Insurance Application

APPLICATION NO.

Important instructions for the advisor

Use this application when applying for:

- All life insurance and critical illness products
- All replacements of insurance contracts

For quicker processing:

1. The Notice of Disclosures (page i) must be given to the **Proposed Insured(s).**
2. ALL pages of the *Insurance Application* must be submitted with the exception of page i, which must be left with the Proposed Insured, and the Receipt for temporary insurance (page 29), which will be given to the Policy Owner if temporary insurance is requested.
3. For term insurance and critical illness protection multi-life applications with more than two Proposed Insureds (other than children under the Children's Insurance Rider), submit a second *Insurance Application*.
4. For replacements of insurance contracts, attach applicable disclosure forms.

Applying for a Temporary Insurance Agreement (TIA)

1. Complete the Application for temporary insurance on page 24 for each Proposed Insured.
2. The Application for temporary insurance must be signed by all the Proposed Insured(s) and the Policy Owner(s).
3. A cheque payable to *ivari* or a written authorization to withdraw the initial premium (one monthly modal premium) must be submitted with the Application for temporary insurance.
4. The TIA receipt (page 29) must be given to the Policy Owner.

Medical questions

1. When a paramedical is required, the Proposed Insured(s) do(es) not need to complete questions 35–44.
2. When a telephone interview is required, the Proposed Insured(s) do(es) not need to complete questions 27–44.

Important for universal life policies only:

1. Multi-life option is not available.
2. Submit a signed illustration and the *Supplement to the Insurance Application*.
3. Ensure all questions shown as **MANDATORY FOR UNIVERSAL LIFE POLICIES** are answered.
4. If the Policy Owner is an entity (i.e. a corporation, non-corporate entity or trust) please complete the *Policy Ownership for Corporate & Non-Corporate Entities or Trusts* form (IP-LP1747).

Let's talk about . . .ivari

ivari provides a full range of insurance products specifically designed to help Canadians and their families make the right choice for their protection needs. The people, products and programs that make up *ivari* have stood the test of time and have been around for over 80 years in the Canadian marketplace.

In 2015, we were acquired by Wilton Re. Wilton Re is a life (re)insurance company specializing in the acquisition and management of life and annuity businesses as well as with assisting companies with product development, underwriting and new business strategies designed to serve the middle market.

Visit us at ivari.ca.

DETACH THIS PAGE AND LEAVE WITH THE PROPOSED INSURED(S)

Notice of Disclosures

Thank you for applying for insurance with *ivari*.

Please make sure that you have read this application carefully and that you fully understand all of it. Once we receive your application, we will assess the eligibility of each Proposed Insured. We base this eligibility on the information you provide to us in this application as well as information from other sources which may include, but is not limited to, medical history, physical condition, occupation, lifestyle and financial situation. Once we have determined the degree of risk for each Proposed Insured, we will let you know if the insurance you applied for can be issued. Questions? Please contact your independent insurance advisor or write to us at **Client Services Department, ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8.**

NOTICE REGARDING MIB, INC.

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

If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. MIB, Inc. receives personal information, and the collection, use and disclosure of such information is governed by the **Personal Information Protection and Electronic Documents Act** (PIPEDA) and provincial laws.

MIB, Inc. has agreed to protect such information in a manner that is substantially similar to *ivari's* privacy and security practices, and in accordance with applicable laws. As a U.S.-based company MIB, Inc. is bound by and such personal information may be disclosed in accordance with applicable U.S. laws. If you have any questions about MIB, Inc.'s commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy department at **privacy@mib.com**. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction.

The address of MIB, Inc.'s information office is 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, tel. no. 416-597-0590. *ivari*, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at **www.mib.com**.

NOTICE REGARDING INVESTIGATIVE CONSUMER REPORTS AND COLLECTION

As part of our review process, we may request an investigative consumer report or credit report be completed on your behalf. These reports, if requested, will be obtained from an investigative or consumer reporting agency or from a credit bureau. Information may also be collected through personal interviews with your neighbours, colleagues, friends or others with whom you are acquainted.

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

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

ivari collects, uses and discloses your personal information as described in the sections of this application regarding MIB, Inc., investigative consumer reports and the personal information authorization. The personal information authorization section of this application can be found on page 23. In addition, we collect personal information about you from this application, any supplementary forms and questionnaires, as described in the above sections, and from the following sources:

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

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

- Evaluating, assessing and investigating this application, our insurance risks and any claims you submit; evaluating your insurance and financial needs; administering and servicing the insurance and/or financial products we provide; and reporting information to the Canada Revenue Agency in accordance with federal legislation.

If you provide your Social Insurance Number (SIN), it will be used for the following purposes only: tax reporting, record keeping and identification, when needed. The use of your SIN for identification purposes is optional. You may withdraw consent for use of your SIN for identification purposes at any time by contacting *ivari's* Client Services department using the contact number listed on your policy. Please note that certain transactions requested under a universal life policy may require you to provide the SIN before processing. You have the option to provide your SIN now to avoid any future delays.

Your personal information may be shared with the entities and persons identified in this disclosure for the purposes of obtaining the information required. It may also be shared with or disclosed to managing general agencies, distributors and market intermediaries and their employees and agents and your independent insurance advisors for purposes identified above. Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit payments. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

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

From time to time we may use your personal information to determine which other insurance and financial products and services may meet your needs and to offer them to you. We may disclose your personal information to our affiliated companies for their own use for such purposes. However, we will not disclose your health information to our affiliates for such purposes.

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

Upon receiving your application, *ivari* will establish and maintain a file containing your personal information, which will be accessible at our head office. Your file will be accessible to only those employees and authorized representatives of *ivari* responsible for administering your file, and other persons authorized by you or by law. Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Officer, *ivari*, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8. Your personal information will be collected, used, disclosed, shared and treated as described herein, or as otherwise described at or before the time of collection, use or disclosure, or as otherwise permitted by law. To review our privacy policy, visit **ivari.ca**.

DISCLOSURE OF COMPENSATION

The insurance product you are being offered is supplied by *ivari*, a company licensed to conduct business in all provinces and territories of Canada. The independent insurance advisor/distributor soliciting this insurance application is a licensed insurance advisor representing *ivari* and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with *ivari*, the advisor/distributor or any other person or entity as a condition of this application.

General information COMPLETE ENTIRE SECTION

Policy no.

