UV INSURANCE

Application

Individual Insurance

Life and Critical Illness Insurance

UNDERWRITING REQUIREMENTS

It is now possible to complete our electronic application for all of our Permanent and Term Life insurance products, according to the requirements specified in the age and coverage amount tables below. You can access the electronic application by logging into **My Universe** via **uvinsurance.ca**.

Permanent Life Insurance (Whole Life High Values, Adaptable and Whole Life Pay to 100)

Application	Amount	Age									
		0 to 15	16 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65	66 to 70	71 to 80
Electronic - Interactive (PDF) or paper accepted (with PDF eligibility questionnaire)	**$10,000 - $150,000**	Express (Whole Life High Values 0-75 — Adaptable 0-75 — Whole Life Pay to 100 18-80)									
Electronic, Interactive (PDF) or paper	**$150,001 - $350,000**	1	1	1	1	1	1	4	4	5	5A
	$350,001 - $500,000	1	1	1	1	3	4	4	5	5	5A
	$500,001 - $1,000,000	13	4	4	4	4	5	5	5	5	5A
	$1,000,001 - $2,000,000	13	4	4	4	5	5	5	5	5	5A
	$2,000,001 - $5,000,000	13	4	4	5	5	5	5	5	7	7A
	More than $5,000,000	8	8	8	8	8	8	8	8	8	8A

Term Life Insurance Superior+ (T-10, T-15 and T-20 | 18-65 years) (T-25 | 18-60 years) (T-30 | 18-55 years)

Application	Amount	Age						
		18 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65
Electronic - Interactive (PDF) or paper accepted (with PDF eligibility questionnaire)	**$10,000 - $150,000** (T-10 | T-15) $25,000 - $150,000	Express						
	$150,001 - $250,000	Immediate						
	$250,001 - $350,000	Immediate					4	4
	$350,001 - $499,999	Immediate			3	4	4	5
Electronic, interactive (PDF) or paper	**$500,000 - $999,999 ***	4	4	4	4	5	5	5
	$1,000,000 - $1,999,999 *	4	4	4	5	5	5	5
	$2,000,000 - $5,000,000 *	4	4	5	5	5	5	5
	More than $5,000,000 *	8	8	8	8	8	8	8

***** Preferred and super preferred premiums available

Juvenile 30/100

Application	Amount	Age
		0 to 15
Electronic - Interactive (PDF) or paper accepted (with PDF eligibility questionnaire)	**$100,000**	Express

Critical Illness Insurance (AdapCi)

Application	Amount	Age							
		0 to 15	16 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65
Electronic, interactive (PDF) or paper	**$0 - $99,999**	1	1	1	1	1	9	9	9
	$100,000 - $250,000	1	3	3	3	3	9	9	10
	$250,001 - $500,000	13	4	4	4	4	10	10	10
	$500,001 - $999,999	13	4	4	5	5	11	11	11
	$1,000,000 or more	13	6	6	6	6	12	12	12

LEGEND

1) Tele interview
2) Paramedical
3) Paramedical with urine
4) Paramedical with full blood profile
5) Paramedical with full blood profile and electrocardiogram
6) Medical exam with full blood profile and electrocardiogram
7) Paramedical with full blood profile and stress ECG
8) Preliminary Application to submit to the head office
9) Paramedical, full blood profile and prostate specific antigen
10) Paramedical, full blood profile, prostate specific antigen and electrocardiogram
11) Medical exam, full blood profile, prostate specific antigen, electrocardiogram and chest-x-ray (for smokers and ex-smokers for 2 years or less)
12) Medical exam, full blood profile, prostate specific antigen, stress ECG and chest-x-ray (for smokers and ex-smokers for 2 years or less)
13) At the discretion of the underwriter

A) "Individuals over 70 years of age" questionnaire EQC082

To determine underwriting requirements, add to the new application all life insurance requests (application under review or contract issued) submitted to UV Insurance or other insurance companies within the last 12 months and still in force.

UV Insurance reserves the right to request any additional requirements in relation to the risk assessment.

Use of french: UV Insurance must ensure compliance with the Act respecting French, the official and common language of Québec. As an advisor, you must present the documentation in French to your English-speaking Québec client. As you are the one completing this electronic application, you must obtain his express wish to proceed in English after presenting him with the French documentation.

☐ My client is francophone ☐ My client doesn't reside in Quebec

☐ I certify that I have provided my client, who resides in Québec, with a copy of the application in French before its signature in English. After examining such version, my client requests that the contract herein and any other related documentation be presented in English. It is his express wish to be bound by the English version of this application only and for all related documents to be drafted in English only.

0

Generate a New Application Number

SECTION A – PROPOSED INSURED(S)

Insured 1

1. First Name _____ Middle Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Nearest Age [ ] **4.** Age in the Contract [ ]

5. Civil Status _____ **6.** Sex ☐ M ☐ F **7.** Smoking Status ☐ Smoker ☐ Non-smoker

8. Country of Birth _____ **9.** Province of Birth _____ **10.** Since when in Canada [Y Y Y Y M M]

11. ☐ Canadian citizen ☐ Permanent resident ☐ American for U.S. tax purposes
☐ Tax resident in a tax jurisdiction other than Canada or the United States

12. Primary Address _____ City _____
Province _____ Country _____ Postal Code [ ]

13. Email _____

14. Tel. nº1 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

15. Tel. nº2 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

16. ☐ Same Mailing Address as Primary Address
Mailing Address _____ City _____
Province _____ Country _____ Postal Code [ ]

17. Are you currently working? ☐ Yes (answer question A) ☐ No (answer question B)
A) Occupation _____ Employer _____ Since when [Y Y Y Y M M]

B) Reason _____ Since when [Y Y Y Y M M] If Student, School Level _____

Before stopping: Occupation _____ Employer _____ Since when [Y Y Y Y M M]

18. What is your total gross annual income? _____ $

Insured 2 (Only for joint insurance)

1. First Name _____ Middle Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Nearest Age [ ] **4.** Age in the Contract [ ]

