beneva

Individual insurance

Policy application

For the following products:

- Permanent life
- Term life
- Critical illness
- Universal life

Version: July 2023

Beneva Inc.
1225 Saint-Charles Street West, Suite 200
Longueuil, Quebec J4K 0B9

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Application – Individual Insurance

Beneva Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

RESET FORM

Policy number	Application number
	T 574 305 768

A – Basic information

- For more than 2 insureds, use additional applications as required.
- Enter the number of the primary application on each additional application and submit all applications together.
- **Submit ALL the pages of this application, even if there is no information written on certain pages.**

☐ Preliminary application ☐ New application Language of correspondence: ☐ English ☐ French

Nature of application: ☐ Primary ☐ Additional to application **or** policy no.: _____

Internal cancellation and replacement **(complete)**: ☐ Yes ☐ No Cancelled policy no.: _____

Internal cancellation and replacement **(partial)**: ☐ Yes ☐ No Coverage cancelled: _____

The cancellation will be processed when the new coverage or new contract upon settling.

Policy changes requiring evidence of insurability

If the policy is not already governed by the tax rules in effect as of January 1st 2017, certain changes that require evidence of insurability may cause a change to the tax rules applicable to the policy.

If there is more than one policyowner, EACH policyowner must sign Section M of this application. For any addition of insured or addition of benefit on a policy, each insured and/or policyowner covered by Waiver of Premium on such policy must complete Sections I and J (use additional applications as required).

To request a policy change requiring evidence of insurability, complete the following sections of this application in accordance with the type of change requested :

☐ **Addition of insured** – Not available for any universal life insurance policy.
- **Addition Policyowner :** B1, B2, B3, B5, B7, C, D5, E, F, G, I, J, K, L, M, N, P and Q
- **Critical illness insurance / Term insurance :** B1, B2, B5, B7, C, D5, E, F, G, I, J, K, L, M, N, P and Q
- **Whole life insurance / Enhanced term-100 life insurance :** B1, B2, B4, B5, B7, C, D5, E, F, G, I, J, K, L, M, N, P and Q
- **Child Rider / Children's Endorsement :** H

☐ **Addition of benefit or additional benefit:**
No addition available for a universal life insurance policy if the policy date is prior to January 1st 2017.
The addition of term insurance benefits or critical illness insurance benefits on a universal life insurance policy is available only if the contract is individual.
- **Addition Policyowner :** B1, B2, B3, B5, B7, C, D5, E, F, I, J, K, L, M, N, P and Q
- **Critical illness insurance / Term insurance :** B1, B2, B5, B7, C, D5, E, F, I, J, K, L, M, N, P and Q
- **Whole life insurance / Enhanced term-100 life insurance :** B1, B2, B4, B5, B7, C, D5, E, F, I, J, K, L, M, N, P and Q
- **Universal life insurance :** B1, B2, B3, B3, B4, B5, B6, C, D5, E, F, I, J, K, L, M, N, P and Q
- **Child Rider / Children's Endorsement :** H

☐ **Revision of rating / Exclusion :** B1, B2, I, J, K, L, M, N, P and Q
☐ **Revision of risk class (12 months after date of issue only) :** B1, B2, I, J, K, L, M, N, P and Q
☐ **Change to non-smoker rate :** use the *Non-smoker rates form* (FIND0241A)
☐ **Reinstatement :** use the *Policy reinstatement form* (FIND0117A)

Amendments that do not require proof of insurability

For any change request that does not require proof of insurability, complete the form according to the type of modification requested :

- **Changes without evidence of insurability :** use the *Policy change without evidence of insurability form* (FIND0116A).
- **Change of beneficiary :** use the *Change of beneficiary(ies) form* (FIND0205A).

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B – General information

B1 – Proposed insured(s)

- The first name and last name will appear on the insurance contract as indicated in this section.
- Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.
- When the address of the insured 2 is not indicated, we consider that it corresponds to that of the insured 1.
- When the insured and the policyowner are the same person, the insured must be a Canadian resident.

Insured 1	Insured 2
☐ Mr. ☐ Mrs. ☐ Ms.	☐ Mr. ☐ Mrs. ☐ Ms.
First name	First name
Last name	Last name
Name at birth (if different)	Name at birth (if different)
Y Y Y Y M M D D — Date of birth; Age*; ☐ Male ☐ Female Sex	Y Y Y Y M M D D — Date of birth; Age*; ☐ Male ☐ Female Sex
Place of birth (country and city)	Place of birth (country and city)
If you were born **outside** of Canada, complete the information below:	If you were born **outside** of Canada, complete the information below:
Arrival date: Y Y Y Y M M D D	Arrival date: Y Y Y Y M M D D
Legal status in Canada:	Legal status in Canada:
☐ Canadian citizen	☐ Canadian citizen
☐ Permanent resident (holds a permanent resident card)	☐ Permanent resident (holds a permanent resident card)
☐ Work permit (attach a copy of the work permit)	☐ Work permit (attach a copy of the work permit)
☐ Refugee	☐ Refugee
☐ Other (specify):	☐ Other (specify):
(attach a letter from Citizenship and Immigration Canada confirming the permanent residence request)	(attach a letter from Citizenship and Immigration Canada confirming the permanent residence request)

* Age at nearest birthday, that is six (6) months before or after the date the application is signed.

Residential Address	Residential Address
Civic number and street name; Apt.	Civic number and street name; Apt.
City	City
Province; Postal code	Province; Postal code
Telephone (residential)	Telephone (residential)
E-mail address (internet)	E-mail address (internet)

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B2 – Employment details

Insured 1	Insured 2
Profession/Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity)	Profession/Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity)
Tasks involved in occupation, and employment status (e.g. employee, executive, owner, self-employed, etc.)	Tasks involved in occupation, and employment status (e.g. employee, executive, owner, self-employed, etc.)
Nature of employer's business	Nature of employer's business
$ Gross annual income	$ Net worth
$ Other income → Specify source	$ Other income → Specify source
Employer's name	Employer's name
Civic number and street name / Suite number	Civic number and street name / Suite number
City	City
Province / Postal code	Province / Postal code
Telephone (office)	Telephone (office)

B3 – Policyowner(s)

- **When the policyowner(s) is (are) not indicated, we consider that it corresponds to the insured(s) - Maximum 2 policyowners per policy.**
- **For universal life insurance, when the policyowner is a corporation or another type of entity, complete the *Verification of the Idendity of Corporations and Other Entities* (FRA1235A) form.**

The policyowner(s) is (are): → ☐ Insured 1 ☐ Insured 2 ☐ A distinct policy will be issued for insured 1 and insured 2. Each insured will be the sole policyowner. ☐ Other (if a policyowner is not one of the insureds, provide the information requested below.