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

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

_____

c) This is a: ○ New policy ○ Replacement of *ivari* policy # _____ ○ Insured Exchange Option
○ Addition of coverage to *ivari* policy # _____

d) **MAIN PURPOSE OF INSURANCE:** MANDATORY FOR UNIVERSAL LIFE POLICIES
☐ Buy and sell ☐ Key person insurance ☐ Retirement planning ☐ Critical illness protection
☐ Estate planning ☐ Life protection ☐ Partnership ☐ Other _____

2 **Proposed Insured 1** PLEASE PRINT IN BLOCK LETTERS

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

First name	Middle initial	Last name

MANDATORY FOR UNIVERSAL LIFE POLICY

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

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

3 Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female Smoking class: ○ Smoker ○ Non-smoker

Country and/or province of birth: _____ Former/Maiden name: _____

SIN: _____ – _____ – _____ *(Complete only if you are the Owner and applying for a universal life policy)*

Driver's licence number: _____ Province: _____

4 Current address: *(Number and street name)*

_____ Apt./Suite: _____

City: _____ Province: _____ Postal code: _____

Home telephone: _____ Mobile telephone: _____ Business telephone: _____

5 I understand the language in which this application is written: ○ yes ○ no If ***"no,"*** have the details of this application been fully explained to you in your preferred language and are they completely understood? ○ yes ○ no

6 a) What is the Proposed Insured's residency status?
○ Canadian citizen
○ Landed immigrant/Permanent resident Number of years/months residing in Canada: _____ years _____ months
○ Contract worker *(provide copy of work permit)* Number of years/months residing in Canada: _____ years _____ months
○ Other *(current status)* Number of years/months residing in Canada: _____ years _____ months
Provide details: _____

b) Are you a resident for Canadian income tax purposes? ○ yes ○ no

7 a) Is the Proposed Insured a student? ○ yes ○ no If ***"yes,"*** ○ Full time ○ Part time

b) Is the Proposed Insured currently employed? ○ yes ○ no
If ***"no,"*** provide details: _____

c) Occupation: _____ Name of employer: _____ # of years: _____
Employer's address: _____
Duties: _____ Annual income: $ _____ Total net worth: $ _____

8 Proposed Insured 2 PLEASE PRINT IN BLOCK LETTERS

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

First name	Middle initial	Last name

MANDATORY FOR UNIVERSAL LIFE POLICY

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

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

9 Date of birth: (DD/MM/YYYY) _____ Sex at birth: ○ Male ○ Female Smoking class: ○ Smoker ○ Non-smoker

Country and/or province of birth: _____ Former/Maiden name: _____

SIN: _____ – _____ – _____ *(Complete only if you are the Owner and applying for a universal life policy)*

Driver's licence number: _____ Province: _____

10 Current address: *(Number and street name)*

_____ Apt./Suite: _____

City: _____ Province: _____ Postal code: _____

Home telephone: _____ Mobile telephone: _____ Business telephone: _____

11 I understand the language in which this application is written: ○ yes ○ no If ***"no,"*** have the details of this application been fully explained to you in your preferred language and are they completely understood? ○ yes ○ no

12 a) What is the Proposed Insured's residency status?

○ Canadian citizen

○ Landed immigrant/Permanent resident Number of years/months residing in Canada: _____ years _____ months

○ Contract worker *(provide copy of work permit)* Number of years/months residing in Canada: _____ years _____ months

○ Other *(current status)* Number of years/months residing in Canada: _____ years _____ months

Provide details: _____

b) Are you a resident for Canadian income tax purposes? ○ yes ○ no

13 a) Is the Proposed Insured a student? ○ yes ○ no If ***"yes,"*** ○ Full time ○ Part time

b) Is the Proposed Insured currently employed? ○ yes ○ no

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

c) Occupation: _____ Name of employer: _____ # of years: _____

Employer's address: _____

Duties: _____ Annual income: $ _____ Total net worth: $ _____

Juvenile Insured – Additional information

PROPOSED JUVENILE INSURED IS LESS THAN 16 YEARS OF AGE

In addition to the Proposed Insured section (pages 1 and 2) complete the following section for juveniles.

14 Proposed Juvenile Insured 1

If the Proposed Insured is less than 2 years old, was the child born prematurely? ..... ○ yes ○ no

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

_____

_____

Does this Proposed Insured live with the Owner? ..... ○ yes ○ no

If ***"no"***, who does this Proposed Insured live with? _____ Relationship: _____

Current year annual income of the parent or legal guardian: $ _____

Total amount of life and critical illness insurance on both parents or legal guardian:

Parent 1: Life $ _____ Parent 2: Life $ _____ Legal guardian: Life $ _____

CI $ _____ CI $ _____ CI $ _____

Does the Proposed Insured have any siblings? ..... ○ yes ○ no

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

If ***"yes"***, what is the amount of life or critical illness insurance on each sibling?

Sibling # 1: $ _____ Sibling # 2: $ _____

Sibling # 3: $ _____ Sibling # 4: $ _____

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

_____

15 Proposed Juvenile Insured 2

If the Proposed Insured is less than 2 years old, was the child born prematurely? ..... ○ yes ○ no

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

_____

_____

Does this Proposed Insured live with the Owner? ..... ○ yes ○ no

If ***"no"***, who does this Proposed Insured live with? _____ Relationship: _____

Current year annual income of the parent or legal guardian: $ _____

Total amount of life and critical illness insurance on both parents or legal guardian:

Parent 1: Life $ _____ Parent 2: Life $ _____ Legal guardian: Life $ _____

CI $ _____ CI $ _____ CI $ _____

Does the Proposed Insured have any siblings? ..... ○ yes ○ no

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

If ***"yes"***, what is the amount of life or critical illness insurance on each sibling?

Sibling # 1: $ _____ Sibling # 2: $ _____

Sibling # 3: $ _____ Sibling # 4: $ _____

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

_____

16 Policy Owner(s) THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNERS

Policy ownership applies to all coverages. The Owner(s) must be at least 16 years of age (at least 18 years of age in the province of Québec).

a) What language do you request related documents be in? ○ English ○ Français

b) **Select the Policy Owner(s) below:**

☐ Proposed Insured 1 – only complete question 16 c) when applying for Universal Life

☐ Proposed Insured 2 – only complete question 16 c) when applying for Universal Life

☐ Owners as identified below:

- Individual(s) other than Proposed Insured(s) – must complete Owner section below and question 16 c) when applying for Universal Life
- Corporation, non-corporate entity or trust – must complete Owner section below and when applying for Universal Life the *Policy Ownership for Corporate & Non-corporate Entities or Trusts* form (IP-LP1747)

OWNER 1 Legal name (First, middle initial, last and/or legal company/entity name)

Date of birth (DD/MM/YYYY)	Relationship to Proposed Insured	Principal business or occupation	SIN (Complete only if you are applying for a universal life policy) – –
Current address (Number and street name)			Apt./Suite
City	Province		Postal code
Home phone number	Mobile phone number		Business phone number
Identification document*	Identification document number*	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

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

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ yes ○ no

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

OWNER 2 Legal name (First, middle initial, last and/or legal company/entity name)

Date of birth (DD/MM/YYYY)	Relationship to Proposed Insured	Principal business or occupation	SIN (Complete only if you are applying for a universal life policy) – –
Current address (Number and street name)			Apt./Suite
City	Province		Postal code
Home phone number	Mobile phone number		Business phone number
Identification document*	Identification document number*	Document expiry date (MM/YYYY)	Issuing jurisdiction and country

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

Is the Owner a Canadian citizen or permanent resident (landed immigrant)? . . . . . ○ yes ○ no

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

c) **Declaration of tax residency**

Instructions:
- Must be completed by the Policy Owner(s) when applying for a Universal Life policy
- When naming the Proposed Insured(s) as Owner(s); in completing the table below, the Proposed Insured 1 is considered Owner 1 and Proposed Insured 2 is considered Owner 2.