5. Civil Status _____ **6.** Sex ☐ M ☐ F **7.** Smoking Status ☐ Smoker ☐ Non-smoker

8. Country of Birth _____ **9.** Province of Birth _____ **10.** Since when in Canada [Y Y Y Y M M]

11. ☐ Canadian citizen ☐ Permanent resident ☐ American for U.S. tax purposes
☐ Tax resident in a tax jurisdiction other than Canada or the United States

12. Primary Address _____ City _____
Province _____ Country _____ Postal Code [ ]

13. Email _____

14. Tel. nº1 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

15. Tel. nº2 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

16. ☐ Same Mailing Address as Primary Address
Mailing Address _____ City _____
Province _____ Country _____ Postal Code [ ]

17. Are you currently working? ☐ Yes (answer question A) ☐ No (answer question B)
A) Occupation _____ Employer _____ Since when [Y Y Y Y M M]

B) Reason _____ Since when [Y Y Y Y M M] If Student, School Level _____

Before stopping: Occupation _____ Employer _____ Since when [Y Y Y Y M M]

18. What is your total gross annual income? _____ $

SECTION B – OWNER(S)

Owner 1

Same as Insured 1 ☐

Contract Ownership _____ % ☐ Individual ☐ Legal entity

Note: If there is more than one owner and the ownership % is not specified, we consider the ownership % to be divided equally.

1. First Name _____ Middle Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Civil Status _____ **4.** Sex ☐ M ☐ F

5. Relationship to Proposed Insured _____

6. Country of Birth _____ **7.** Province of Birth _____ **8.** Since when in Canada [Y Y Y Y M M]

9. ☐ Canadian citizen ☐ Permanent resident ☐ American for U.S. tax purposes
☐ Tax resident in a tax jurisdiction other than Canada or the United States

10. Full Corporate Name _____

11. Primary Address _____ City _____
Province _____ Country _____ Postal Code [ ]

12. Business Number (NEQ or BN) _____ Email _____

13. Tel. nº1 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

14. Tel. nº2 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

15. ☐ Same Mailing Address as Primary Address
Mailing Address _____ City _____
Province _____ Country _____ Postal Code [ ]

16. Occupation _____ **17.** Employer _____

Owner 2

Same as Insured 2 ☐

Contract Ownership _____ % ☐ Individual ☐ Legal entity

Note: If there is more than one owner and the ownership % is not specified, we consider the ownership % to be divided equally.

1. First Name _____ Middle Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Civil Status _____ **4.** Sex ☐ M ☐ F

5. Relationship to Proposed Insured _____

6. Country of Birth _____ **7.** Province of Birth _____ **8.** Since when in Canada [Y Y Y Y M M]

9. ☐ Canadian citizen ☐ Permanent resident ☐ American for U.S. tax purposes
☐ Tax resident in a tax jurisdiction other than Canada or the United States

10. Full Corporate Name _____

11. Primary Address _____ City _____
Province _____ Country _____ Postal Code [ ]

12. Business Number (NEQ or BN) _____ Email _____

13. Tel. nº1 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

14. Tel. nº2 ☐ Cell ☐ Home ☐ Office [ ] [ ]-[ ], ext. _____ Availability ☐ AM ☐ PM ☐ Evening

15. ☐ Same Mailing Address as Primary Address
Mailing Address _____ City _____
Province _____ Country _____ Postal Code [ ]

16. Occupation _____ **17.** Employer _____

Owner 1	Owner 2	Communications, documents and contracts to the contract owner
		Note: The delivery requirements kit is always sent in an **electronic format** to the MGA and the advisor on the MY UNIVERSE portal.
☐	☐	**Electronic delivery of the contract** The contract and communications relating to the contract will be sent to the contract owner on the **MY UNIVERSE** portal.
☐	☐	**Paper contract delivery** The contract and communications relating to the contract will be sent in hard copies to the contract owner through the MGA and the advisor.
☐	☐	**Electronic contract delivery and Hard copy** The contract and communications relating to the contract will be sent in hard copies and will also be available on the **MY UNIVERSE** portal.
☐	☐	This owner wants to receive **UV Insurance**'s newsletter.

ⓘ Please note that the contract and all related communications are available at all times via **MY UNIVERSE**, for online reference as well as in PDF format.

Company Information

The information required below is intended to verify whether the insurance amount requested is in relation to the company's value and the position held by the proposed insured.

If the owner is a legal entity, complete the section below:

1. Is the applicant the president, secretary and majority shareholder of the company? ☐ Yes ☐ No
   If yes, we authorize this person to sign the application on behalf of the company.
   If no, please provide a Resolution of the Board of Directors authorizing this person to act on behalf of the company on this insurance application and the contract that may arise from it. Please use our standard form (EQC088-Resolution of the Board of Directors - Certified Copy).
2. Purpose of Insurance ☐ Buy/Sell Agreement ☐ Key person protection ☐ Loan guarantee ☐ Other _____
3. How long has the company existed? _____ year(s)
4. What is the company's net worth? $_____
5. What is the company's market value? $_____
6. Net income for the last two (2) years $_____ 20[ ][ ] year 1, $_____ 20[ ][ ] year 2
7. What is the proposed insured's share in the company? _____ %
8. What is the commercial life insurance amount held by each shareholder/partner?

Name of Shareholder/Partner	Insurance Amount	Share %	Name of Shareholder/Partner	Insurance Amount	Share %
1.			3.		
2.			4.		

CONTINGENT OWNER

The contingent owner will become the contract owner following the death of the owner to whom he/she is related. If you wish to name more than one contingent owner, please complete the **EQC079**.