When the address of the policyowner 2 is different from that of the policyowner 1, we consider that the mailing address corresponds to that of the policyowner 1.

Policyowner 1 (if not an insured)	Policyowner 1 (if not an insured)
First and last names or full legal name of company or other entity	First and last names or full legal name of company or other entity
Relationship to insured / Business number (if applicable)	Relationship to insured / Business number (if applicable)
Residential address (policyowner must be a Canadian resident)	Residential address (policyowner must be a Canadian resident)
Telephone	Telephone
Complete for universal life insurance	**Complete for universal life insurance**
Principal business or detailed occupation and field of activity (if retired, indicate the last profession and field of activity)	Principal business or detailed occupation and field of activity (if retired, indicate the last profession and field of activity)
Name of employer	Name of employer
Employment status (e.g. employee, executive, owner, self-employed, etc.)	Employment status (e.g. employee, executive, owner, self-employed, etc.)
Date of birth Y Y Y Y M M D D	Date of birth Y Y Y Y M M D D
Complete if Waiver of Premium is requested	**Complete if Waiver of Premium is requested**
Y Y Y Y M M D D Date of birth / Place of birth	Y Y Y Y M M D D Date of birth / Place of birth
Age* _____ Sex ☐ M ☐ F	Age* _____ Sex ☐ M ☐ F

*Age at nearest birthday, that is six (6) months before or after the application.

Upon the death of a policyowner, the rights and interests of such deceased policyowner in the policy shall be transferred to the contingent/successor policyowner designated in this section.

First and last name of contingent/successor policyowner 1	First and last name of contingent/successor policyowner 1
Relationship to insured / Date of birth Y Y Y Y M M D D	Relationship to insured / Date of birth Y Y Y Y M M D D

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B4 – Declaration of tax residence of policyowner(s) (self-certification)

(applicable to whole life insurance, enhanced term-100 life insurance and universal life insurance products)

The insured(s) and the policyowner(s) must be tax residents of Canada in order for an insurance policy to be issued. The information provided in the Declaration of Tax Residence section must be correct and complete. The policyowner(s) must provide Beneva Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to become incomplete or inaccurate (e.g., changing a bank account for one in a financial institution in a country other than Canada, changing an address for an address in a country other than Canada, etc.).

The policyowner is a corporation or other type of entity

For **whole life insurance** or **enhanced term-100 life insurance,** the Declaration of Tax Residence must be completed on the form *Declaration of Tax Residence (Self-Certification) – Entity* (FRA1748A).

For **universal life insurance**, the Declaration of Tax Residence must be completed on the form *Verification of the Idendity of Corporations and Other Entities* (FRA1235A).

Policyowner 1 (individual)	Policyowner 2 (individual)
Check (✓) all options that apply to you:	**Check (✓) all options that apply to you:**
☐ I am a tax resident of Canada	☐ I am a tax resident of Canada
☐ I am a tax resident of a jurisdiction other than Canada → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is required.**	☐ I am a tax resident of a jurisdiction other than Canada → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is required.**

B5 – Identity verification

At all times for all product types: The financial security advisor/representative must verify the identity of each **insured**.

For universal life (UL) insurance: If the policyowner is different from the insured, the financial security advisor/representative must verify the identity of each **policyowner** as required by the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* (the Act).

How are you verifying the identity of each insured (at all times for all product types) and each policyowner (for UL insurance, if different from the insured)?

Check the box(es) that apply:

☐ **In the physical presence of each person:** using an **authentic (original), valid and unexpired (if applicable) government-issued photo identification document** → If you check this box, indicate below for each person, the identification document that has been reviewed, its number, its expiration date (if applicable) and jurisdiction. If the document selected below is "Other photo identification document admissible by Law", specify the type of document verified. In Quebec, you are not allowed to request the client's Health Card, but you can accept it only if the client offers it to you. In the provinces of Ontario, Manitoba, Nova Scotia and Prince Edward Island, the use of a Health Card for identification purposes is prohibited.

☐ **Using the dual process method (if verification done remotely or if identification document not valid):** using two legible, valid and up-to-date documents from two different, independent and reliable sources → **If you check this box, the form *Dual process method for identity verification – Individual – Financial security advisor/ Representative declaration* (FRA1913A) is required.**

Insured 1	Insured 2
Name of the insured (as appearing on the document)	Name of the insured (as appearing on the document)
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo
☐ Other photo identification document admissible by Law (specify):	☐ Other photo identification document admissible by Law (specify):
Document number / Jurisdiction	Document number / Jurisdiction
Y Y Y Y M M D D Document expiration date	Y Y Y Y M M D D Document expiration date

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Complete *the Identity verification for each policyowner, if not an insured (applicable to universal life insurance).*

B5 – Identity verification (continued)

Policyowner 1	Policyowner 2
Name of the policyowner (as appearing on the document)	Name of the policyowner (as appearing on the document)
The policyowner must be a canadian resident.	The policyowner must be a canadian resident.
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo
☐ Other photo identification document admissible by Law (specify):	☐ Other photo identification document admissible by Law (specify):
Document number / Jurisdiction	Document number / Jurisdiction
Y Y Y Y M M D D Document expiration date	Y Y Y Y M M D D Document expiration date

B6 – Third party determination (applicable to universal life insurance products)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, the financial security advisor / representative must take reasonable measures to determine, with regard to the present application, if the policyowner(s) is (are) acting on behalf of a third party (individual or entity).

When you must determine whether a "third party" is involved, it is not about who "owns" the money, but rather about who gives instructions to deal with the money. If the individual in front of you is acting on someone else's instructions, that someone else is the third party.

When the premium payer is a different person or entity than the policyowner(s), the payer is considered a third party and the section below must be completed.

Is (are) the policyowner(s) acting on behalf of a third party (individual or entity) or is there a third party to this contract?

☐ Yes → complete the "Third party identification" section below.

☐ No

☐ It is impossible to determine whether the policyowner(s) is (are) acting on behalf of a third party, but I have reasonable grounds to believe that he/she (they) is (are).
→ complete the "Third party identification" section below.

Is the person or entity paying the premiums/amounts in the insurance contract different from the policyowner(s)?

☐ Yes → complete the "Third party identification" section below.