MANDATORY FOR UNIVERSAL LIFE POLICIES

Declaration of tax residency

Please answer the following three statements. Depending on your situation, you may answer ***"yes"*** to more than one.

		OWNER 1 YES	OWNER 1 NO	OWNER 2 YES	OWNER 2 NO
a)	**I am a tax resident of Canada.**	○	○	○	○
b)	**I am a tax resident or a citizen of the United States.**	○	○	○	○
	If you do not have a TIN from the United States, have you applied for one?	○	○	○	○
c)	**I am a tax resident in a country other than Canada or the United States.**	○	○	○	○

Owner 1 _____ **Owner 2** _____

If ***"yes,"*** to statement c), provide your country of tax residence and taxpayer identification numbers (TIN). If you do not have a TIN for a specific country, give the reason using one of these choices:

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

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

Reason 3: Other reason, provide details.

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

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

d) **MULTIPLE OWNERS**

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

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

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

e) **CONTINGENT OWNER**

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

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

f) **MAILING ADDRESS**

All notices and statements will be mailed to the address of Owner 1 unless another address is indicated below:

Number and street name	City	Province	Postal code

g) **POLITICALLY EXPOSED PERSONS AND HEAD OF INTERNATIONAL ORGANIZATION**

MANDATORY FOR UNIVERSAL LIFE POLICIES

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

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

h) **POLICY OWNER'S CONSENT TO RECEIVE EMAILS**

Canada's anti-spam legislation regulates the distribution of email messages to consumers. To comply with this law, *ivari* is required to obtain your consent for the purposes of sending you email messages regarding policy information, product information and marketing material.

By providing your email address below, you consent to receiving email messages as outlined above from *ivari*.

Owner 1 email address: _____

Owner 2 email address: _____

You may withdraw your consent at any time by contacting us at *ivari*:

500-5000 Yonge Street, Toronto, ON M2N 7J8. Telephone: 1-800-846-5970 or Fax: 416-883-5520 or 1-877-767-0477

Beneficiary information

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

If applying for a Critical Illness Protection policy or a Critical Illness Protection Rider on a life policy, read sections 17 b) & 18 b) carefully.

Primary/Contingent Beneficiaries:

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

Irrevocable/Revocable Beneficiaries:

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

Where a minor is designated as a beneficiary, it is recommended that a trustee *be appointed to avoid a payment into court (not applicable in Québec)*.

17 Proposed Insured 1

a) **BENEFICIARY – Life insurance**

If no beneficiary is designated, then the proceeds are payable to the Owner, if living, or the Owner's estate, if deceased.
A Contingent Beneficiary is always revocable*.

FIRST NAME, LAST NAME	DATE OF BIRTH (DD/MM/YYYY)	CHECK ONLY ONE	CHECK ONLY ONE	SHARE %	RELATIONSHIP TO PROPOSED INSURED (IN QUEBEC TO OWNER)
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec):

b) **BENEFICIARY – Critical illness** *(Critical Illness Protection policy or a Critical Illness Protection Rider on a life policy)*

Note: For a Critical Illness Protection policy, you may only designate a Beneficiary if the legislation in your province allows you to name a beneficiary.

Critical Illness Benefit and/or Early Detection Benefit – ***The beneficiary will be the Insured unless otherwise stated below. If the Insured is a minor, the beneficiary is the Owner, if living, or the Owner's estate, if deceased.***

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

Relationship to Proposed Insured (Proposed Owner in Québec)

○ revocable ○ irrevocable

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec)

Critical Illness Benefit – Return of Premium on Death – ***The proceeds are payable to the Owner, if living, or the Owner's estate, if deceased, unless otherwise stated below.***

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

Relationship to Proposed Insured (Proposed Owner in Québec)

○ revocable ○ irrevocable

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec)

18 Proposed Insured 2

a) **BENEFICIARY – Life insurance**

If no beneficiary is designated, then the proceeds are payable to the Owner, if living, or the Owner's estate, if deceased.
A Contingent Beneficiary is always revocable*.

FIRST NAME, LAST NAME	DATE OF BIRTH (DD/MM/YYYY)	CHECK ONLY ONE	CHECK ONLY ONE	SHARE %	RELATIONSHIP TO PROPOSED INSURED (IN QUEBEC TO OWNER)
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		
		○ primary ○ contingent*	○ revocable ○ irrevocable		

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec):

b) **BENEFICIARY – Critical illness** *(Critical Illness Protection policy or a Critical Illness Protection Rider on a life policy)*
Note: For a Critical Illness Protection policy, you may only designate a Beneficiary if the legislation in your province allows you to name a beneficiary.

Critical Illness Benefit and/or Early Detection Benefit – ***The beneficiary will be the Insured unless otherwise stated below. If the Insured is a minor, the beneficiary is the Owner, if living, or the Owner's estate, if deceased.***

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

Relationship to Proposed Insured (Proposed Owner in Québec)

○ revocable ○ irrevocable

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec)

Critical Illness Benefit – Return of Premium on Death – ***The proceeds are payable to the Owner, if living, or the Owner's estate, if deceased, unless otherwise stated below.***

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

Relationship to Proposed Insured (Proposed Owner in Québec)

○ revocable ○ irrevocable

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec)

Insurance history

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
19 a) Has any application, reinstatement, modification for life, critical illness, long-term care or disability insurance ever been rated, declined, postponed, cancelled, rescinded or modified in any way?	○	○	○	○
b) i) Is this insurance intended to replace, or will it cause a change, in any existing life or critical illness insurance?	○	○	○	○
If ***"yes"***, for life, attach completed Replacement/Comparison Disclosure forms, LIRD (where applicable).				
ii) Will the insurance applied for in this application replace an existing *ivari* policy/coverage?	○	○	○	○
If ***"yes"***, provide policy number:				
PROPOSED INSURED 1: _____ **PROPOSED INSURED 2:** _____				
iii) Does the Owner instruct *ivari* to cancel the above stated policy/coverage only when the new policy being applied for is in force? (To ensure continuous coverage the premium under the existing policy is required until this new policy is in force. Failure to do so will result in a lapse/termination of insurance coverage resulting in the inability to offer a reinstatement.)	○	○	○	○
Note: Only the Policy Owner of the above stated policy has the right to cancel the existing policy/coverage. If there is a change in ownership, you must submit a Transfer of Ownership signed by the original Owners of the policy being replaced.				
c) Do you have any of the following insurance in force or pending: life insurance, critical illness, disability, long-term care with *ivari* or any other company? If ***"yes"***, complete the table in question 20.	○	○	○	○

If ***"yes"***, to questions 19 a), b) or c), provide additional information in the Remarks section.

