LIVING PROTECTION™ Simple issue critical illness insurance

DATA COLLECTION WORKSHEET

The following worksheet will help you determine whether your client qualifies for Living 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 Living Protection.** Consider presenting another Equitable Life product which is fully underwritten.

CLIENT/COVERAGE		
Plan Type	❑ 10 year renewable to age 75	❑ Level to age 75
Premium Mode	❑ Annual Cheque	❑ Monthly PAD
Face Amount or Total Premium (Solve for Face Amount.)	$	
Riders	❑ Return of Premiums at Expiry	❑ Return of Premiums on Death
First Name / Initial		
Last Name		
Previous Last Name (optional)		
Sex	❑ Male	❑ Female
Date of Birth (dd/mm/yyyy)		
Country of Birth		
Occupation & Duties (if retired, indicate former occupation)		
	Yes	**No**
Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids, or smoked marijuana or hashish within the last 12 months?		
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? ❑ Advisor ❑ Family Member ❑ Other		

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Equitable Life of Canada®
Works for me.™

STATEMENT OF HEALTH		
	Yes	No
1. In the past two (2) years, have you had an application for critical illness insurance or life insurance declined or postponed or modified in any way?		
2. Do you currently suffer from, or have you ever suffered from, or had symptoms of, or have consulted a doctor for, or been treated for, any of the following: a) Coronary artery disease, angina, shortness of breath, chest pain, angioplasty, bypass, heart surgery, heart attack, stroke, transient ischemic attack (TIA) or any other cerebrovascular disease or disease of the heart or the blood vessels? b) Diabetes, abnormal blood sugar, abnormalities of the thyroid, pituitary, lymph or adrenal glands, chronic kidney disease or endocrine disorder? c) Cancer or other malignant disease such as leukemia or lymphoma, or tumor, abnormal PAP test (without a follow up normal test), or recurrent colon polyps (without a follow up normal colonoscopy)? d) AIDS, HIV or AIDS-related illness, persistently enlarged lymph glands, chronically abnormal blood work or any immunological disorder? e) Hepatitis B or C (including hepatitis B carrier state), abnormal liver function tests, biopsy or ultrasound results or any form of liver disease?		
3. In the last 5 years have you suffered from, or had symptoms of, or have consulted a doctor for, or been treated for any of the following: a. Breast disease or disorder, breast mass, breast cyst, abnormal mammogram or breast biopsy or undiagnosed breast pain or prostate disorder, prostate nodule or abnormal PSA or ultrasound results? b. Crohn's, ulcerative colitis, persistent, undiagnosed abdominal pain, rectal bleeding, or any other disorder of the colon, rectum, stomach or esophagus other than esophageal reflux or ulcer controlled with medication or irritable bowel?		
4. In the last 5 years have you: a) Been counseled, treated for or joined or been advised to join an organization or program due to alcohol or drug use? b) Used narcotics, cocaine, heroin, morphine, Demerol, LSD, hashish, hallucinogens, amphetamines, barbiturates, tranquilizers, or anabolic steroids or any drugs not prescribed by a licensed physician, or methadone whether prescribed by a physician or not?		
5. Do you have any symptoms or complaints for which you are being investigated, are under observation or treatment, or for which you are awaiting investigation or test results? (Exclude normal pregnancy, cold, flu, musculoskeletal injuries or routine checkups for which no follow up is required.)		
6. Have 2 or more of your immediate family members (mother, father, brother or sister) been diagnosed with or treated for, heart disease, aneurysm, stroke, polycystic kidney disease, or cancer prior to age 60.		

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STATEMENT OF HEALTH continued

	Yes	No
7. Does your current weight exceed the weight indicated for your height in the table below?		

Height (in)	Weight max. (lbs)	Height (cm)	Weight max (kgs)
56	174	142	79
57	180	145	82
58	186	147	84
59	196	150	88
60	199	152	90
61	206	155	93
62	213	157	97
63	220	160	100
64	227	163	103
65	234	165	106
66	241	168	109
67	249	170	113
68	256	173	116
69	264	175	120
70	272	178	123
71	279	180	127
72	287	183	130
73	295	185	134
74	303	188	137
75	312	190	142
76	320	193	145
77	329	196	149
78	337	198	153

If your client qualifies for Living 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).

ADDRESS

	Client
Address (including City, Province and Postal Code)	
Home/Mobile Telephone	
Work Telephone (optional)	
E-mail (optional)	

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OWNER					
If the policy is to be co-owned, the information in this section must be provided for both owners.					
Owner/Applicant	❑ Client	❑ Other person			
Title (optional)	❑ Mr.	❑ Mrs.	❑ Ms.	❑ Miss	❑ Dr.
Social Insurance Number (optional)					
Preferred Language of correspondence	❑ English	❑ French			
If Owner is someone other than client					
First Name / Last Name					
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			
Co-Owner/Contingent Owner	❑ Client	❑ Other Person ❑ Contingent Owner			
Title (optional)	❑ Mr.	❑ Mrs.	❑ Ms.	❑ Miss	❑ Dr.
Social Insurance Number (optional)					
If Co-Owner / Contingent Owner is Other Person					
First Name / Last Name					
Date of Birth (dd/mm/yyyy)					
Occupation & Duties (if retired, indicate former occupation)					
Address (including City, Province & Postal Code)					
Home/Mobile Telephone		Work Telephone (optional)			
E-mail (optional)		Relationship to Insured			
If Co-Owner / Contingent Owner is Contingent Owner					
First Name / Last Name					
Relationship to Insured					

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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 survivor ship, 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	❑ Client ❑ Co-Owner ❑ Owner ❑ Other Person
Account Holder(s) Name(s) as shown on cheque	(cannot be a Corporation)
Complete for monthly premium mode only (PAD)	❑ Establish new PAD (VOID cheque required) ❑ Match Issue Date ❑ Preferred Withdrawal Date ________ (Indicate 1st to 28th of each month) ❑ Use existing PAD Equitable Policy Number ____________ ❑ Add to existing PAD Date ❑ Preferred Withdrawal Date ________ (Indicate 1st to 28th of each month)
If Payor is Other Person	
Date of Birth (dd/mm/yyyy)	
Occupation & Duties (if retired, indicate former occupation)	
Address (including City, Province and Postal Code)	
Relationship to Owner	
Source of Funds	
Reason for purchasing the policy	

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