☐ No

Third party identification (if applicable)

Name of the third party

Y Y Y Y M M D D
Date of birth (if third party is an individual)

Full permanent address of the third party

Telephone number of the third party

Principal business or occupation: provide complete and detailed information, including the job title, the field of activity, the name of the employer and the employment status (employee, executive, owner, self-employed, etc.); if retired, provide the details on the last occupation prior to retirement

Relationship between the third party and the policyowner(s)

If the third party is an entity:

Business number

Place of issuance of its certificate of constitution

If you cannot obtain the above-mentioned information on the third party, provide the reasons in the space below:

If you cannot determine if the policyowner is acting on behalf of a third party, but have reasonable grounds to suspect that he is, provide the reasons in the space below:

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B7 – Beneficiary(ies) – life insurance, critical illness rider and critical illness insurance

- Indicate both the first name and the last name of the person who will receive the sums insured when they become payable under the chosen benefits. If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) or their estate(s), as the case may be.
- **If more than one beneficiary is designed, the total unit allocation should equal 100%.** If the allocated percentages are not indicated, the sums insured will be divided evenly among the surviving eligible beneficiaries.
- Beneficiary designations are revocable, unless stated otherwise. In Quebec however, the designation of a legally married or civil union spouse of the policyowner is irrevocable unless stated to be revocable.
- If the beneficiary predeceases the proposed insured, the sums insured are payable to the contingent beneficiary upon the death of the proposed insured.
- In Quebec, unless otherwise indicated in a court judment, the surviving parent is always the legal tutor of the child.
- When a minor child is irrevocably designated, we must obtain a court order or wait for the child to reach majority before proceeding with all contract modifications, including partial withdrawals, loans, redemptions and other related changes.

Proposed insured 1

Beneficiary(ies) for life insurance

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable	Share % Total 100%
1				☐	☐	
2				☐	☐	
3				☐	☐	

Contingent(s) beneficiary(ies)

- In case of death of the beneficiary(ies) designated above, the percentage must be equivalent.

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable
1				☐	☐
2				☐	☐
3				☐	☐

Trustee for a minor beneficiary (not applicable in Quebec)

- When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes (not applicable in Quebec).
- If a trust is constituted, complete the information below.

First name of minor beneficiary	Last name of minor beneficiary	Last and first name of trustee	Relationship to the proposed

Proposed insured 2

Beneficiary(ies) for life insurance

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable	Share % Total 100%
1				☐	☐	
2				☐	☐	
3				☐	☐	

Contingent(s) beneficiary(ies)

- In case of death of the beneficiary(ies) designated above, the percentage must be equivalent.

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable
1				☐	☐
2				☐	☐
3				☐	☐

Trustee for a minor beneficiary (not applicable in Quebec)

- When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes (not applicable in Quebec).
- If a trust is constituted, complete the information below.

First name of minor beneficiary	Last name of minor beneficiary	Last and first name of trustee	Relationship to the proposed

B7 – Beneficiary(ies) – life insurance, critical illness rider and critical illness insurance (continued)

Proposed insured 1

Beneficiary for Critical Illness RIDER

- If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) for the Critical Illness Rider.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Critical Illness INSURANCE

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Return of Premium on Death benefit (critical illness)

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Return or Premium Surrender benefits (critical illness)

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Proposed insured 2

Beneficiary for Critical Illness RIDER

- If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) for the Critical Illness Rider.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Critical Illness INSURANCE

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Return of Premium on Death benefit (critical illness)

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

Beneficiary for Return or Premium Surrender benefits (critical illness)

- If there is no beneficiary designation, the sums insured will be payable tot the policyowner(s) or their estate(s), as the case may be.

Last name	First name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Irrevocable
			☐	☐

C – Insurance products and benefits

C1 – Permanent life insurance

- Specify coverage and face amount for each insured.

Insured 1		Insured 2	
	Face amount		**Face amount**
Whole Life 20 ☐ Individual/Multi-Life	$	**Whole Life 20** ☐ Individual/Multi-Life	$
Whole Life 100 ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$	**Whole Life 100** ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$
Enhanced Term 100 ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$	**Enhanced Term 100** ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$
Term 100 ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$	**Term 100** ☐ Individual/Multi-Life ☐ Joint, First to die ☐ Joint, Last to die	$

C2 – Term life insurance

- Specify coverage and face amount for each insured.

Insured 1		Insured 2	
	Face amount		**Face amount**
Term Plus 10 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 10** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Term Plus 15 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 15** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Term Plus 20 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 20** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Term Plus 25 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 25** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Term Plus 30 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 30** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$

C2 – Term life insurance (continued)

Term Plus 35 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 35** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Term Plus 40 ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$	**Term Plus 40** ☐ Individual/Multi-Life – level ☐ Individual/Multi-Life – decreasing ☐ Joint, First to die – level ☐ Joint, First to die – decreasing	$
Total face amount:	$ _____	**Total face amount:**	$ _____

Disability Rider (Term life insurance only)

- The monthly indemnity amount requested must be determined following a needs analysis and based on eligible loans and monthly payments. The benefit payable in the event of a total disability claim may differ from the amount requested, as mentioned in Section M (article 7).
- Certain occupations are not insurable. Please refer to the *List of non-insurable occupations* available in the library of the illustration software. Note that a spouse on parental leave must have a regular occupation insurable according to our criteria to be eligible for a maximum amount of $1,000.

	Insured 1	Insured 2
1. Eligibility		
a) Are you a stay-at-home spouse? If Yes, maximum amount of up to $1,000 and duration of two (2) years. Note: eligible only if the spouse is covered under the present policy.	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you a spouse on parental leave? If Yes, maximum amount of up to $1,000 and duration of two (2) years. Note: eligible only if the spouse is covered under the present policy.	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you currently work at least 21 hours per week? If No, not eligible for disability rider.	☐ Yes ☐ No	☐ Yes ☐ No
d) Do you work eight (8) months or more a year for at least 21 hours a week? If No, not eligible for disability rider.	☐ Yes ☐ No	☐ Yes ☐ No
2. Home-based work (or from the home(s) of your clients) What percentage of your time do you work from home (or from the home(s) of your clients)?	_____ %	_____ %
3. Disability rider (only one option can be chosen per insured)		
- With guarantee – Proof of loan upon purchase (please submit proof of loan with the application)	☐	☐
- Without guarantee – Proof of loan upon claim	☐	☐
4. Insurance need (based on needs analysis)	$ / month	$ / month
5. Amount requested (min. $300, max. 1.5% of the life insurance amount requested without exceeding $3,500)	$ / month	$ / month
6. Duration	☐ 2 years ☐ 5 years ☐ Up to age 65	☐ 2 years ☐ 5 years ☐ Up to age 65
7. a) Are the loans for which the disability insurance amount is requested already covered by another disability insurance policy?	☐ Yes ☐ No	☐ Yes ☐ No
b) If Yes, will this insurance be replaced?	☐ Yes ☐ No	☐ Yes ☐ No

Critical Illness Rider

* Available only when the initial life insurance request is submitted or when adding a life insurance face amount for which evidence of insurability is required.