20 Insurance in force

PROPOSED INSURED 1	PROPOSED INSURED 2	COMPANY	AMOUNT OF INSURANCE	TYPE OF INSURANCE PLAN				PERSONAL/ BUSINESS		ISSUE YEAR	REPLACING	IN FORCE	PENDING
				LIFE	CI	DI	LTC	P	B				
○	○		$	○	○	○	○	○	○		○	○	○
○	○		$	○	○	○	○	○	○		○	○	○
○	○		$	○	○	○	○	○	○		○	○	○
○	○		$	○	○	○	○	○	○		○	○	○
○	○		$	○	○	○	○	○	○		○	○	○

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

QUESTION #	PROPOSED INSURED #	DETAILS

Financial information

Personal – Where the face amount is $1,000,000 or more, complete question 21.

Business – Where the insurance is for business purposes, and the Owner or beneficiary is a corporation, non-corporate entity or trust, complete question 22.

21 Personal

FINANCIAL DETAILS	PROPOSED INSURED 1	PROPOSED INSURED 2	OWNER (Where individual Owner is not a Proposed Insured)
Earned income (last year)	$	$	$
Unearned income (last year) bonus, dividends, interest, etc.	$	$	$
Assets: cash, real estate, stocks, bonds, etc.	$	$	$
Liabilities: mortgages, loans, etc.	$	$	$
Total net worth	$	$	$

22 Business

a) Name of business: _____

b) Nature of the business: _____

c) Financial details:

Assets **$** _____ **Percentage of ownership held by the Proposed Insured:**

Liabilities **$** _____ **PROPOSED INSURED 1** _____ **%**

Net worth **$** _____ **PROPOSED INSURED 2** _____ **%**

Fair Market Value of the business: _____

d) Insurance of other partners of the business:

NAME/TITLE/OCCUPATION	LIFE INSURANCE		CRITICAL ILLNESS INSURANCE		% OF BUSINESS OWNERSHIP
	IN FORCE	PENDING	IN FORCE	PENDING	
	$	$	$	$	
	$	$	$	$	
	$	$	$	$	

Financial statement: ○ enclosed ○ to follow

Letter of explanation: ○ enclosed ○ to follow

Additional comments: _____

Plan coverage

23 Insurance applied for Proposed Insured 1

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

☐ **UNIVERSAL LIFE INSURANCE**

Face amount: $ _____

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

Complete this section when applying for a term insurance policy:

☐ **TERM LIFE INSURANCE**

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

Term riders	Face amount
☐ 10 year rider	$ _____
☐ 20 year rider	$ _____
☐ 30 year rider (Available only on a Term 30 policy)	$ _____

Additional benefits	Face amount
☐ Children's Insurance	$ _____
☐ Accidental Death & Dismemberment	$ _____
○ Waiver of Premium	
○ Payor Waiver of Premium*	

*Name of parent or legal guardian. In addition complete, questions 27 to 44:

_____

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

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

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

☐ **CRITICAL ILLNESS PROTECTION**

Benefit: $ _____

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

Additional benefits

○ Waiver of Premium
○ Payor Waiver of Premium*

*Name of parent or legal guardian. In addition complete, questions 27 to 44:

_____

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

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

24 Insurance applied for Proposed Insured 2 (for Multi-Life Term & Critical Illness Protection policies only)

Complete this section when applying for a term insurance policy:

☐ **TERM LIFE INSURANCE**

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

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

*Name of parent or legal guardian. In addition complete, questions 27 to 44:

_____

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

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

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

☐ **CRITICAL ILLNESS PROTECTION**

Benefit:	$ _____	**Additional benefits**
○ Term 10 Critical Illness – 4 conditions		○ Waiver of Premium
○ Term 20 Critical Illness – 4 conditions		○ Payor Waiver of Premium*
○ Term to age 65 Critical Illness – 4 conditions		
○ Term 10 Critical Illness – 25 conditions		*Name of parent or legal guardian. In addition complete, questions 27 to 44:
○ Term 20 Critical Illness – 25 conditions		_____
○ Term to age 65 Critical Illness – 25 conditions		

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

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

25 Other plan details

a) Special policy dates:

☐ Date to save age: ☐ Proposed Insured 1 ☐ Proposed Insured 2

☐ Specific policy/Future date: (DD/MM/YYYY) _____

PROPOSED INSURED 1

b) ☐ Alternate/Optional policy:

Plan: _____ Face Amount/Benefit: $ _____

c) ☐ Additional policy:

Plan: _____ Face Amount/Benefit: $ _____

PROPOSED INSURED 2

d) ☐ Alternate/Optional policy:

Plan: _____ Face Amount/Benefit: $ _____

e) ☐ Additional policy:

Plan: _____ Face Amount/Benefit: $ _____

26 Payment details

Premium quoted: $ _____

a) Initial premium/Deposit of $ _____ to be paid by:

Check **ONLY ONE** option below:

○ Withdraw from bank account immediately upon receipt of this insurance application.
(Attach VOID cheque, pre-printed with the Payor's name or a bank Letter of Direction.)

or

○ Cheque made payable to *ivari* attached

or

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

b) Future premiums/Deposits to be paid by:

Pre-authorized debit: (Complete authorization on page 25) ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

The date of withdrawal will be the same as the policy effective date. If you wish a different withdrawal date, please indicate preferred date of withdrawal (days 1–28 only) _____

For universal life policies, if you select a withdrawal date that is after your policy date, we will automatically set the withdrawal date to match the policy date.

Direct bill: ○ Annually ○ Semi-annually ○ Quarterly

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

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

Name of third party: _____

Relationship of third party to Owner: _____

Address of third party: _____

Date of birth of third party: (DD/MM/YYYY) _____ Occupation of third party: _____

If a corporation, provide incorporation #: _____

Place of registration if third party is a corporate entity: _____

Personal history

INSTRUCTIONS ***For Proposed Insureds 16 years of age or greater, complete questions 27 and 28 and proceed to next page except if a telephone interview is required.***

27 Have you smoked or used any of the products listed in the table below:

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
a) In the last 12 months?	○	○	○	○
b) In the last 24 months?	○	○	○	○

If ***"yes"*** to a) or b), complete the table below.

