

FINAL PROTECTION[®] Simple Issue Whole Life

DATA COLLECTION WORKSHEET

The following worksheet will help you determine whether your client qualifies for Final Protection. You can use it to gather the information necessary to complete and submit the electronic application. If you choose to use this worksheet, you should have your client review, verify, and sign it.

PRE-SCREENING CHECKLIST

Does your client qualify? The shaded boxes indicate qualifying questions. **If any response falls outside of a shaded box, your client does not qualify for Final Protection.** Consider presenting another Equitable Life product which is fully underwritten.

CLIENT/COVERAGE			
Premium Mode	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly PAD		
Face Amount Specified or Total Premium (Solve for Face Amount.)			
First Name / Initial			
Last Name			
Previous Last Name (optional)			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth (dd/mm/yyyy) Must be age 40 to 80, age nearest			
Country of Birth			
Occupation & Duties (if retired, indicate former occupation)			
		Yes	No
Have you used any tobacco, nicotine or marijuana product, or smoking cessation aids in the 12 months preceding the application?			
Are you a Canadian citizen or do you have permanent resident status in Canada?			
Do the Owner(s) and Person to be insured currently reside in Canada?			
Do the Owner(s) and Person to be insured understand the language that this application is written in?			Go to A
A. Will someone be translating the application to a language that the Owner(s) and Person to be insured understand?	Go to B		
B. What is the relationship of the person who will translate?			
<input type="checkbox"/> Advisor <input type="checkbox"/> Family Member <input type="checkbox"/> Other			

STATEMENT OF HEALTH		
	Yes	No
1. In the past two (2) years, have you had an application for life insurance (other than group insurance or group mortgage insurance) rejected or postponed?		
2. Are you presently hospitalized, in a nursing facility, bedridden or confined to a wheelchair, or have you been advised that this is required due to your present condition?		
3. In the past two (2) years, have you had an amputation as a result of disease?		
4. In the past two (2) years, have you been diagnosed, hospitalized, treated (other than by medication) or are you presently under investigation for any of the following conditions: a) Angina, heart attack, heart failure, or cardiomyopathy? b) Cancer (other than basal cell carcinoma)? c) Leukemia? d) Lymphoma? e) Chronic kidney disease?		
5. In the past two (2) years, have you been prescribed a new medication or required an increase in dosage in your medication for any of the following conditions: a) Angina, heart attack, heart failure, or cardiomyopathy? b) Cancer (other than basal cell carcinoma)? c) Leukemia? d) Lymphoma? e) Chronic kidney disease?		
6. In the past two (2) years have you been diagnosed or hospitalized for: a) Chronic respiratory condition that required the administration of oxygen? b) Liver disease (other than fatty liver)? c) Diabetic coma or insulin shock? d) Cerebrovascular accident (stroke)?		
7. In the past five (5) years have you received an organ transplant or bone marrow transplant or were you advised that one was required?		
8. In the past five (5) years have you had a cancer reoccurrence or cancer diagnosed in more than one location of your body?		
9. Have you ever tested positive for HIV or undergone treatments (including medication) for AIDS or AIDS-related complex?		
10. Have you ever been diagnosed or treated (including medication) for any of the following conditions: amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease or dementia?		
11. Have you been diagnosed or treated for any incurable terminal illness, for which you have been advised that you have less than 12 months' life expectancy?		

If your client qualifies for Final Protection, collect the remaining information outlined in this Data Collection Worksheet and **proceed with the electronic application**. You will also need 1) a Simple Issue Application Authorization Form (1344) completed and signed by the client and 2) payment (VOID cheque for monthly PAD or cheque for first annual premium). For more information go to www.advisor.equitable.ca