Critical Illness Rider – $20,000	☐ Yes ☐ No	☐ Yes ☐ No

C3 – Critical illness insurance

Critical illness insurance - adult

- Complete Section B7.
- Critical illness insurance is only available in Individual/Multi-Life coverage.
- The Return of Premium (ROP) is available only when the initial critical illness insurance is submitted or when adding a critical illness insurance face amount for which evidence of insurability is required.

Insured 1				Insured 2			
Critical illness insurance	Basic	Enhanced	**Face amount**	**Critical illness insurance**	Basic	Enhanced	**Face amount**
T10	☐	☐	$	T10	☐	☐	$
T20	☐	☐	$	T20	☐	☐	$
T75	☐	☐	$	T75	☐	☐	$
T100	☐	☐	$	T100	☐	☐	$
T100 paid-up 20 years	☐	☐	$	T100 paid-up 20 years	☐	☐	$

Additional benefits

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation**

*ROP at expiry is available for T10, T20 and T75.

**ROP on cancellation is available for T75, T100 and T100 paid-up 20 years.

Additional benefits

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation**

*ROP at expiry is available for T10, T20 and T75.

**ROP on cancellation is available for T75, T100 and T100 paid-up 20 years.

Critical illness insurance - Child

- Complete Section B7.
- Critical illness insurance is only available in Individual/Multi-Life coverage.

Insured 1		Insured 2	
Critical illness insurance	**Face amount**	**Critical illness insurance**	**Face amount**
T75	$	T75	$
T100	$	T100	$
T100 paid-up 20 years	$	T100 paid-up 20 years	$

Additional benefits

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation

*ROP at expiry is available for T75 only.

Additional benefits

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation

*ROP at expiry is available for T75 only.

C4 – Universal life insurance

Type of coverage	☐ Individual ☐ Joint, First to die ☐ Joint, Last to die
Face Amount	$ _____
Cost of insurance type	☐ Yearly Renewable Term (YRT) ☐ T100 ☐ Other (specify): _____
Death benefit option	☐ Level death benefit (only available for the YRT cost of insurance type) ☐ Increasing death benefit When the death benefit is increasing: **For a Joint, Last to die policy, funds will be payable upon last death.**
Waiver of Premium - For a Joint policy, when more than one insured subscribes to Waiver of Premium, each insured will be covered by the same type of Waiver of Premium and for the same Duration.	**Insured 1:** ☐ Yes ☐ No **Insured 2:** ☐ Yes ☐ No **Duration:** ☐ 4 months ☐ 6 months **Type:** ☐ Waiver of minimum premium: $ _____ ☐ Waiver of billing premium (up to the maximum premium): $ _____ Waiver of Premium for the policyowner(s) – (if the policyowner is not one of the insureds) Name(s) of the policyowner(s): _____ - Complete Sections B3, I and J if the Waiver of Premium is for the policyowner and the policyowner is not one of the insureds.
Face amount adjustment (tax exemption) - If there is no option chosen, the "No Increase" option will be applied by default.	☐ Option 1: No Increase – No face amount increase (transfer of the excess funds to the transitory deposit account); ☐ Option 2: Exempt Test Increase – Face amount increase (maximum 8%) and, if necessary, transfer of the excess funds to the transitory deposit account; ☐ Option 3: Increase and Decrease – Increase and decrease of the face amount (minimum equals initial face amount); ☐ Option 4: Maximizer (complete the "Information for the Maximizer option" section below). The Maximizer option is only available for the YRT cost of insurance type.

Maximizer option

- Do not forget to specify durations and face amount.
- In the absence of details regarding the durations and minimum face amount, the default values are as follows: The beginning of duration will correspond to *10 years from the issue date*, the end of the duration will correspond to *100 years less the insured's age at issue* and the minimum face amount will correspond to *face amount of the policy*.

Optimization of exemption test

☐ Beginning of the duration: _____ years (minimum duration: 10 years from issue date)

☐ End of the duration: _____ years (maximum duration: 100 years minus the age of the insured at issue date)

☐ Minimum face amount: $ _____ (minimum $25,000, maximum face amount chosen)

C4 – Universal life insurance (continued)

In order to help you choose an appropriate investment strategy, it is necessary to assess your risk tolerance and the amount of return you hope to achieve, while taking into account your time horizon. Each investor's target asset allocation mix is determined according to their situation, needs and constraints. With these factors in mind, it is necessary that your financial security advisor / representative establishes your investor profile with you in order for him/her to advise you accordingly.

Investment options and percentage split

- Please indicate your investment choices and percentage split below.
- The total percentage split must equal 100% (minimum 10% per account).
- In case no investment account is chosen, premiums and deposits are credited in the daily interest account.
- For two accounts or more, if no split percentage is specified, premiums and deposits are equally divided between the accounts.

Managed accounts		**Interest accounts**	
Conservative Strategy	%	Daily interest account	%
Balanced Strategy	%	1-year guaranteed interest account	%
Growth Strategy	%	3-year guaranteed interest account	%
Aggressive Strategy	%	5-year guaranteed interest account	%
100% Equity Strategy	%	10-year guaranteed interest account	%
CI Canadian Asset Allocation	%	**Indexed accounts**	
CI Global Income and Growth	%	Canadian Money Market (3-month Treasury Bill)	%
Guardian Conservative Monthly Income	%	Canadian Bonds (FTSE Canada Universe Bond)	%
Guardian Monthly Income	%	Canadian Equity (S&P/TSX)	%
PIMCO Bond	%	US Equity (S&P 500)	%
PIMCO Global Bond	%	US Equity, Technology (MSCI US IM Information Technology 25/50)	%
Triasima Canadian Equity	%	Small Cap US Equity (S&P SmallCap 600)	%
Guardian Canadian Dividend Equity	%	International Equity (MSCI EAFE)	%
Hillsdale US Equity	%	Global Equity (MSCI World Ex Canada)	%
Fiera Capital Global Equity	%	Emerging Market Equity (MSCI Emerging Markets)	%
TD Global Dividend Equity	%	**Other (specify)**	
C WorldWide International Equity	%		%
Lazard Global Infrastructure	%		%
Fisher Emerging Markets Equity	%		%
CI Global Real Estate	%		%
		TOTAL	**100%**

Transitory deposit account

- The transitory deposit account will be credited in accordance with the yield of the daily interest account.