PROPOSED INSURED 1

PRODUCTS	QUANTITY	FREQUENCY
Cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts		○ day ○ week ○ month ○ year ○ single use
Traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe		○ day ○ week ○ month ○ year ○ single use
Pipe, chewing tobacco		○ day ○ week ○ month ○ year ○ single use
Marijuana/hashish (joints/consumption)		○ day ○ week ○ month ○ year ○ single use
Any other smoking cessation products, or used tobacco in any other form		○ day ○ week ○ month ○ year ○ single use

PROPOSED INSURED 2

PRODUCTS	QUANTITY	FREQUENCY
Cigarettes, cigarillos, electronic cigarette, nicotine patch, Nicorette chewing gum, snuff, betel nuts		○ day ○ week ○ month ○ year ○ single use
Traditional large and small cigars, shisha/hookah (water pipe), spiritual pipe		○ day ○ week ○ month ○ year ○ single use
Pipe, chewing tobacco		○ day ○ week ○ month ○ year ○ single use
Marijuana/hashish (joints/consumption)		○ day ○ week ○ month ○ year ○ single use
Any other smoking cessation products, or used tobacco in any other form		○ day ○ week ○ month ○ year ○ single use

28 Do you drink alcohol? If ***"yes"***, complete the table below.

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
	○	○	○	○

PROPOSED INSURED 1

TYPE	NUMBER/AMOUNT		FREQUENCY PER
Beer		Bottles per	○ day ○ week ○ month ○ year ○ occasionally/socially
Wine		Glasses per	○ day ○ week ○ month ○ year ○ occasionally/socially
Liquor		○ oz ○ ml per	○ day ○ week ○ month ○ year ○ occasionally/socially

PROPOSED INSURED 2

TYPE	NUMBER/AMOUNT		FREQUENCY PER
Beer		Bottles per	○ day ○ week ○ month ○ year ○ occasionally/socially
Wine		Glasses per	○ day ○ week ○ month ○ year ○ occasionally/socially
Liquor		○ oz ○ ml per	○ day ○ week ○ month ○ year ○ occasionally/socially

Personal history

INSTRUCTIONS ***Complete questions 29–44 for Proposed Insureds of all ages, except if a telephone interview is required. If a Child Rider Benefit is requested, complete the Children's Insurance Rider section questions 45–53.***

TRAVEL

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
29 With the exception of travelling 6 months or less per year within North America, the Caribbean or European Union countries, do you have any plans to travel or reside outside of Canada in the next 12 months?	○	○	○	○

If ***"yes"*** provide details: countries, cities, purpose of travel, length of stay and expected number of trips per year.

If you require more space, please use the remarks section or complete the *Foreign Travel Questionnaire* (UW-FTQ399).

PROPOSED INSURED 1

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

PROPOSED INSURED 2

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

LIFESTYLE AND AVOCATION

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
30 a) Are you using a wearable fitness tracker to track calories burned, steps taken, heart rate measured, hours slept, etc.? If ***"yes"*** would you be willing to share the data you collected with *ivari* (If willing, please attach data collected to your insurance application)?	○	○	○	○
b) In the last 12 months, have you piloted an aircraft other than with a commercial/major airline carrier, or do you intend to do so in the next 12 months? If ***"yes"*** complete the *Aviation Questionnaire* (UW-AVIQ312).	○	○	○	○
c) In the last 12 months, have you engaged in any hazardous or extreme sports (including, but not limited to, mixed martial arts, combat sports, ski jumping, bungee jumping, base jumping, motorized vehicle racing, cliff diving, scuba diving, sky diving, parachuting, sky surfing, hang-gliding and mountain climbing, out of bound snowmobiling, out of bound skiing), or do you intend to do so in the next 12 months? If ***"yes"*** complete the appropriate questionnaire	○	○	○	○
d) In the last 10 years, have you had your driver's licence suspended or revoked?	○	○	○	○
e) In the last 2 years, have you refused to provide a breathalyzer sample, and/or have you had 2 or more highway traffic violations?	○	○	○	○

If ***"yes"*** to question d) and e) provide driver's licence number and provide reason(s), date(s) and type of offence.

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
f) In the last 10 years, have you been convicted of any criminal offence or fraudulent financial charges, or do you have any charges pending? If ***"yes"*** provide reasons(s), date(s) and type(s) of offence(s)	○	○	○	○
g) In the last 5 years, have you filed for bankruptcy and not received a discharge, or are you currently involved in a bankruptcy proceeding? If ***"yes"*** provide details	○	○	○	○

Health history **PROPOSED INSUREDS OF ALL AGES**

PROPOSED INSURED 1

31 Name of the Proposed Insured:

_____

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

Weight change in last 12 months:

☐ None, **or** loss: _____ Gain: _____

Reason for weight change: _____

32 Do you have a family doctor? . . . . . ○ yes ○ no

If ***"yes"***, give the name of the doctor and the name of the clinic.

Name of doctor/clinic: _____

Date of last visit: (DD/MM/YYYY) _____

Address: _____

Phone: _____

Reason for visit: _____

Results: _____

Follow-up needed or scheduled (other than routine check-up): . . . . . ○ yes ○ no

Details: _____

PROPOSED INSURED 2

33 Name of the Proposed Insured:

_____

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

Weight change in last 12 months:

☐ None, **or** loss: _____ Gain: _____

Reason for weight change: _____

34 Do you have a family doctor? . . . . . ○ yes ○ no

If ***"yes"***, give the name of the doctor and the name of the clinic.

Name of doctor/clinic: _____

Date of last visit: (DD/MM/YYYY) _____

Address: _____

Phone: _____

Reason for visit: _____

Results: _____

Follow-up needed or scheduled (other than routine check-up): . . . . . ○ yes ○ no

Details: _____

Health history PROPOSED INSUREDS OF ALL AGES

INSTRUCTIONS ***If a paramedical or telephone interview is required, there is no need to complete questions 35–44.***

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
35 In the last 5 years, have you consulted any medical advisors other than as identified on page 16? If ***"yes"***, provide name and address in the remarks section.	○	○	○	○
36 Are you now being observed or treated by any medical advisor, or taking any medication other than as identified on page 16?	○	○	○	○
37 Have you ever had, or ever been told to have, or received treatment or advice for:				
Heart and circulatory system: a) The heart or blood vessels, such as chest pain, shortness of breath, palpitations, irregular pulse, high cholesterol levels, high blood pressure, heart attack, stroke, or Transient Ischemic Attack (TIA), rheumatic fever, murmur, poor circulation, abnormal ECG, bypass or angioplasty, angina, aneurysm, arteriosclerosis, peripheral vascular diseases, blood clot or any other disease or disorder of the blood vessels, the heart, congenital heart disorder or circulatory system?	○	○	○	○
Eyes, ears, nose, throat, lungs, respiratory system: b) The lungs, nose, throat, such as shortness of breath, persistent cough or hoarseness, blood spitting, chronic bronchitis, persistent fever, emphysema, asthma, tuberculosis, chronic obstructive pulmonary disease, sleep apnea, sarcoidosis, blindness, optic neuritis or other visual disturbance, deafness or any other disorder or disease of the eyes, ears, nose, throat, lungs or respiratory system?	○	○	○	○
Gastrointestinal system: c) The digestive organs, such as ulcer, bleeding, recurrent indigestion, gastrointestinal problem, including persistent or chronic diarrhea, inflammatory bowel disease, celiac disease, ulcerative colitis, colitis, Crohn's disease, hepatitis, hepatitis carrier or jaundice, cirrhosis of the liver or any other disease or disorder of the mouth, esophagus, stomach, liver, pancreas, intestines or rectum?	○	○	○	○
Kidney, bladder and reproductive organs: d) The kidney, bladder, prostate, genital or urinary organs, such as nephritis, sexually transmitted diseases, sugar, abnormal protein levels, blood or abnormality in the urine, abnormal Pap or elevated Prostate Specific Antigen (PSA)?	○	○	○	○
Nervous system and brain: e) The nervous system such as chronic headaches, dizziness, chronic fatigue, seizure, epilepsy, memory loss, Alzheimer disease, paralysis, loss of sensation, loss of balance, loss of speech, weakness of the extremities, numbness or tingling, neuritis, neuropathy, multiple sclerosis, motor neuron disease, Parkinson's disease, muscular dystrophy, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), cerebral palsy, down syndrome, muscular dystrophy, head or brain injuries, meningitis, loss of consciousness, coma, any congenital abnormality, hereditary disorder or any other disease or disorder of the brain or nervous system?	○	○	○	○
Blood, glandular and endocrine system: f) The blood or the glandular system such as anemia, enlarged glands, diabetes, abnormal blood sugar, disorder of the endocrine system, hemophilia, persistent anemia, hormone disorders, thyroid, adrenal or pituitary gland disorder or tumour, breast disorder, abnormal mammogram, abnormal ultrasound or biopsy of the breast or any other disease or disorder of the glands or the blood?	○	○	○	○
Nervous, mental or mood disorder: g) Mental or mood disorder such as anxiety, stress, burnout, depression, bipolar disorder, schizophrenia, suicide attempt or ideation, behavioural, Attention Deficit Disorder (ADD), autism, eating or emotional disorder, cognitive impairment, developmental handicap or any other psychological, psychiatric disease or disorder?	○	○	○	○

