is made.
- You must select a debit date between the 1st and the 28th of the month, inclusively. The debits will be made at this date each month for the duration stipulated in the policy contract.
- You can change the debits instructions provided the premium for the current month is paid or is due at least 10 days after the new date selected.
- The amount of the debit will vary in accordance with the premium as provided for in the policy contract.
- If the amount of the debit should vary, Humania Assurance is not required to provide notification.
- Unless otherwise indicated by you, this Agreement shall be valid for all renewals and conversions of your policy contract.

CANCELLING THIS AGREEMENT

- You can end this Agreement at any time for all policies included in it, by proving 10 days written notice.
- You may obtain further information on your right to cancel a PDA Agreement by visiting the Canadian Payments Association website at www.cdnpay.ca.

THE CONSEQUENCES OF NON-PAYMENT

- You are solely responsible for the consequences of a non-payment and any obligations that it may give rise to under the terms and conditions of the policy contract.
- You are in default of payment when a PDA is not honoured because of non-sufficient funds, closed account or other similar reasons.
- If your financial institution does not honour a debit because of non-sufficient funds, Humania Assurance will debit that amount again with the next monthly debit along with a fee of $25 for each debit not honoured. Humania Assurance may also terminate this Agreement and the annual premium would then be due for all policies covered by this Agreement.
- A notice of "Stop Payment" initiated by you without prior agreement with Humania Assurance for the payment of the premium, may result in the cancellation of all policies covered by this Agreement.

RIGHT TO REIMBURSEMENT

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

PART 14 - Pre-Authorized Debit Agreement (PDA) (…continued)

PERSONAL INFORMATION

In establishing your PDA, Humania Assurance will release and exchange with your financial institution only information that is legally required.

BANK ACCOUNT INFORMATION

These services are for (check one) Personal Business Use

Name of bank or financial institution

Transit Number Bank Number Account Number

Address

City Province

Postal Code

The financial institution named above is hereby authorized now or at any subsequent time to honour the requests for PDA or fees made by Humania Assurance on the above account, including a redraw within 30 days for any debit that was not honoured the first time it was presented. The Payor named above authorizes Humania Assurance to debit such amounts on another account, as the Payor may direct from time to time, upon oral or written instructions.

Signed

this day of
(month/year)

Name of Payor (Account Holder)

First Name of Payor (Account Holder)

Name of Second Payor
(account Holder) (if any)

First Name of Second Payor
(account Holder) (if any)

Signature of Payor

Signature of Second Payor, if any

ATTACH A SAMPLE VOID CHEQUE HERE (if applicable)

SAMPLE
"VOID"
CHEQUE

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PART 15 - Method of Payment

Verification of the individual paying the premiums is required if the premium to be paid to Humania Assurance Inc. is over $10,000. (Documents accepted: birth certificate, driver's license, passport or citizenship certificate)

Name of Payor:

Document Type: Document number:

In the case of a corporation or an entity that is not a corporation or is acting on behalf a third party, you must attach the applicable form: https://extranet.humania.ca / Individual Insurance Documentation / Forms and questionnaires / Determination of Persons.

If the amount of payment is $100,000 or more, you must attach the form concerning politically exposed foreign persons (PEFP): https://extranet.humania.ca / Individual Insurance Documentation / Forms and questionnaires / Determination of Persons.

Monthly pre-authorized debit

Monthly pre-authorized debit (Complete the **Pre-Authorized debit Agreement PART 14**)

Date of withdrawals (1st to 28th):

Amount paid with application: $ (cash payments or postal money orders are not accepted)

Annual payment by cheque

Annual payment by cheque

Amount paid with application: $

PART 16 - Credit Card payment mode

Credit Card payment mode **(Annual or first monthly premium only)**

Authorized debit amount: $ **If no amount is indicated, the initial premium amount will be deduct.**

Visa Master Card

Name of card holder:

All payments by credit card will be processed upon receipt of the application at the Head Office of Humania Assurance Inc.