C5 – Additional benefits

		Insured 1	Insured 2
Critical Illness Rider – $20,000*		☐	☐
Accidental Death and Dismemberment (ADD)*		Face amount: $	Face amount: $
Benefit in case of fracture*		☐	☐
Waiver of Premium (WP)	4 months	☐	☐
	6 months	☐	☐

Waiver of Premium for the policyowner(s) – (if the policyowner is not one of the insureds)

Name(s) of the policyowner(s): _____

- Sections B3, I and J must be completed by each policyowner who is not one of the insureds and is applying for Waiver of Premium.

* available only when the initial life insurance request is submitted or when adding a life insurance face amount for which evidence of insurability is required.

Coverage for children

Child Rider (CR) – (life insurance products only), complete Section H	Face amount: $
Children's Endorsement (CE) – (critical illness products only), complete Section H	Face amount: $

D – Payment of premiums

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, the financial security advisor / representative must complete the *Determination of politically exposed persons and heads of an international organization (FRA1234A)* form for any lump sum deposit of $100,000 or more for a universal life insurance product.

D1 – First premium payment

Amount of first premium payment (amount paid with this application): $ _____

- The payment of the first premium by pre-authorized debit will be withdrawn from the bank account indicated in Section O and appearing on the specimen cheque attached to this application.

Only check one box:

☐ Enclosed cheque payable to Beneva (cashed upon receipt of this application)
☐ Withdrawal upon receipt of this application
☐ Withdrawal upon settling of the policy
☐ On delivery of policy (payable upon receipt of settling requirements)

D2 – Payment of premiums

Total of annual premium, including the primary application, as well as all additional applications: $ _____

Chosen or initial modal premium: $ _____

Annual billing premium for universal life insurance only (including all additional benefits): $ _____

D3 – Payment frequency

☐ Annual
☐ Annual (pre-authorized debits)
☐ Monthly (pre-authorized debits)

- If left blank, the payment frequency will be monthly.
- For pre-authorized debits, attach a specimen cheque and complete Section O.

D4 – Day of withdrawal

☐ Day of withdrawal at issue date

OR

☐ Specify the day: _____

- If left blank, the day of withdrawal will be the policy issue date.
- If the day of withdrawal specified is the 29th, 30th or 31st, the day of withdrawal will be the 28th.
- **Universal life only: If the day of withdrawal specified is after the policy issue date, the day of withdrawal will be automatically changed to coincide with the policy issue date.**

D5 – Policy change

Total premium amount for this policy change request: $ _____

New billing premium for the policy following the change (universal life insurance only): $ _____

Method of payment

☐ Enclosed cheque for the amount of: $ _____ Date of cheque: Y Y Y Y M M D D

☐ Pre-authorized debit drawn from the same bank account associated with the policy number mentioned on page 3 of this application

☐ Pre-authorized debit drawn from a new bank account (complete Section O and attach a specimen cheque)

E – Insurance in force (Section E must be completed at all times)

- If this application replaces any insurance in force, the prior notice of replacement form(s) must be completed and submitted, in accordance with the applicable terms of the concerned provinces, with the application or at the latest in the five (5) following working days (three (3) working days outside Quebec). A notice of replacement form is not required for the replacement of critical illness insurance, except in Quebec.

1. Do you have existing individual insurance coverage? If so, complete the table below:

Insured 1 : ☐ NO ☐ YES → If yes, provide the information below.
Insured 2 : ☐ NO ☐ YES → If yes, provide the information below.

Insured No.	Company name	Amount	Type (Life, Disability, Critical Illness)	Year	Will this application replace in force insurance?		Purpose of insurance	
					Yes	No	Personal	Business
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

	Insured 1		Insured 2	
	Yes	No	Yes	No
2. Do you currently have one or more applications for insurance being assessed by another insurer? If yes, indicate the name of company, the total amount of insurance that will be put into force and the type of insurance. _____	☐	☐	☐	☐
3. In the last ten (10) years, have any of your applications for life, critical illness or disability insurance or requests for reinstatement been declined or deferred? If so, provide the type of insurance, the date and the reason. _____	☐	☐	☐	☐

4. If insurance for children:
   a) indicate the total amount of life insurance in force on the parents of the child: $ _____
   b) indicate the total amount of critical illness insurance in force on the parents of the child: $ _____
   c) specify if there are other children and if so, indicate
      - the amount of life insurance in force on each one of them: $ _____
      - the amount of critical illness insurance in force on each one of them: $ _____

F – Purpose of insurance

F1 – Personal insurance

☐ Income / Loan protection ☐ Estate conservation ☐ Charitable donations

F2 – Business insurance

1. Purpose of insurance

☐ Buy / sell agreement ☐ Collateral loan (specify the amount: $ _____) ☐ Estate planning ☐ Key person protection ☐ Other (specify at no. 5)

2. How long has the business been in operation? _____

3. Financial information of the company covering the last two (2) years:

Year:	Y Y Y Y	Year:	Y Y Y Y
Assets:	$ _____	Assets:	$ _____
Liabilities:	$ _____	Liabilities:	$ _____
Shareholders' Equity :	$ _____	Shareholders' Equity:	$ _____
Net profit:	$ _____	Net profit:	$ _____
Fair market value:	$ _____	Fair market value:	$ _____

F2 – Business insurance (continued)

4. Are you the sole owner? ☐ **Yes** ☐ **No** If No, complete the following table for each shareholder.

Indicate the name, percentage of shares as well as the amount of insurance in force and pending for each shareholder in the organization.

Name	% of shares	Insurance in force (business)	Insurance pending (business)
		$	$
		$	$
		$	$
		$	$

4.1 If the shareholders are not insured for the same amount, explain the reasons below.

5. Additional remarks

G – Temporary insurance agreement questions

- When questions 1 to 6 are answered "No" and the first premium has been received and is cashable on the date when the proposed insured(s) sign(s) the application, you are automatically eligible for temporary insurance.
- The temporary insurance agreement is not available for critical illness products and additional benefits.
- If the temporary insurance agreement is not applicable, any payment cashed upon receipt of this application will be applied towards the coming into effect of the insurance contract.