ADDRESS	
Address (including City, Province and Postal Code)	
Home/Mobile Telephone	
Work Telephone (optional)	
E-mail (optional)	
OWNER	
If the policy is to be co-owned, the information in this section must be provided for both owners.	
Owner/Applicant	<input type="checkbox"/> Client 1..... <input type="checkbox"/> Other Person
Title (optional)	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.
Social Insurance Number	
Preferred Language of correspondence	<input type="checkbox"/> English <input type="checkbox"/> French
Are you a tax resident of Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a tax resident or citizen of the United States? If yes, list your US Taxpayer Identification Number (TIN) or provide a reason for not having a TIN.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a tax resident in a jurisdiction other than Canada or the United States? If yes, provide your jurisdiction of tax residence (country) and your Taxpayer Identification Number (TIN)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Owner is Other Person	
First Name / Last Name	
Social Insurance Number	
Preferred Language of correspondence	<input type="checkbox"/> English <input type="checkbox"/> French
Date of Birth (dd/mm/yyyy)	
Occupation & Duties (if retired, indicate former occupation)	
Address (including City, Province and Postal Code)	
Home/Mobile Telephone	
Work Telephone (optional)	
E-mail (optional)	
Relationship to Insured	

VERIFICATION OF ID

If the policy is to be co-owned, the information in this section must be provided for both owners.

Canadian identification must be verified by the advisor. Choose one of the following: driver's license, provincial photo card (excluding provincial health cards), passport, citizenship card, permanent resident card, or certificate of Indian status card. If you do not have one of the pieces of identification indicated, please go to www.equitable.ca/go/alternative-identification for information on our alternative identification requirements.

Identification Type	_____	Expiry Date	_____
Identification Number	_____	Date Advisor Verified	_____
Issuing Jurisdiction/Country	_____		

Upon proceeding with the electronic application, you will be asked to select one of the following options to indicate if client identification was suitably verified.

- I, the advisor, have held and viewed the original photo identification of the owner.
- I, the advisor, have followed the alternative identification instructions, including reviewing two original documents as set out in the instructions. Copies of the two documents are attached with this application.

If this application is being completed non-face-to-face, you will later be asked on the *Advisor Declaration* tab to indicate if the client's information was obtained via telephone, Skype, etc. Equitable Life head office will validate owner ID after the application is submitted.

TENANTS IN COMMON

In all provinces, **except Quebec**, if a policy is owned by more than one owner, policy ownership will be joint tenants with right of survivorship, so a deceased owner's interest will automatically pass to the surviving owner(s) on their death. If you want policy ownership to be tenants in common instead of joint tenants with right of survivorship, select tenants in common by ticking the box below.

- I/we stipulate tenants in common policy ownership.

In Quebec, if a policy is to be owned by more than one owner and one of the owners die, that owner's interest will pass to their estate.

BANKING	
Payor	<input type="checkbox"/> Client 1 <input type="checkbox"/> Owner <input type="checkbox"/> Other Person
Account Holder(s) Name(s) as shown on cheque (cannot be a Corporation)	
Complete for monthly premium mode only (PAD) Note: The first payment will be taken on receipt of the Authorization Form. Subsequent payments will be taken on the same day each month as indicated.	<input type="checkbox"/> Establish new PAD (VOID cheque required) <ul style="list-style-type: none"> <input type="checkbox"/> Match Issue Date <input type="checkbox"/> Preferred Withdrawal Date _____ (indicate 1st to 28th of each month) <input type="checkbox"/> Use existing PAD <ul style="list-style-type: none"> <input type="checkbox"/> Equitable Policy Number _____ <input type="checkbox"/> Add to existing PAD date <input type="checkbox"/> Preferred Withdrawal Date _____ (indicate 1st to 28th of each month)
Source of funds	
Reason for purchasing the policy	
If Payor is Other Person	
Account Holder(s) Name(s) as shown on cheque (cannot be a Corporation)	
Date of Birth (dd/mm/yyyy)	
Occupation & Duties (if retired, indicate former occupation)	
Address (including City, Province and Postal Code)	
Relationship to owner	

The statements and answers in all parts of this *Data Collection Worksheet* are true, complete and correctly recorded as at the date I sign this *Data Collection Worksheet*.

Life insured's signature

Date

Owner's signature

Date

NOTE: Do not submit the *Data Collection Worksheet* with your application. Retain it for your records.

For more information go to www.advisor.equitable.ca

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