N°:

Credit card number: | | | | | Expiry:

PART 17 - Authorizations to Release Information

N°:

I authorize all medical professionals, all public or private health or social services agencies, organizations, or institutions, all insurance companies, the Medical Information Bureau, financial institutions, third party personal information agencies, investigation and security agencies, credit and claim agencies, crime detection and prevention agencies, financial intermediaries, my employer or ex-employer or any other person I may indicate as well as all public or private organizations or institutions or person that has any records or knowledge on me, my health or my insurability, to release full particulars including all prior medical history to Humania Assurance Inc., its reinsurers, other insurers and its agents, for the purpose of underwriting my application for life, critical illness or health insurance and for the adjudication and processing of claims. In the event of death, the Policyowner, contingent Policyowner, beneficiary, heir or the liquidator of the estate is expressly authorized to release to Humania Assurance all the information and authorizations required for the adjudication and processing of claims. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period. A photocopy of this signed consent shall be as valid as the original.

Name of Proposed Insured

Date of Birth Date

Signature of Person to be Insured

(children 14 and over must also sign)

DETACH HERE

PART 17 - Authorizations to Release Information

N°:

I authorize all medical professionals, all public or private health or social services agencies, organizations, or institutions, all insurance companies, the Medical Information Bureau, financial institutions, third party personal information agencies, investigation and security agencies, credit and claim agencies, crime detection and prevention agencies, financial intermediaries, my employer or ex-employer or any other person I may indicate as well as all public or private organizations or institutions or person that has any records or knowledge on me, my health or my insurability, to release full particulars including all prior medical history to Humania Assurance Inc., its reinsurers, other insurers and its agents, for the purpose of underwriting my application for life, critical illness or health insurance and for the adjudication and processing of claims. In the event of death, the Policyowner, contingent Policyowner, beneficiary, heir or the liquidator of the estate is expressly authorized to release to Humania Assurance all the information and authorizations required for the adjudication and processing of claims. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period. A photocopy of this signed consent shall be as valid as the original.

Name of Proposed Insured

Date of Birth Date

Signature of Person to be Insured

(children 14 and over must also sign)

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

Right of Cancellation

At the Policyowner's request, the policy could be cancelled by submitting a written request and returning the policy to the Insurer within 10 days of its receipt. Any premium paid under the policy will then be refunded to the Policyowner.

Advisor Disclosure Statement

The transaction represented by this application is between the Policyowner and Humania Assurance Inc. The financial advisor or representative soliciting this insurance application is an independent contractor and will receive compensation from Humania Assurance when the insurance becomes effective. The advisor may also be eligible to receive additional compensation under the form of a bonus, participation at conventions or other incentives. The applicant is not obligated to transact any other business with Humania Assurance as a condition of this application.

Notice – Medical Information Bureau

The information on your insurability will be kept confidential. However, Humania Assurance Inc., may submit a brief report to MIB Inc, formerly known as the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply for life, critical illness or health insurance to another MIB Inc. member company, or if a claim for benefits is submitted to a member company, MIB Inc. will supply, on request, such company with the information in its file. Upon receipt of a request from you, MIB Inc. will arrange a disclosure of any information it may have in your file.

If you question the accuracy of information in MIB's file, you may contact MIB by email at Canadadisclosure@mib.com or by telephone at 866-692-6901. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

Humania Assurance Inc., may also release information in this file to other insurance companies to which you may apply for life, critical illness or health insurance, or from which you may have claimed benefits.

Conditional Insurance Agreement

Humania Assurance Inc., agrees to insure the person to be insured for life or critical illness from the date this application is completed if the person to be insured qualifies for conditional insurance, and if the person to be insured meets all of the following conditions:

1. All required medical exams have been completed.
2. **The person to be insured has truthfully answered *NO* to all of the eligibility questions in part 11 of the application.**
3. The person to be insured must be insurable without a rating, restrictions, exclusions, limitations or modification.
4. The age of the person to be insured is between 1month and 60 years old inclusively.
5. There is no fraud or material misrepresentation in this Agreement or non-disclosure in the application forms or the telephone interview questionnaire that would affect our decision to provide insurance or the terms on which we provide it.