	Insured 1		Insured 2	
	Yes	No	Yes	No
1. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, rated, postponed or otherwise modified?	☐	☐	☐	☐
2. Have you ever suffered from any cardiovascular condition such as heart murmur, chest pain, palpitations, heart attack, peripheral vascular disease, cancer, AIDS or any other abnormality of the immune system?	☐	☐	☐	☐
3. In the last three (3) months, have you been admitted to a medical facility, learned that you will be or that you are to undergo a medical procedure or evaluation for any reason other than for dental care, pregnancy or caesarean section?	☐	☐	☐	☐
4. Have you ever been treated or have you been advised to undergo treatment for alcohol or drug abuse?	☐	☐	☐	☐
5. In the last three (3) years, have you been found guilty of impaired driving, hazardous driving or refusing to submit to a breathalyzer test and/or has your driver's licence been suspended for any of the above reasons?	☐	☐	☐	☐
6. Have you reached the age of 66 on the nearest birthday when the application is signed or is one of the insureds younger than 15 days old?	☐	☐	☐	☐

H – Child Rider / Children's Endorsement

Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.

1. _____ _____ Y Y Y Y M M D D ☐M ☐F
a) First name (please print) Last name (please print) b) Date of birth c) Sex

_____ _____ ☐ft ☐m _____ ☐lbs ☐kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the treatment or follow-up recommended, if applicable

2. _____ _____ Y Y Y Y M M D D ☐M ☐F
a) First name (please print) Last name (please print) b) Date of birth c) Sex

_____ _____ ☐ft ☐m _____ ☐lbs ☐kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the treatment or follow-up recommended, if applicable

3. _____ _____ Y Y Y Y M M D D ☐M ☐F
a) First name (please print) Last name (please print) b) Date of birth c) Sex

_____ _____ ☐ft ☐m _____ ☐lbs ☐kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the treatment or follow-up recommended, if applicable

	Yes	No
4. Answer the following for all children to be insured:		
a) Was any child born prematurely (less than 37 weeks of pregnancy)? Answer only if child is less than 6 years old. If so, specify the child's name, the number of weeks of pregnancy and the child weight at birth. _____	☐	☐
b) Do any have ever consulted for, been treated for or had signs or symptoms with any of the following conditions : heart murmur, heart or blood vessel disorder, leukemia, cancer, tumor, diabetes, disorder of the kidney, cystic fibrosis, muscular dystrophy, Down syndrome, physical or intellectual deficiency, developmental or behavioral disorder including autism spectrum disorder or any other congenital illness or disorder? If so, specify the child's name, the condition, the date of diagnosis, the treatment and the name and contact information of the physician. _____ _____ _____	☐	☐
c) Are any suffering or ever suffered from any other illness or disorder that required hospitalization, consultation with a specialist or medication for more than 21 consecutive days? If so, specify the child's name, the condition, the date of diagnosis, the treatment and the name and contact information of the physician. _____ _____ _____	☐	☐

	Yes	No
d) Do any have signs or symptoms for which a physician has not yet been consulted or for which he was advised to consult a specialist or been advised to undergo exams, diagnostic tests, treatments or surgery which have not yet been performed or for which he is awaiting results? If so, specify the child's name and details accordingly. _____ _____ _____	☐	☐
e) Do any have a family member (father, mother, brother or sister, living or deceased) ever been diagnosed with one more of the following conditions: diabetes, cancer, muscular dystrophy, Huntington's Chorea, polycystic kidney disease or any other hereditary disease? If so, specify the child's name who is concern (relationship), the condition (if cancer, provide the localization) and age at onset. _____ _____ _____	☐	☐
f) Do any currently hold a life (LIFE) or critical illness (CI) insurance contract or have a pending application for any of these types of insurance? if so, for each child specify the child's name, type of product, insured amount, company name, issued date or indicate pending if applicable. _____ _____ _____	☐	☐
g) Do any ever had life or critical illness insurance application been declined, modified, deferred or rated with a higher premium? If so, specify the child's name, the date and the reason. _____ _____ _____	☐	☐

The next Sections I and J will be about your personal and medical history. It is important for us to understand your situation in order to offer you the best protection.

- By answering questions completely and accurately, you ensure that you are well protected.

I – Personal history

- IF THE PARAMEDICAL IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION I.

Provide the details of all "Yes" answers. If you need more space, continue in Section K.	**Insured 1**		**Insured 2**	
	Yes	**No**	**Yes**	**No**
1. In the last five (5) years, have you used tobacco or consumed any product containing nicotine such as cigars, cigarillos, cigarettes, marijuana (cannabis) with tobacco, electronic cigarettes, vaping products, pipes, nicotine gum or patches?	☐	☐	☐	☐

If so, please complete the following table:

Insured's name	Type	Quantity	Date of last use
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M

I – Personal history (continued)

Provide the details of all "Yes" answers. If you need more space, continue in Section K.	Insured 1		Insured 2	
	Yes	No	Yes	No
2. a) Do you consume alcoholic beverages? One serving equals 341 ml or 12 oz. of beer, 45 ml or 1.5 oz. of spirits or 150 ml or 5 oz. of wine. If so, please complete the following table:	☐	☐	☐	☐

Insured's name	Type	Number of drinks	Frequency
	☐ Beer ☐ Wine ☐ Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	☐ Beer ☐ Wine ☐ Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	☐ Beer ☐ Wine ☐ Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	☐ Beer ☐ Wine ☐ Spirits		☐ Day ☐ Week ☐ Month ☐ Year

	Insured 1		Insured 2	
	Yes	No	Yes	No
b) Has your consumption been higher in the past? If so, indicate type, number of drinks, frequency as well as the reason and date of the change in the habits. _____	☐	☐	☐	☐
3. a) Do you consume cannabis products for recreational or medicinal purposes? Please complete the following table and include all forms of cannabis, marijuana and hashish.	☐	☐	☐	☐

Insured's name	Forms	Quantity	Frequency	Use date	Type of usage
	Joint	Number of joints: _____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD	☐ Recreational ☐ Medicinal*
	☐ Edible products ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD	☐ Recreational ☐ Medicinal*
	Joint	Number of joints: _____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD	☐ Recreational ☐ Medicinal*
	☐ Edible products ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD	☐ Recreational ☐ Medicinal*

*If you were using it for medicinal purposes, please complete the following table:

Insured's name	For what condition	Prescribed	Prescribing physician (name and address)
		☐ Yes ☐ No	
		☐ Yes ☐ No	

	Insured 1		Insured 2	
	Yes	No	Yes	No
b) Has your consumption been higher in the past two (2) years? If so, indicate form, quantity, frequency as well as the reason and date of the change in the habits. _____ _____	☐	☐	☐	☐

I – Personal history (continued)

Provide the details of all "Yes" answers. If you need more space, continue in Section K.	Insured 1		Insured 2	
	Yes	No	Yes	No
4. In the last ten (10) years have you used drugs or narcotics that were not prescribed by a physician (e.g., cocaine, ecstasy, LSD, magic mushrooms, heroin, fentanyl, anabolic steroids, etc.)? If so, please complete the following table:	☐	☐	☐	☐