Identification of Contingent Owner

To replace: ☐ Owner 1 ☐ Owner 2

1. First Name _____ Middle Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Civil Status _____ **4.** Sex ☐ M ☐ F

5. Relationship to Proposed Insured _____

6. Country of Birth _____ **7.** Province of Birth _____ **8.** Since when in Canada [Y Y Y Y M M]

9. ☐ Canadian citizen ☐ Permanent resident ☐ American for U.S. tax purposes
☐ Tax resident in a tax jurisdiction other than Canada or the United States

10. Full Corporate Name _____

11. Primary Address _____ City _____
Province _____ Country _____ Postal Code [ ]

12. Business Number (NEQ or BN) _____ Email _____

13. Main Telephone [ ][ ]-[ ], ext. _____ ☐ Cell phone ☐ Home ☐ Office

14. Best Time for Contact ☐ AM ☐ PM ☐ Evening

15. Other Telephone [ ][ ]-[ ], ext. _____ ☐ Cell phone ☐ Home ☐ Office

16. ☐ Same Mailing Address as Primary Address
Mailing Address _____ City _____
Province _____ Country _____ Postal Code [ ]

SECTION C – BENEFICIARY(IES)

LIFE INSURANCE

Important: In the province of Quebec, in the absence of choice on question 6, a married or civil union spouse designation is irrevocable and any other beneficiary designation is revocable. The contingent beneficiary designation is always revocable. The contingent beneficiary will become a contract beneficiary following the death of the beneficiary to whom he/she was related.

Beneficiary 1

☐ Insured 1 ☐ Insured 2
☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Sex ☐ M ☐ F

4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable

7. For a legal entity, please provide the business number (NEQ or BN) _____

8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 1

1. First Name _____ Last Name _____

2. Date of Birth [Y Y Y Y M M D D] **3.** Sex ☐ M ☐ F

4. Relationship to Proposed Insured _____

5. For a legal entity, please provide the business number (NEQ or BN) _____

6. Full Corporate Name _____

Beneficiary 2

☐ Insured 1 ☐ Insured 2
☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 2

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

Beneficiary 3

☐ Insured 1 ☐ Insured 2
☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 3

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

Beneficiary 4

☐ Insured 1 ☐ Insured 2
☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 4

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

CRITICAL ILLNESS

Beneficiary for the insurance amount for critical illness

If no beneficiary is designated, any insurance amount for critical illness resulting from a covered illness or condition as per the critical illness contract will be paid to the owner(s).

Beneficiary

☐ The insured ☐ The owner(s) ☐ Other (fill out below)

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

Beneficiary(ies) in the event of the death of the proposed insured (payment of premiums paid)

Beneficiary 1

☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 1

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

Beneficiary 2

☐ Legal heirs ☐ Other (fill out below)
☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable
7. For a legal entity, please provide the business number (NEQ or BN) _____
8. Full Corporate Name _____

CONTINGENT BENEFICIARY TO BENEFICIARY 2

1. First Name _____ Last Name _____
2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F
4. Relationship to Proposed Insured _____
5. For a legal entity, please provide the business number (NEQ or BN) _____
6. Full Corporate Name _____

SECTION D – PERMANENT LIFE AND CRITICAL ILLNESS INSURANCE COVERAGES

TYPES OF ISSUE

Please refer to the underwriting requirements table to confirm the requested coverage amount corresponds with the desired type of issue.

LIFE INSURANCE

Underwriting Requirements Table

☐ **Refer to the illustration** Note: If you check this box, you do not need to complete this part but an endorsement is to be signed for the contract to come into force.

Joint Insurance ☐ First to die ☐ Last to die

1. a) Basic Coverage	Insurance Amount
PERMANENT LIFE	
Adaptable (20 years payments minimum)	
Payable: ☐ For 20 years or until: ☐ 25 ☐ 35 ☐ 45 ☐ 55 ☐ 65 ☐ 75 ☐ 85	
▶ Chapter A — Initial insurance amount	$_____
▶ Chapter B — Deferred paid-up insurance amount	$_____
Whole Life Pay to 100	$_____
Whole Life High Values (20-Pay Only)	$_____
TERM LIFE	
T-10 Superior+*	$_____
T-15 Superior+*	$_____
T-20 Superior+*	$_____
T-25 Superior+*	$_____
T-30 Superior+*	$_____
Juvenile 30/100	$_____
_____	$_____
Total insurance amounts for the requirements	

1. b) Additional Coverages

WAIVER OF PREMIUM

In the Event of...	Insured	Owner	Payer
Disability	☐	☐	☐
Disability or Death		☐	☐
Loss of Empl.	☐	☐	☐

Name of Payer _____

☐ **Acc. Death and Dismemberment** — Ins. amount $_____

☐ **Accidental Fracture**

☐ **Credit Insurance Rider**
Coverage Option ☐ 2 years ☐ 5 years ☐ To age 65
Amount $_____/month

☐ **Preapproved Critical Illness Insurance**
$1,000 monthly benefit up to 24 months

CRITICAL ILLNESS INSURANCE

☐ **Refer to the illustration** Note: If you check this box, you do not need to complete this part but an endorsement is to be signed for the contract to come into force.

2. a) Basic Coverage	Insurance Amount
AdapCI (20 years payments minimum)	
Payable: ☐ For 20 years or until: ☐ 25 ☐ 35 ☐ 45 ☐ 55 ☐ 65 ☐ 75 ☐	
▶ Chapter A — Initial insurance amount	$_____
▶ Chapter B — Deferred paid-up insurance amount	$_____
Total insurance amounts for the requirements	

2. b) Additional Coverages

WAIVER OF PREMIUM

In the Event of...	Insured	Owner	Payer
Disability	☐	☐	☐
Disability or Death		☐	☐
Loss of Empl.	☐	☐	☐

Name of Payer _____

☐ **Accidental Fracture**

An insured may hold more than one simplified issue life insurance product. However, the total sum insured for all of these products cannot exceed the maximum allowed based on age. Please refer to the table above for details.

EARLY LEARNING: Use the EARLY LEARNING application available in the portal **MY UNIVERSE** and in the section Resources for Advisors via **uvinsurance.ca.**
*Preferred and Super Preferred premiums are available for T-10, T-15, T-20, T-25 and T-30 for eligible insurance amounts, as indicated on the requirements table.