Irrespective of the number of Conditional Insurance Agreements that may be issued at any one time:

- The maximum amount payable for critical illness is limited to the lesser of the amount of critical illness applied for or $100,000.
- The maximum amount payable for life coverage is limited to the lesser of the amount of life insurance applied or $100,000.

The maximum amount payable for critical illness is limited to the lesser of the amount of critical illness applied for or $100,000. The maximum amount payable for life coverage is limited to the lesser of the amount of life insurance applied or $100,000.

There is no coverage under this Agreement if disability or death results from suicide or attempted suicide whether sane or insane, drug or alcohol use or abuse, or while operating a motor vehicle with a blood alcohol level above the legal limit.

The conditional insurance outlined in this Agreement will end on the earliest of the date we mail you a notice informing you that your application for insurance has been declined, or 90 days from the date of your application for insurance.

Humania Assurance may terminate this agreement at any time by notice mailed to the Policyowner at the address indicated on the application form. NO FINANCIAL ADVISOR OR REPRESENTATIVE IS AUTHORIZED TO MODIFY THIS AGREEMENT.

Regarding the Telephone Interview and Exams

The present application is subject to the completion of a telephone interview for the purpose of obtaining medical and other information on the person to be insured, as may be required to underwrite an application for life, disability or critical illness insurance.

The information you provide will serve to determine your eligibility for and the conditions of the insurance you requested. This is commonly referred to as «underwriting» and is a critical step in the processing of your application for insurance.

DETACH HERE

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER (…continued)

The interviewer will ask you questions regarding your health, your alcohol consumption, your use of drugs and tobacco, your driving record, sporting activities, travel outside of Canada, your employment, your finances and other questions concerning your insurability. Please allow 25 minutes for the interview.

To best prepare for the interview please have the following information ready beforehand:

- The name and address of your attending or personal physician;
- The names of all health professionals you consulted over the past 2 years;
- The date of your last medical consultation;
- A list of medications you are currently taking;
- Your height and weight;
- The age and state of health of your parents and siblings.

The more precise your responses to the questions, the quicker your application can be processed. The accuracy and sincerity of your responses are a legal requirement. A misrepresentation can result in the cancellation of your policy.

If required, a nurse will meet with you in the days following your interview, to collect fluids for testing and to take your physical measurements (height, weight, pulse, blood pressure).

When you receive your policy you must read the transcription of your responses to the questions of the telephone interview and immediately inform Humania Assurance Inc. of any omission, false or inaccurate information.

Notice Concerning Files and Personal Information

In order to ensure the confidentiality of the personal information held concerning you, Humania Assurance Inc., will establish a file in which the information concerning your application for insurance and information concerning any insurance claim will be held.

Access to this file will be restricted to Humania Assurance employees, reinsurers or mandatories who will be responsible for underwritting, administration, investigation and claims, or any other person designated or authorized by you. Your file will be kept at the Company's head office.

You are entitled to examine the personal information contained in this file and, if required, to have the information corrected by submitting a written request to the address below:

Access to Information Officer, Humania Assurance, 1555, Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6.

Please be informed that, in the regular process of examining your application, Humania Assurance may request an investigation report to gather information based on personal interviews with your acquaintances. The investigation may cover your reputation, lifestyle and finances. A representative of the company retained to prepare these reports may also visit or telephone you.

PART 18 - Deposit Receipt

N°:

A deposit does not confer any insurance coverage by virtue of the Conditional Insurance Agreement if any of its conditions are not respected.

Received the sum of 00 $ ( )

As a deposit only for an application submitted to Humania Assurance Inc., for disability, life or critical illness coverage of the Insured

Dated on 20

Signed at on 20

Signature of Advisor/Representative

Humania Assurance Inc.

1555, Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6
Web site: www.humania.ca

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