Insured's name	Type of Drug or narcotics	Quantity per occasion	Frequency	Dates of use
		_____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD
		_____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD
		_____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD
		_____	☐ Day ☐ Week ☐ Month ☐ Year	From YYYYMMDD To YYYYMMDD

	Insured 1		Insured 2	
	Yes	No	Yes	No
5. With regard to your consumption of alcohol, cannabis or other drugs, have you been advised to reduce or cease your consumption, consulted a healthcare professional, had therapy or treatment or attended support group meetings? If so, complete the appropriate questionnaire (alcohol or drug usage) and attach it to the application.	☐	☐	☐	☐
6. In the last three (3) years, have you been found guilty of two (2) or more violations of the Highway Safety Code? If so, indicate the dates, types of infractions and km per hour over the speed limit. _____	☐	☐	☐	☐
7. In the last ten (10) years: a) Have you been charged with or found guilty of impaired driving or has your driver's licence been suspended? If so, provide the reason, the date of the infraction and the date your licence was restored. _____	☐	☐	☐	☐
b) Have you been charged with or found guilty of any criminal offence or fraudulent transactions? If so, provide the circumstances, the date, the charge(s) and the sentence (start and end dates of probation, if applicable). _____	☐	☐	☐	☐
8. In the last five (5) years, have you declared personal or business bankruptcy or made a consumer proposal? If Yes, please provide details below: ☐ Personal bankruptcy Amount: $ _____ ☐ Professional/commercial bankruptcy Amount: $ _____ ☐ Consumer proposal Date filed or proposed: YYYYMMDD Date of release: YYYYMMDD	☐	☐	☐	☐
9. In the last twelve (12) months have you been on a flight other than as a passenger or do you intend to do so in the next twelve (12) months? If so, specify your profession and complete the aviation questionnaire and attach it to the application (except crew member). _____	☐	☐	☐	☐
10. In the last twelve (12) months, have you participated in activities such as motorized vehicle races, scuba diving, skydiving, flying ultralights, hang gliding, mountaineering or rock climbing, bungee jumping, off-trail skiing (heliskiing, catskiing, etc.), combat sports or any other hazardous sport or do you intend to do so in the next twelve (12) months? If so, indicate the activity, complete the appropriate questionnaire, and attach it to the application. _____	☐	☐	☐	☐
11. In the last twelve (12) months, have you travelled or resided outside of Canada or the United States or do you intend to do so in the next twelve (12) months? If so, indicate the departure and return dates, the destination (country, city) and the reason. _____	☐	☐	☐	☐

T 574 305 768
Application number

J – Medical history (do not provide any information about genetic testing)

- **IF THE PARAMEDICAL IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION J.**

Insured 1

1. a) Height _____ ☐ ft ☐ m
   Weight _____ ☐ lbs ☐ kg
   b) Weight loss of more than 10lbs (4.5 kg) in the last 12 months? ☐ Yes ☐ No
   If yes, how much: _____ Reason(s): _____
   c) Date and reason of last medical appointment: _____
   d) Name and address of the physician or clinic consulted: _____
   e) Treatments or exams performed and or medication prescribed: _____
   f) Results: _____
   g) Referred to another healthcare professional? If so, explain. _____
   h) Further exams or a follow-up recommended? If so, explain: _____
   i) Name and address of the physician or the clinic holding your medical file if different from the one mentioned above. ☐ None
   _____

Insured 2

1. a) Height _____ ☐ ft ☐ m
   Weight _____ ☐ lbs ☐ kg
   b) Weight loss of more than 10 lbs (4.5 kg) in the last 12 months? ☐ Yes ☐ No
   If yes, how much: _____ Reason(s): _____
   c) Date and reason of last medical appointment: _____
   d) Name and address of the physician or clinic consulted: _____
   e) Treatments or exams performed and or medication prescribed: _____
   f) Results: _____
   g) Referred to another healthcare professional? If so, explain. _____
   h) Further exams or a follow-up recommended? If so, explain: _____
   i) Name and address of the physician or the clinic holding your medical file if different from the one mentioned above. ☐ None
   _____

For women only:	**Insured 1**		**Insured 2**	
	Yes	**No**	**Yes**	**No**
2. a) Are you currently pregnant? If so, specify the number of weeks of pregnancy and your weight before pregnancy. _____	☐	☐	☐	☐
b) Do you have or ever had any pregnancy or childbirth complications (e.g., gestational diabetes, caesarean section, preeclampsia, ectopic pregnancy, premature labour, miscarriage, etc.)? If so, indicate the complications and the dates. _____ _____	☐	☐	☐	☐

J – Medical history (continued)