Health history **PROPOSED INSUREDS OF ALL AGES**

		PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
	Back, muscles and bones:				
	h) The musculoskeletal system, such as arthritis, paralysis, deformity, fibromyalgia, osteoarthritis, rheumatoid arthritis, repetitive strain injury, any other disease or disorder of the back, muscles, bones, joints, limbs, spine, other conditions causing limited motion or requiring adaptive devices?	○	○	○	○
	Immune system:				
	i) The immune system, such as an immune deficiency syndrome, AIDS or test results indicating exposure to the virus causing AIDS (HIV), lupus, scleroderma or any other disease or disorder of the immune system?	○	○	○	○
	Tumours or growths:				
	j) Cancer or any other form of malignant disease, cyst, tumour, lymphoma, leukemia, melanoma, any growth, lump, polyp or any other symptoms, treatment related to any tumour, lump, cyst, growth or cancer?	○	○	○	○
	Skin disorders:				
	k) Psoriasis, skin sores or ulcers, mole or dysplastic nevus syndrome or any other disease or disorder of the skin?	○	○	○	○
38	a) Have you ever had, or ever been told you had, any disease, condition, abnormality or hereditary disorder not already mentioned?	○	○	○	○
	b) Have you ever applied for or received a pension, disability benefit or any compensation because of an illness, injury or surgery not yet completed?	○	○	○	○
39	a) Do you have any reason to believe that you are not in good health, or are you aware of any symptoms for which you have not yet sought treatment or consultation?	○	○	○	○
	b) Have you been advised to have treatment, consultation, or medical testing which has not yet been completed or for which you have not yet received the results?	○	○	○	○
40	a) In the last 5 years, have you ever had or been recommended to have a Computer Tomography Scan (CT Scan) including a coronary calcium scan or Magnetic Resonance Imaging (MRI) and/or any other diagnostic testing not mentioned above?	○	○	○	○
	b) In the last 5 years, have you ever had an electrocardiogram, x-ray or other diagnostic test?	○	○	○	○
41	Have you been absent from work: not applicable to a juvenile (Proposed Insureds less than 16 years of age)				
	a) For more than 7 days in the last 6 months because of sickness or injury?	○	○	○	○
	b) For more than 2 weeks due to disability in the last 24 months?	○	○	○	○
42	In the past 10 years have you used any sedative, tranquilizer, heroin, morphine, cocaine, barbiturates, amphetamines, LSD, marijuana or any depressants, ecstasy, stimulants or hallucinogenic, narcotic or any other habit-forming or illicit drug(s)?	○	○	○	○
43	Have you ever decided to or been advised to decrease consumption of alcohol or drugs, or ever received, or been advised to receive, counselling or treatment for drug dependency or the use/abuse of alcohol or chemicals? If ***"yes"***, provide details including date of last use in the *remarks* section.	○	○	○	○

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

QUESTION #	PROPOSED INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Family history

PROPOSED INSUREDS OF ALL AGES

	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
44 Has any family member (whether living or deceased) ever suffered from, or is any family member suffering from, high blood pressure, heart disease, stroke, cancer (specify type), diabetes, polycystic kidney disease, mental illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), motor neuron disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease or any other hereditary disease?	○	○	○	○

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

PROPOSED INSURED 1

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

PROPOSED INSURED 2

FAMILY MEMBER	CONDITION	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

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

QUESTION #	PROPOSED INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Children's Insurance Rider

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

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

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

Name and address of family doctor: _____

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

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

Name and address of family doctor: _____

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

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

Name and address of family doctor: _____

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

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

Name and address of family doctor: _____

Refer to children named in question 45

If ***"yes"*** to any question(s), identify the child and provide additional information in the remarks section.

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

53 Are there any children on whom coverage is not being requested? ○ yes ○ no
If ***"yes"***, provide details in the remarks section.

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

QUESTION #	PROPOSED INSURED #	DETAILS (PROVIDE DATES, DIAGNOSIS, RESULTS OF INVESTIGATIONS, NAMES OF MEDICAL ADVISORS, MEDICAL FACILITIES AND TREATMENT)

Acknowledgement and authorization

Acknowledgement of variability of UL policies

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

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

Exclusions and limitations for Critical Illness Protection

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

Applicant's acknowledgement

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

Authorization to disclose information to your independent insurance advisor

By agreeing to the authorization below, you are giving us permission to disclose your personal information to your independent insurance advisor, who may use it to help you with your insurance options.

This information could include:

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

The information will be shared only with the independent insurance advisor indicated below. You may also cancel this authorization at any time by calling us at 1-800-846-5970. This authorization will remain in effect for 45 days after we issue a policy or send you a letter indicating that your insurance request has been declined.