SECTION E – CREDIT INSURANCE RIDER

Insured 1

REQUESTED COVERAGE

Table of Loans to be Insured					
Loan to Insure	Balance	Monthly Payment	Loan Already Insured	To Replace	Name of Insurer
Personal mortgage loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal mortgage line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Motor vehicle loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Student loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Lease	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial mortgage loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
	$	$	☐ Yes ☐ No	☐ Yes ☐ No	

APPLICANT INFORMATION

1. What is your current status? ☐ Salaried employee ☐ Self-employed ☐ Stay at home spouse ☐ Parental leave

2. Name of your employer or business _____
Address _____ City _____
Province _____ Country _____ Postal Code |_|_|_| |_|_|_|

3. Nature of business (sector of activity) _____

4. If self-employed, what is the % of your shares in the business? _____ %

5. Number of years with your employer or self-employed _____ year(s)

6. Number of hours worked per week _____ hour(s)

7. Number of weeks worked per year _____ week(s)

8. Number of years in a similar business _____ year(s)

9. Briefly describe your tasks _____

10. What percentage of your work is considered manual? _____ %

11. Do you work from home? ☐ Yes ☐ No
If yes, confirm the number of hours worked from home per week _____ hour(s)

12. Do you have income replacement insurance with your employer? ☐ Yes ☐ No
If yes, name of insurer _____
_____ % of income ☐ In force ☐ Pending

Insured 2

REQUESTED COVERAGE

Table of Loans to be Insured					
Loan to Insure	Balance	Monthly Payment	Loan Already Insured	To Replace	Name of Insurer
Personal mortgage loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal mortgage line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Personal loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Motor vehicle loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Student loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Lease	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial mortgage loan	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
Commercial line of credit	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
	$	$	☐ Yes ☐ No	☐ Yes ☐ No	
	$	$	☐ Yes ☐ No	☐ Yes ☐ No	

APPLICANT INFORMATION

1. What is your current status? ☐ Salaried employee ☐ Self-employed ☐ Stay at home spouse ☐ Parental leave
2. Name of your employer or business _____
   Address _____ City _____
   Province _____ Country _____ Postal Code |_|_|_| |_|_|_|
3. Nature of business (sector of activity) _____
4. If self-employed, what is the % of your shares in the business? _____ %
5. Number of years with your employer or self-employed _____ year(s)
6. Number of hours worked per week _____ hour(s)
7. Number of weeks worked per year _____ week(s)
8. Number of years in a similar business _____ year(s)
9. Briefly describe your tasks _____
10. What percentage of your work is considered manual? _____ %
11. Do you work from home? ☐ Yes ☐ No
    If yes, confirm the number of hours worked from home per week _____ hour(s)
12. Do you have income replacement insurance with your employer? ☐ Yes ☐ No
    If yes, name of insurer _____
    _____ % of income ☐ In force ☐ Pending

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SECTION F – CHILD RIDER (LIFE INSURANCE)

Identification of Child(ren)

Child Rider (life insurance) ☐ Yes ☐ No

If yes, please complete the following table:

Child(ren)	Last Name, First Name	Born	Height		Weight		Sex	School Level	Relationship to Contract Owner
			ft. in.	m. cm.	lb	kg			
1		Y Y Y Y M M D D					☐ M ☐ F		
2		Y Y Y Y M M D D					☐ M ☐ F		
3		Y Y Y Y M M D D					☐ M ☐ F		
4		Y Y Y Y M M D D					☐ M ☐ F		

Beneficiary 1

☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____

2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F

4. Relationship of Owner to Child _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable

CONTINGENT BENEFICIARY TO BENEFICIARY 1

1. First Name _____ Last Name _____

2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F

4. Relationship of Owner to Child _____

Beneficiary 2

☐ With accretion upon the death of the beneficiary

1. First Name _____ Last Name _____

2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F

4. Relationship of Owner to Child _____ **5.** Beneficiary _____ % **6.** ☐ Revocable ☐ Irrevocable

CONTINGENT BENEFICIARY TO BENEFICIARY 2

1. First Name _____ Last Name _____

2. Date of Birth Y Y Y Y M M D D **3.** Sex ☐ M ☐ F

4. Relationship of Owner to Child _____

SECTION F – CHILD RIDER (LIFE INSURANCE) CONTINUED

0

Health Questionnaire	Child 1	Child 2	Child 3	Child 4
1. Has an application for this child to be insured already been declined, postponed or changed in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. If the child to be insured is under 12 months old, was the birth premature by more than four (4) weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Does the child to be insured suffer from: Cystic fibrosis, cerebral palsy, muscular dystrophy, intellectual disability, autism, Asperger's syndrome, pervasive developmental disorder (PDD) or trisomy 21?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Does the child to be insured suffer from a disease or a condition requiring daily or weekly treatment and/or regular medical follow-ups, other than: attention deficit disorders with or without hyperactivity (ADD/ADHD), asthma, otitis, cold, flu or benign skin conditions?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. **In the last six (6) months:**				
a) Has the child to be insured been hospitalized?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Did a physician mention abnormal results following a diagnostic test on the child to be insured?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Did a physician advise the child to be insured to undergo a diagnostic test, a special test, or any surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Did a physician advise the child to be insured to consult another physician, a specialist, or to undergo a medical investigation that has not yet been done?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

For all affirmative answers, please complete the following table:

Child(ren)	Question #	Date	Reason	Relevant details for the question
☐ 1 ☐ 2 ☐ 3 ☐ 4		Y Y Y Y M M D D		
☐ 1 ☐ 2 ☐ 3 ☐ 4		Y Y Y Y M M D D		
☐ 1 ☐ 2 ☐ 3 ☐ 4		Y Y Y Y M M D D		
☐ 1 ☐ 2 ☐ 3 ☐ 4		Y Y Y Y M M D D		

SECTION G – CONVERSION AND EXCHANGE PRIVILEGES

Specific Instructions

1. **Conversion Privilege** – Contract # _____

   Note: If you want to make changes to the owner(s) and beneficiary(ies), please complete the appropriate form(s) (EQC090).

2. **Exchange Privilege** – Contract # _____

   Note: If you want to make changes to the owner(s) and beneficiary(ies), please complete the appropriate form(s) (EQC090).

3. Further Instructions

SECTION H – INSURANCE HISTORY

Insured 1

Important: In Force Insurance ☐ Yes ☐ No
If yes, complete the table and specify life, disability, credit or critical illness insurance.

Company	Year and Month of Issue	Type of Contract (life or other)	Insurance Amount	
			Individual Insurance	Commercial Insurance
	Y Y Y Y M M			
	Y Y Y Y M M			
	Y Y Y Y M M			

Insured 2

Important: In Force Insurance ☐ Yes ☐ No
If yes, complete the table and specify life, disability, credit or critical illness insurance.

Company	Year and Month of Issue	Type of Contract (life or other)	Insurance Amount	
			Individual Insurance	Commercial Insurance
	Y Y Y Y M M			
	Y Y Y Y M M			
	Y Y Y Y M M			

In Force Insurance	Insured 1	Insured 2
1. Were there applications or insurance contracts (life, disability, credit, critical illness, preferred risk or income replacement insurance) pending and/or terminated within the last two (2) years for this proposed insured?	☐ Yes ☐ No	☐ Yes ☐ No
2. Has an application for a life, disability, credit, critical illness, preferred risk or income replacement insurance been declined, changed or rated for this proposed insured?	☐ Yes ☐ No	☐ Yes ☐ No
3. Is there one or more applications pending in one or several other companies for this proposed insured?	☐ Yes ☐ No	☐ Yes ☐ No
4. Is the purpose of this application to replace a contract currently in force? Refer to note 2 page 17.	☐ Yes ☐ No	☐ Yes ☐ No

For all affirmative answers, please complete the following table:

Proposed Insured(s)	Question #	Date	Reason	Relevant details for the question
☐ 1 ☐ 2		Y Y Y Y M M D D		
☐ 1 ☐ 2		Y Y Y Y M M D D		
☐ 1 ☐ 2		Y Y Y Y M M D D		
☐ 1 ☐ 2		Y Y Y Y M M D D		

SECTION I – AGE CONSERVATION AND MULTI-CONTRACT

Specificities

1. **Age Conservation**
   You can ask for age conservation. This concept applies to all insureds in the application.

   ☐ Age conservation

2. **Multi-contract**
   The multi-contract discount is $15 on all contracts, including the first contract, with the exception of the Juvenile 30/100. Check this box if the contracts are held by insureds, owners or payers living at the same address for all contracts involved and if one of them already has a contract with **UV Insurance**, excluding the Early Learning contracts.

   ☐ Yes ☐ No Ref. Application/Contract # _____

SECTION J – PAYMENT

Payer

1. First Name _____ Last Name _____
2. Date of Birth [Y Y Y Y M M D D] **3.** Sex ☐ M ☐ F
4. Primary Address _____ City _____
   Province _____ Country _____ Postal Code [ ]
5. For a legal entity, please provide the business number (NEQ or BN) _____
   In addition, please complete the form **EQC088**.
6. Main Telephone [ ][ ]-[ ], ext. _____ ☐ Cell phone ☐ Home ☐ Office
7. Email _____

Payment Method and Frequency

1. Payment Method ☐ Cheque ☐ Pre-authorized debit (PAD)
2. Payment Frequency ☐ Annual ☐ Monthly **3.** Premium for the payment frequency selected $_____
4. Amount paid with the application* $_____

   * The amount paid must not exceed the premium for a life or critical illness insurance of $500,000.

PRE-AUTHORIZED DEBIT (PAD)

I, the undersigned, the payer, authorize **UV Insurance** to debit my account at the financial institution referred to below of the amounts due to **UV Insurance** under the insurance contract issued following the application whose number appears in the top right corner on each page of this document.

Banking Information

1. Name of Financial Institution _____

2. Branch Address _____ City _____
Province _____ Country _____ Postal Code _____

3. Type of Account ☐ Checking ☐ Savings **4.** Type of Service ☐ Personal ☐ Business

5. Transit Number _____ Institution Number _____ Account Number _____

6. Frequency ☐ Monthly ☐ Annual **7.** Please take the first payment in the account ☐ Yes ☐ No

Important: Attach a void cheque from your financial institution.

This authorization should be read as plural if signed by more than one person.

This authorization is to remain in force until **UV Insurance** has received written notice from me of its change or cancellation. This notice must be received at least ten (10) business days before the next debit at **UV Insurance**'s head office. I may obtain a sample cancellation form, or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.cdnpay.ca.

UV Insurance may not assign this authorization, directly or indirectly, by application of the law, change of control or otherwise, without at least ten (10) days' written notice.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement.

To obtain a reimbursement form or for more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

X _____ Date Y Y Y Y M M D D
Signature as it appears on the cheque

X _____
Signature as it appears on the cheque

X _____
Signature of contract owner

N.B.: If this is a joint account where multiple signatures are required, all account holders must sign the authorization.

UV INSURANCE

CONDITIONAL INSURANCE AGREEMENT

Do you want the Conditional Insurance Agreement? ☐ Yes ☐ No If yes, payment method ☐ Cheque ☐ Pre-authorized debit (PAD)

Received from _____ the amount of* $_____ for an insurance application submitted to **UV Insurance** and bearing the same number and the same date as this agreement. *The amount paid must not exceed the premium for a life or critical illness insurance of $500,000.

Notwithstanding the provisions of the application, if all conditions and restrictions listed below are fully complied with, the life or critical illness insurance on the proposed insured(s) will come into force on the latest of the following dates:
a) Date of the application; **or**
b) Date of the last evidence of insurability required by the Company.