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

Does **PROPOSED INSURED 1** agree to the disclosure of information? ..... ○ yes ○ no

Does **PROPOSED INSURED 2** agree to the disclosure of information? ..... ○ yes ○ no

Declaration

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

ACKNOWLEDGEMENT AND AGREEMENT

I/We acknowledge and agree that:

1. This application consists of pages i and 1–23, any supplement to it (if applicable) and any other declaration made in connection with this application. Together all of this information will form the basis for any policy/coverage issued.
2. This application does not include any "Temporary Insurance Agreement."
3. No information acquired by any representative of *ivari* will be binding on *ivari* unless set out in writing in this application.
4. Any policy issued on this application will not take effect unless all of the following conditions are satisfied:
   a) the full amount of the first premium is received by *ivari* during the lifetime of all proposed insured(s) under the policy;
   b) the policy is delivered to the owner during the lifetime of the proposed insured(s) under the policy;
   c) all statements and answers given in this application continue to be true and complete on the date of delivery of the policy; and
   d) no change has taken place in the insurability of any proposed insured(s) between the time this application is completed and the time the policy is delivered to the owner.
5. Only the president together with a vice-president or secretary of *ivari* has the authority to bind *ivari* or to make any change in this application or any policy issued. *ivari* will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend or modify any of the terms or provisions in this application or any policy issued. However, *ivari* may make certain changes to this application as provided for in your policy contract. The owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements or amendments.
6. If the answer to any question(s) in this application is misstated or omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
7. All premium payments must be made payable to *ivari*.
8. I/We have received and fully understand the contents of the Disclosure of Compensation, where applicable.

PERSONAL INFORMATION AUTHORIZATION

I/We have read and fully understand the contents of the notices regarding MIB, Inc., investigative consumer reports and collection, use and disclosure of personal information (collectively, the "notices") and acknowledge and consent to the collection, use and disclosure of my/our personal information by *ivari* and its affiliates for the purposes identified in those notices.

For the purposes of risk assessment, investigation and loss analysis, I/we authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or any other organization, institution, association or person identified in the notices that now has or may in future have any records or knowledge concerning me/us or my/our health to disclose to *ivari*, its authorized representatives and its reinsurers, upon the request of *ivari*, any such information that is deemed to be material by *ivari* for the purposes identified in the notices. I/We authorize *ivari*, or its reinsurers, to make a brief report of my/our personal health information to MIB, Inc.

I/We further authorize a representative of *ivari* to perform such tests, examinations, x-rays, electrocardiograms and blood or urine tests as may be required by *ivari*. I/We understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus and the presence of medications, drugs, nicotine or their metabolites. *ivari* may release the results of these tests and examinations to my personal physician(s).

I/We certify that the information given in this section is correct and complete. I/We agree to immediately notify *ivari* of any errors, omissions or changes in the information provided in this section. As the policy owner(s), I/We acknowledge that I/we have an obligation under the *Income Tax Act* to notify *ivari* of any changes in my/our tax residency status. I/We acknowledge that the information contained in this section and information regarding my/our policy, contract and account may be reported to Canada Revenue Agency (CRA).

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

The consent you provided in the Notice regarding collection, use and disclosure of personal information relating to the use of your personal information to provide you with details about other insurance and financial services and products is optional. If you do not wish your personal information to be used for this optional purpose, check here ☐ or you can write to us at: ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8 Attention: Privacy Officer.

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

Sign here

Signature of **PROPOSED INSURED 1**

If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **PROPOSED INSURED 2**

If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **OWNER 1**, if not a Proposed Insured

Sign here

Signature of **OWNER 2**, if not a Proposed Insured

Print name of signing officer and title, if entity owned

Print name of signing officer and title, if entity owned

Sign here

Witness to signature(s)

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

Application for temporary insurance

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

Name of life insured: **PROPOSED INSURED 1:** _____ Date of birth: _____ (DD/MM/YYYY)

PROPOSED INSURED 2: _____ Date of birth: _____ (DD/MM/YYYY)

Note: Temporary insurance is not available for Proposed Insured(s) if:

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

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

Has any proposed insured:	PROPOSED INSURED 1 YES	PROPOSED INSURED 1 NO	PROPOSED INSURED 2 YES	PROPOSED INSURED 2 NO
a) Ever been treated or had any indication of Alzheimer's disease, Parkinson's disease, disorder of the heart or the blood vessels, chest pain, stroke, Transient Ischemic Attack (TIA), loss of speech, loss of limbs, severe burns, deafness, blindness, kidney, liver or lung disease, diabetes, multiple sclerosis, paralysis, coma, cancer or tumour, AIDS or HIV infection or any other immunological disorder, congenital heart disease, cerebral palsy, cystic fibrosis or muscular dystrophy?	○	○	○	○
b) Within the last 6 months, been unable to perform regular activities for more than 15 consecutive days because of sickness or injury?	○	○	○	○
c) Within the last three months, been admitted to a medical facility, been advised to be admitted to a medical facility or had a diagnostic test and/or surgery recommended or performed (other than for normal childbirth)?	○	○	○	○
d) Ever had an application for life or critical illness insurance on his or her life declined, postponed and/or received a life or critical illness insurance policy that was rated or modified in any way?	○	○	○	○

Declaration

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

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

Sign here

Signature of **PROPOSED INSURED 1**
If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **PROPOSED INSURED 2**
If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here

Signature of **OWNER 1**, if not a Proposed Insured

Sign here

Signature of **OWNER 2**, if not a Proposed Insured

Print name of signing officer and title, if entity owned

Print name of signing officer and title, if entity owned

Sign here

Witness to signature(s)

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

I/We authorize *ivari* to make automatic withdrawals from my/our bank account at the financial institution identified on the attached sample (VOID) cheque, bank letter of direction, or as otherwise set out in this application, for insurance premiums which become due on or after the date. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with my/our insurance contract including for renewal and conversion premiums and as required to administer my/our policy. **I/We waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.** If the bank or financial institution does not honour an automatic premium withdrawal when first presented for payment, *ivari* may attempt to withdraw that payment again within 5 days. *ivari* reserves the right to ask for an alternative method of payment if payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We or *ivari* may end this agreement at any time by giving 10 days written notice. I/We understand that canceling this authorization may result in loss of insurance coverage unless *ivari* receives another form of payment. Any refund of premium made pursuant to this authorization shall be paid to the Policy Owner.

I/We certify that all required signatures for the authorization of the withdrawals are present in this authorization. I/We further authorize such financial institution to deal with these withdrawals as if authorized directly by me/us. I/We understand and agree to all of the terms and conditions printed on the next page, which my advisor has reviewed with me/us.

I hereby direct *ivari* to:

○ Establish a new PAD account using:
- ○ the same account shown on the first cheque provided with this application
- ○ the account shown on the attached VOID cheque (pre-printed with the payor's name) or bank letter of direction

○ Add to existing PAD account – *ivari* policy no.: _____

Initial premium/PAD start date:
The initial premium/PAD start date will be the date which is identified in the application.

Date signed: (DD/MM/YYYY) _____

Sign here _____
Signature(s) of Payor(s)

Sign here _____
Signature(s) of Payor(s)

_____
Payor(s) name(s) shown on bank records

_____
Payor(s) name(s) shown on bank records

Sign here _____
Signature of Policy Owner(s), if not a Payor(s)

Sign here _____
Signature of Policy Owner(s), if not a Payor(s)

NOTE: ALL PAYORS/ACCOUNT HOLDERS MUST SIGN THIS AUTHORIZATION

If the Payor is someone **other than** the Insured, Owner or Beneficiary, complete question 26 d) third party determination on page 13.

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

EFFECTIVE DATE

I/We understand and agree that the fully completed authorization on the previous page will take effect for the policies applied for, on the latest of the following dates:

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

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

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

GENERAL

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

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

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

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

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

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

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

TERMINATION

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

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

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

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

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

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

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

ivari
500-5000 Yonge Street
Toronto, ON M2N 7J8
Tel: 1-800-846-5970

Independent Insurance Advisor's Report **MUST BE COMPLETED IN ALL CASES**

1. Third party determination must be completed for all applications. Every reasonable effort must be made by you to determine if the owner(s) is/are acting on behalf of a third party. The ***Proceeds of Crime (Money Laundering) and Terrorist Financing Act*** requires each Proposed Insured's identity to be verified by referring to certain documents. The law also requires the existence of third parties, if any, to be determined and recorded.

   When asked whether the Owner(s) is/are acting on behalf of a third party, the individual submitting the application answered:
   ○ No
   ○ Yes, complete and submit the *Identity and Third Party Determination* form (IP-LP782)
   ○ Unable to determine; however, I have reasonable grounds to suspect there is a third party.
   Provide details (attach separate page if necessary):

   _____

   _____

2. Did you complete the application in person with all Proposed Insured(s)/Owner(s)? . . . . . ○ yes ○ no
   If ***"no,"*** explain why: _____

	ADVISOR 1	ADVISOR 2
3. Are you the Proposed Insured, Owner or beneficiary on this policy?	○ yes ○ no	○ yes ○ no
4. If you have a family relationship with the Proposed Insured, please specify:	_____	_____

5. By signing below, I/we acknowledge that I/we have disclosed, where applicable, the following items to the Owner of the policy resulting from this application:
   a) The company or companies I/we represent;
   b) That I/we will receive compensation in the form of bonuses *(such as commissions or a salary);* and
   c) That I/we have disclosed any conflicts of interest that I/we may have with respect to this transaction.

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

_____

_____

Advisor's email address: _____

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

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

Sign here

Signature of advisor _____ Name of advisor _____

Sign here

Signature of advisor _____ Name of advisor _____

Sign here

Signature of supervising advisor (where required) _____ Name of supervising advisor _____

Grouped policies

INSTRUCTIONS If you wish to have this policy issued on the same day as another policy or policies for families, partnership or other business reasons, please give the names of the other Proposed Insured(s) below (not applicable to any policy with a Critical Illness Protection Rider or any Critical Illness Protection policy): Group with:

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

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

To be completed by advisor and distributor **MUST BE COMPLETED IN ALL CASES**

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

1. Distributor contact name: _____ Distributor name and code: _____

   Distributor contact email: _____ Distributor contact phone number: _____

   Advisor name or managing broker (1): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

   Advisor name or managing broker (2): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

   Advisor name or managing broker (3): _____ Advisor code: _____ Share %: _____

   Unpaid solicitor name: _____ Advisor code: _____

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

2. Advisor/Distributor notes:

   _____

   _____

   _____

   _____

3. **Underwriting requirements** ○ **Ordered by advisor** ○ **Ordered by distributor**

PROPOSED INSURED 1

ORDERED	ORDERED FROM	SUBMITTED
☐ Paramedical	_____	☐ Signed illustration
☐ Telephone interview	_____	☐ Signed supplement to the insurance application
☐ Urine/HIV	_____	☐ Replacement/Disclosure forms
☐ Blood/HOS	_____	☐ Financial statements
☐ ECG	_____	☐ Questionnaires: _____
☐ Stress ECG	_____	
☐ Inspection/BBR	_____	☐ Other: _____
☐ Other	_____	

PROPOSED INSURED 2

ORDERED	ORDERED FROM	SUBMITTED
☐ Paramedical	_____	☐ Signed illustration
☐ Telephone interview	_____	☐ Signed supplement to the insurance application
☐ Urine/HIV	_____	☐ Replacement/Disclosure forms
☐ Blood/HOS	_____	☐ Financial statements
☐ ECG	_____	☐ Questionnaires: _____
☐ Stress ECG	_____	
☐ Inspection/BBR	_____	☐ Other: _____
☐ Other	_____	

Receipt for temporary insurance

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

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

Name of **PROPOSED INSURED 1** _____ Name of **PROPOSED INSURED 2** _____

Signed at (city) _____ on (DD/MM/YYYY) _____

Sign here

Print full name of advisor _____ Signature of advisor _____

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

Note: If you do not hear from *ivari* regarding the proposed insurance within ninety (90) days of the date of your Insurance Application, contact your independent insurance advisor or *ivari* at its Head Office, **500-5000 Yonge Street, Toronto, Ontario M2N 7J8. Telephone: 1-800-846-5970 or Fax: 416-883-5520 or 1-877-767-0477.**

Temporary Insurance Agreement (TIA)

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

TERMS AND CONDITIONS

1. EFFECTIVE DATE

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

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

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

c) The initial payment has been honoured.

2. BENEFIT

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

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

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

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

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

3. LIMITATIONS

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

This agreement is void if:

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

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

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

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

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

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

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

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

4. TERMINATION

This Agreement will terminate on the earliest of the following dates:

a) The standard termination date, which is the 90th day after the date the Insurance Application is signed;

b) The date on which *ivari* electronically communicates or mails a notice to your independent insurance advisor or distributor to advise the Owner and/or Proposed Insured(s) in the insurance application that *ivari* is either (a) terminating this Agreement, or (b) declining to issue the policy as applied for or (c) making a counter offer;

c) The date on which the Owner in the insurance application requests the withdrawal of the application for insurance or temporary insurance; and

d) The date that the policy(ies) applied for become(s) effective.

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

Let's talk about…ivari

ivari provides a full range of insurance products specifically designed to help Canadians and their families make the right choice for their protection needs. The people, products and programs that make up *ivari* have stood the test of time and have been around for over 80 years in the Canadian marketplace.

In 2015, we were acquired by Wilton Re. Wilton Re is a life (re)insurance company specializing in the acquisition and management of life and annuity businesses as well as with assisting companies with product development, underwriting and new business strategies designed to serve the middle market.

Visit us at ivari.ca.

Checklist

To advisors and/or distributors, before submitting your application to *ivari*, did you remember to:

☐ Detach the "Let's talk about…*ivari"*/Notice of Disclosures (page i) and leave with the Proposed Insured(s)?

☐ Detach the receipt for temporary insurance on page 29 and leave it with the Policy Owner if your client is applying for TIA?

☐ Complete the Pre-Authorized Debit payment section on page 25 and attach a VOID cheque pre-printed with the payor's name or a bank letter of direction if your client selected the PAD payment method?

☐ Complete all the **MANDATORY FOR UNIVERSAL LIFE POLICIES** sections if your client is applying for a universal life product?

☐ Attach a signed copy of the Illustration and a *Supplement to the Insurance Application* if your client is applying for a universal life product?

500-5000 Yonge Street
Toronto, Ontario M2N 7J8