CONDITIONS AND LIMITATIONS

1. The amount specified above must be immediately cashable or be received by mail within a maximum of two (2) weeks. This amount must be at least equal to a monthly premium under this application.
2. If a cheque is provided for this application, it must be honored the first time it is presented for payment.
3. On the latest of the dates mentioned, namely the date of the application or the date of the last evidence of insurability, each proposed insured must be insurable at standard premium rate, without rating or limitation or exclusion or adjusted premium as per **UV Insurance's** underwriting rules in force during the study of said application.
4. The maximum insurance amount that can be paid under this agreement, any other similar agreement and other insurance in force with the Company is equal to the requested amount of life or critical illness insurance without exceeding a total of $500,000.
5. Any insurance under this agreement is subject to the terms of the application and ceases at the first of the three (3) following events:

   a) The date on which the contract applied for comes into force;
   b) The end of the sixty (60) day period following the in force date of this agreement;
   c) When the Company sends a cancellation notice to the owner.
6. No life or critical illness insurance amount will be paid under this agreement if the proposed insured:

   a) is less than 15 days old or 66 years old or more; **or**
   b) has had an application or reinstatement request declined, postponed or accepted with rating or limitation or exclusion at **UV Insurance** or elsewhere; **or**
   c) was hospitalized for more than five (5) days during the last twelve (12) months; **or**
   d) has committed suicide, made a false declaration or omission, or a fraudulent statement in the insurance application; **or**
   e) has committed, has tried to commit or has intended to commit a criminal act.
7. No insurance amount for critical illness will be paid if the proposed insured:

   a) is diagnosed with cancer, as defined in the contract pending to come into force; **or**
   b) is diagnosed with any other condition covered by the contract pending to come into force and does not meet the survival period as defined in the said contract.

No representative of the Company is authorized to modify any of the conditions and limitations stated above.

If one or more of these conditions and limitations are not fully complied with, the sole responsibility of the Company under this agreement is to refund all premiums paid.

I have read and signed this agreement and I certify that all requested explanations were given to me by the advisor to my satisfaction.

Signed in _____ Date Y Y Y Y M M D D

X _____ **X** _____

Signature of advisor Signature of owner

IMPORTANT: Please detach and leave with the client if the above "Conditions and limitations" are fully complied with.

UV INSURANCE

NOTICE OF COMMUNICATION OF YOUR PERSONAL INFORMATION TO MIB, LLC

All applications for life, disability and critical illness insurance require the most complete information gathering possible. This information is of a medical nature or relating to your solvency.

In order to allow a more equitable selection of risks for each of their insureds, most life insurance companies, including UV Insurance, deal with an organization called MIB, LLC ("MIB"), a non-profit organization, which performs an exchange of information on behalf of its member companies.

All information relating to your insurability is treated confidentially. However, UV Insurance may send a summary to the MIB.

If you apply for life, disability or critical illness insurance or if you file a claim with a member company, the MIB provides that company, at the request of the latter, with the information it has about you. The personal information communicated to the MIB may include your last name, first name, date of birth, place of birth, place of residence, the type of insurance requested as well as information on your state of health or your lifestyle declared during the study of your case. If it receives a request from you, the MIB will take the necessary steps to provide you with the information appearing on your file. If you question the accuracy of MIB information, you can request a correction by contacting them at the coordinates below.

You can contact MIB by e-mail at canadadisclosure@mib.com or by telephone at 1-866-692-6901. The address of the MIB Information Office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. If you have any questions about MIB's commitment to protecting your personal information or if you dispute the accuracy of any information on file with MIB, you may contact them and request information or a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Your information may be transferred or stored outside Canada and may be subject to the laws of foreign countries or states.

NOTE TO FINANCIAL ADVISOR — Give this notice to the owner

NOTICE – In order to proceed with the analysis of your insurance application, it is possible that we should obtain additional information.

Investigation: A representative from an investigation company may contact you in order to get more personal and financial information.

Medical examination: A physician or a nurse from a paramedical organization may ask you to undergo a medical examination.

Tests: A physician or a nurse from a paramedical organization or from a medical clinic may ask for blood or urine sample. The test will focus on the presence of many possible abnormalities like cholesterol, diabetes, liver problems, the presence of medication, drugs, nicotine and AIDS detection or other. In order to take a blood or urine sample, your written consent will be required.

UV INSURANCE

NOTICE OF COMPLETION OF A FILE AND OF COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION TO INSUREDS AND OWNER(S)

In this section, the term “personal information” refers to information about you that allows you to be identified, directly or indirectly. Your personal information will be collected, used, disclosed and processed:

- For the reasons and purposes described in this policy contract;
- According to the means determined in this policy contract;
- As may be described before collecting, using or disclosing it; And
- As otherwise permitted by law.

Why does UV Insurance collect your personal information?

For UV Insurance, protecting your personal information is essential. This is why we inform you that we collect, use and communicate your personal information with your consent, unless the law authorizes us to do otherwise, and this, for the duration necessary for the purposes below:

- Identify you;
- Establish and update your profile, your needs and your objectives;
- Assess your requests and your eligibility for our products and services;
- Provide you with advice related to your situation;

- Administer your contracts as well as your products or services (e.g., pricing, risk selection, underwriting, handling of your claims, etc.);
- Comply with legal and regulatory requirements (e.g., to prevent, detect or repress offences, cyber threats, fraud, etc.);
- Obtain your opinion in relation to our products or services;
- Provide you with personalized offers and advice on our products or services (see your right to withdraw consent) according to your preferences and in accordance with the rules relating to electronic and telephone communications;
- Conduct studies and research including the design and application of statistical models, some of which may create or infer new information about you.

How does UV Insurance collect your personal information?

We may collect your personal information over the phone, in person, and through our forms and digital interfaces.

To whom does UV Insurance communicate your personal information?

For the reasons mentioned earlier, and only as related to your products or services, we share your personal information with our affiliates and our distribution networks as well as third parties, some of whom may be located at outside Quebec and Canada. A third party is an external person who is not a party to the relationship between UV Insurance and you.

These third parties may include:

- The MIB;
- Your financial security advisor and his firm or general agent;
- Other financial institutions, such as yours, insurers or reinsurers;
- Any physician, health professional or other practitioner;
- Any hospital, laboratory, medical clinic or paramedical organization;
- Personal Information Officers;
- Your employer or former employer;
- Other organizations or entities holding information about you, among others, in insurance, fraud or compensation;
- Government departments and agencies or regulatory authorities;
- Agents and service providers (e.g., technology services, document printing and shipping services, etc.)
- Any person or organization to whom you have given your consent;
- Any person authorized by law.

Note that in all cases, we ensure that they respect the protection of your personal information.

Upon receipt of this document, i.e. your insurance proposal, you consent to UV Insurance opening a file where your personal information will be kept and treated confidentially.

UV Insurance will be able to access your file as well as said personal information from its head office and they will only be consulted by employees and authorized representatives of UV Insurance who need to have access to it in the course of their work. Your information may also be used, stored and accessed securely in other countries according to the laws applicable there. For example, information may be disclosed in response to requests from the governments, courts or law enforcement authorities of those countries.

If necessary and depending on the insurance product chosen, we collect your social insurance number ("SIN") for the purposes of identification confirmation and income tax reporting with Revenu Québec and the Canada Revenue Agency in accordance with provincial and federal laws. It is also possible that your banking information will be communicated to the financial institutions responsible for processing your pre-authorized debits ("PAD"). It is also possible that your personal information will be communicated to your beneficiaries in connection with a claim (for example, in the event of death).

Withdrawal of your consent

At any time, you can withdraw your consent to the communication or use of your personal information. Be aware that the withdrawal of your consent may lead to legal or contractual consequences in the context of your insurance application, such as the impossibility of offering you the financial product or the services requested. In such a case and at your request, the UV Insurance representative will make sure to explain these consequences to you.

Access to your file and correction of your personal information

Upon request, you can also be informed of the categories of persons who have access to your information within UV Insurance and the retention period of this information. You may have access to your file and your information collected to verify its accuracy and have information rectified if you demonstrate that it is inaccurate, incomplete, ambiguous, outdated or unnecessary. To access your file, have your information corrected, be informed of the retention period of your information, withdraw your consent or simply have your questions answered, you must make a written request to the attention of Privacy Officer of UV Insurance at the following coordinates:

Privacy Officer

1990 rue Jean-Berchmans-Michaud

Drummondville (QC) J2C 7G7

ResponsiblePRP@uvassurance.ca

To view our privacy policy, visit our website at **https://uvinsurance.ca/privacy-policy/**.

DECLARATIONS

1. We declare that we have read all the questions contained in this application and that the answers given have been faithfully reproduced and are complete and true. In addition, we agree that they serve as the basis for the insurance contract requested and acknowledge that any false declaration or omission may result in the termination of the insurance contract obtained as a result of this proposal.
2. We declare that we have been informed that the insurance comes into force upon acceptance of this policy contract provided that the latter has been accepted without modification, that the first premium has been paid and that no change has occurred in the insurability of the people to be insured in the last 90 days.
3. We declare that we have been informed that the advisor is remunerated by commission in relation to the transaction described in the above-mentioned proposal.
4. We declare that we have read and received the notice of communication of personal information to the MIB.
5. We declare that we have read the above notices and we consent to the creation of a file as well as the collection, use and communication of personal information. We understand that any information disclosed in this application and any supplemental documents, if any, may be collected, used, retained or disclosed by or to other participants in the insurance application process and any potential assignee of the insurance policy.
6. We declare that we have been informed that UV Insurance may collect our personal information using technologies that include functions allowing identification, localization or profiling, which are necessary in order to assess our request. This is the case of the application in electronic, PDF and paper format, which enables us to establish our risk profile and obtain the best possible premium. We agree that submitting the proposal triggers the activation of these functions.
7. We declare that we have been informed that UV Insurance may use our personal information to make exclusively automated decisions, that is, without any human intervention. For example, when an electronic application is submitted, an automated decision may be made to speed up underwriting, including the calculation of the premium and the selection of risks.
8. We declare that we have been informed that the illnesses covered by this insurance are limited to those defined in the contract
9. We declare that we informed the insurer about having other citizenship(s) than the Canadian citizenship.
10. We declare that we have been informed that the financial security advisor is independent of UV Insurance and that he is not its representative.
11. We declare that the answers and declarations contained in this application, if they have been completed, and in any paramedical questionnaire, telephone interview and all other questionnaires are complete and true and form an integral part of the application for life or Critical illness insurance and cannot be dissociated from it.

AUTHORIZATIONS

Your authorizations are necessary to provide and administer your products or services offered by UV Insurance:

1. We authorize any professional and participant in the field of health, any health care provider, any public or private health or social services establishment, any insurer or reinsurer, the MIB, any investigation agency as well as any natural or legal person likely to hold personal information related to our state of health, our medical history or our lifestyle habits necessary for the reasons mentioned in the notice of constitution of a file and the collection, use and communication of information personal, to communicate them to UV Insurance or its reinsurers. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.
2. We authorize UV Insurance, and its reinsurers to collect, use and communicate the personal information necessary for the reasons mentioned in the notice of constitution of a file and the collection, use and communication of personal information from any professional and intervener in the field of health, health care provider, public or private health or social services establishment, insurer or reinsurer, investigation agency, natural or legal person likely to hold personal information related to our state of health , our medical history or our lifestyle habits as well as the MIB. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.
3. We authorize UV Insurance to communicate to the undersigned financial security advisor and owner, all personal information collected on the application or during the risk assessment process and which could have an impact on the premium or the issuance of the contract. This information includes, but is not limited to, the results of medical tests or laboratory tests, information provided during a telephone interview, a paramedical examination, a questionnaire or a declaration of insurability, medical history, criminal, work, alcohol or drug use, financial information or any other element considered during the evaluation of the proposal. The financial security advisor, thus informed, will be able to better guide us through the various insurance options available to us.
4. We authorize UV Insurance and its reinsurers to collect, use and disclose personal information held by any credit reporting agency for the purposes of pricing, risk selection, study, research and development, design and application of statistical models, regulatory and contractual compliance and prevention and detection of fraud, errors and misrepresentations. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.
5. We authorize, in the event of death, the beneficiary, the heir or the liquidator of their succession to communicate to UV Assurance and its reinsurers, when required by the latter(s), all the information and authorizations necessary to the study of the death claim and obtaining the required justifications.
6. We authorize UV Insurance to cancel the contracts currently in force covered by the replacement and cited in section H (question 4) upon the entry into force of the contract resulting from this proposal.

These authorizations may be canceled at any time by sending a written notice to UV Insurance.

UV INSURANCE

By signing and submitting this application on my behalf, I consent to the collection, communication and use of my personal information as described above and elsewhere in this policy contract.

I acknowledge having read and agree to the eleven (11) declarations and the six (6) authorizations above.

Signed in _____ province of _____ Date Y Y Y Y M M D D

X _____ X _____

Signature of proposed insured (if 14 years or older) | Signature of owner (if legal entity, authorized signatory)

X _____ X _____

Signature of father, mother or guardian (if proposed insured is a minor) | Signature of owner (if legal entity, authorized signatory)

X _____ X _____

Full name of advisor (in block letters) | Signature of advisor

X _____ X _____

Full name of witness (in block letters) | Signature of witness (other than the beneficiary)

Christian Mercier, OMM, MSM, CD, MDS
Chief Executive Officer

UV Insurance is a member of Assuris. Assuris is a non-profit organization that protects Canadian policyholders in the event that their life insurance company should become insolvent.

UV INSURANCE

AUTHORIZATIONS – HEREBY, I, THE UNDERSIGNED,

1. Authorize any professional and participant in the field of health, any health care provider, any public or private health or social services establishment, any insurer or reinsurer, the MIB, any investigation agency as well as any person natural or legal person likely to hold personal information related to my state of health, my medical history or my lifestyle habits necessary for the reasons mentioned in the notice concerning the protection of personal information, to communicate them to UV Insurance or its reinsurers . This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.
2. Authorize UV Insurance and its reinsurers to collect, use and communicate the personal information necessary for the purposes mentioned in the notice concerning the protection of personal information from any professional and intervener in the field of health, health care provider, public or private health or social services establishment, insurer or reinsurer, investigative agency, natural or legal person likely to hold personal information related to my state of health, my medical history or my lifestyle as well as the MIB . This authorization is only valid for the duration necessary to achieve the purposes for which it was requested.
3. Authorize UV Insurance and its reinsurers to collect, use and disclose personal information held by any credit reporting agency for purposes of pricing, risk selection, study, research and development, design and application of statistical models, regulatory and contractual compliance and prevention and detection of fraud, errors and misrepresentations. This authorization is only valid for the duration necessary to achieve the purposes for which it was requested
4. Authorize, in the event of death, the beneficiary, the heir or the liquidator of their succession to communicate to UV Insurance and its reinsurers, when required by the latter(s), all the information and authorizations necessary to study the death claim and obtain the required justifications.
5. Agree that any photocopy of these authorizations has the same value as the original.

Signed in _____ Date Y Y Y Y M M D D

X _____ X _____ X _____

Signature of proposed insured (if 14 years or older) | 1st Signature of owner (if legal entity, authorized signatory) | 2nd Signature of owner (if legal entity, authorized signatory

X _____ X _____

Signature of advisor | Signature of father, mother or guardian (if proposed insured is a minor)

UV INSURANCE

REPORT OF THE FINANCIAL ADVISOR

SECTION A – ORIGIN OF THE SALE

☐ Client request ☐ Acquaintance/friend ☐ Offer made to the client ☐ Case referred by a client

☐ Relative Degree _____ ☐ Contract with oneself ☐ Other _____

Client known since _____

Present at signature ☐ Yes ☐ No

If no, how was the transaction conducted ☐ Telephone ☐ Webcam/videoconference ☐ Chat ☐ Other _____

SECTION B – SUPPLIERS

I requested the following underwriting requirements from one of these organizations:

Underwriting Requirements	Supplier	Portal address	Order Reference #
☐ Tele interview only	Dynacare	orders.dynacare.ca	
☐ Paramedical ☐ Blood profile ☐ Urine testing ☐ ECG ☐ Other _____	ExamOne	portal.examone.com/Login	
	Dynacare	orders.dynacare.ca	
	MediFast	wa.medifast.ca/headoffice/Login.aspx	

SECTION C – ADVISOR IDENTIFICATION

Last Name, First Name	%	Advisor Code	General Agent (MGA)	General Agent Code

☐ I want to notify a change in MGA.

Comments

SECTION D – DECLARATION

I confirm that I have declared to the owner of this contract the names of the companies I represent, the possibility that I will receive compensation (such as a commission) and additional compensation (such as a bonus) and that I have no conflict of interest neither with **The Union Life Mutual Assurance Company**, nor with the owner, with regard to the proposed transaction. In addition, I confirm that I have verified using official and original documents the information obtained to complete the information on the proposed insureds, beneficiaries, owners, child riders, the product, the premium, the insurance history, special instructions and replacement notices, if applicable.

I declare that I hold a valid licence in the jurisdiction where this application was signed.

If I am not the service advisor for this contract, I declare that I have notified the owner(s) of this fact and of the identity of their service advisor as it appears in this section.

Verification of the Owner(s) Identity (Permanent Life Insurance):

I have ascertained the identity of the person(s) whose signature appears as the owner(s) herein in accordance with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations by examining all valid and original identification documents provided and by discussing with the owner(s) to complete this application.

Third Party Determination (Permanent Life Insurance):

I have made reasonable efforts in accordance with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations to determine whether the owner(s) is(are) acting on behalf of a third party.

I confirm that I am compliant with this declaration ☐ Yes ☐ No If no, please specify why _____

Signed in _____ Date Y Y Y Y M M D D

X _____ **X** _____

Signature of advisor Signature of training supervisor

uvinsurance.ca

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