For every "Yes" answer in question 3, underline the condition(s) and provide details in Section K. Please specify the dates, diagnosis, exams, results, consultations, medications, and treatments as well as the contact information of the physicians and hospitals consulted.	Insured 1		Insured 2	
	Yes	No	Yes	No
3. Have you ever consulted for, been treated for, or showed signs or symptoms of the following conditions?				
a) **Cardiovascular system:** high blood pressure, high cholesterol, heart murmur, aneurysm, chest pain, heart attack (infarct), angina, palpitations, transient ischemic attack (TIA), cerebrovascular accident (CVA) or any other heart, blood vessel or circulation disorder?	☐	☐	☐	☐
b) **Respiratory system:** asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea, sarcoidosis, coughing up blood, shortness of breath or any other respiratory disorder?	☐	☐	☐	☐
c) **Digestive system:** Crohn's disease, ulcerative colitis, celiac disease, polyps, hepatitis (including hepatitis carrier), cirrhosis, pancreatitis, bleeding, ulcers or any other disorder of the esophagus, stomach, liver, pancreas, or intestines?	☐	☐	☐	☐
d) **Genitourinary system:** urine abnormalities, disorders of the kidney, urinary tract, bladder, prostate, or genital organs, including sexually transmitted diseases or abnormal PAP or PSA (prostate-specific antigen) tests?	☐	☐	☐	☐
e) **Endocrine system:** diabetes, glucose abnormalities, disorder of the thyroid, pituitary gland, adrenal gland or any other glandular or hormonal disorder?	☐	☐	☐	☐
f) **Musculoskeletal system:**				
1) Back or neck pain or disorder?	☐	☐	☐	☐
2) Arthritis, muscular dystrophy, fibromyalgia, pain, disease or disorder of the muscles, bones, ligaments, or joints such as the shoulders, elbows, wrists, hands, hips, knees, ankles, feet, etc.?	☐	☐	☐	☐
g) **Neurological system:** cerebral palsy, loss of consciousness, loss of balance or dizziness, paralysis, concussion, migraines, epilepsy/convulsions, numbness, tremors, weakness in extremities, loss of sensation, blurred vision, optic neurosis, multiple sclerosis, Huntington's chorea, amyotrophic lateral sclerosis (ALS), Parkinson's disease, loss of memory, Alzheimer's disease, degenerative disease or any other cognitive disorder or condition affecting the brain, the spinal cord or the nerves?	☐	☐	☐	☐
h) **Mental health, behavioural or developmental disorders:** Depression, anxiety, panic attacks, burnout, insomnia, bipolar disorder, psychosis, suicide attempt, eating disorder, attention deficit disorder with or without hyperactivity (ADD/ADHD), autism spectrum disorder, intellectual impairment, Down syndrome or any other developmental, behavioural, or mental health disorder?	☐	☐	☐	☐
i) **Immune system:** acquired immunodeficiency syndrome (AIDS), positive test results for human immunodeficiency virus (HIV), lupus, scleroderma, any unexplained lymph node infection or swelling or any other immune system disorder?	☐	☐	☐	☐
j) **Cancer or tumor:** leukemia, cancer, tumor, cyst, nodule, polyp, lump, or growth?	☐	☐	☐	☐
k) **Breast disorder:** Lump, bump, cyst, or any other breast disorder?	☐	☐	☐	☐
l) **Eye, ear, nose, or throat disorders:** Partial or total blindness, macular degeneration, glaucoma, partial or total deafness, tinnitus, Meniere's disease, labyrinthitis or any other eye, ear, nose or throat disorder (excluding tonsillectomy, adenoidectomy, presbyopia and myopia)?	☐	☐	☐	☐
m) **Other conditions:** Skin disease or abnormal skin lesion, blood disorder such as persistent anemia, coagulation disorder or any other physical or mental disease or disorder not mentioned above?	☐	☐	☐	☐
4) **In the last five (5) years** (except for what you previously declared):				
a) Have you been admitted for more than 24 hours to a hospital, clinic, therapy center, convalescence home or any other healthcare facility? (Do not include childbirth) If so, provide the dates, locations, reasons, and results. _____	☐	☐	☐	☐
b) Have you had a blood test, resting or stress electrocardiogram, echocardiogram, colonoscopy, X-ray, mammography, ultrasound, CT scan, MRI, biopsy, or any other test for diagnostic purposes? If so, specify the tests, dates, reasons, and results. _____	☐	☐	☐	☐
c) Have you been absent from work or been unable to perform your regular duties for more than one week due to an accident or illness? If so, specify the dates, reasons, and duration. _____	☐	☐	☐	☐

J – Medical history (continued)

Provide the details of all "Yes" answers. If you need more space, continue in Section K.	Insured 1		Insured 2	
	Yes	No	Yes	No
d) Have you ever consulted a chiropractor, physiotherapist, occupational therapist, osteopath, acupuncturist, podiatrist, audiologist, psychologist, or any other healthcare professional? If so, provide the reason, date of the first and last consultations, the number of consultations per year, the date of the last symptoms and your current condition.	☐	☐	☐	☐

Insured's name	Health care professional	Reason/diagnosis	Date of first consultation	Date of last consultation	Number of consultation per year	Date of last symptoms

	Insured 1		Insured 2	
	Yes	No	Yes	No
5. Do you currently take medication, or have you previously taken medication for more than 21 consecutive days in the last twelve (12) months? (other than those mentionned above) If so, specify the name, dosage, reason and the start and end dates of treatment. _____	☐	☐	☐	☐
6. Have you been advised to undergo treatment, surgery, diagnostic exams, or tests which have not yet been performed or for which you are awaiting results? If so, give details. _____	☐	☐	☐	☐
7. Do you have any symptoms, signs, or discomfort for which you have not yet consulted? If so, provide details. _____	☐	☐	☐	☐
8. Family history: a) Has your father, mother, a brother, or sister (living or deceased) ever been diagnosed with one or more of the following conditions: polycystic kidney disease, Huntington's chorea, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), multiple sclerosis, familial adenomatous polyposis, muscular dystrophy, or any other hereditary disease? If so, please complete the table below.	☐	☐	☐	☐

Insured's name	Relationship	Illness	Age at onset	Current age	Age at death	Cause of death

	Insured 1		Insured 2	
	Yes	No	Yes	No
b) Has your father, mother, a brother, or sister (living or deceased) ever been diagnosed before age 60 with one or more of the following conditions: heart disease, cerebrovascular accident, cancer (specify the type) or diabetes? Don't indicate family history of high blood pressure or high levels of cholesterol. If so, please complete the table below.	☐	☐	☐	☐

Insured's name	Relationship	Illness	Age at onset	Current age	Age at death	Cause of death

K – Details and additional information

Question No.	Insured's First Name	Details Specify the disorder(s) or condition(s) and provide details, including the dates, diagnosis, exams, results, consultations, medications, and treatments as well as the contact information of the physicians and hospitals consulted.

L – Notice to proposed insured(s) and policyowner(s)

Notice regarding the investigative consumer report

For the insurance applications to be processed, all insurance companies, including Beneva Inc., may ask for a personal investigative consumer report in order to obtain information through personal interviews with neighbours, friends, associates and other designated people. The investigative consumer report may concern your reputation, lifestyle and finances. A representative of a consumer reporting agency may visit you or call you.

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including Beneva Inc. (Beneva), work with an organization called the MIB, LLC (MIB).

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva or its reinsurers, may also release information in 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 may be obtained on its website at www.mib.com.

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva1. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and 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, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g. : preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers
- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

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

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:
Personal Information Protection Officer

Beneva
625 rue Jacques-Parizeau
Quebec QC G1R 2G5

ResponsablePRP@beneva.ca.

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at www.beneva.ca.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services.

For the sole use of Beneva financial advisors (BFA)

Consent to receive personalized product offers and advice on products and services (optional)

I consent to the necessary collection, use and disclosure of my personal information by Beneva to service providers as well as websites and applications belonging to third parties to receive personalized offers and advice on products or services.

I understand that I may withdraw my consent by calling 1 844 781-0860 or visiting Beneva.ca

☐ Policyowner 1 ☐ Policyowner 2

1. The term "Beneva" refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. Affiliates of Beneva Inc. designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L'Unique General Insurance Inc. and Unica Insurance Inc.

M – Declarations

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor / representative, during a personal meeting or a RECORDED telephone conversation with a paramedical company or another authorized person representing or acting for Beneva Inc. The undersigned agree that the additional questionnaire shall be deemed to form part of this application and that the information it contains shall be used to draw up a contract with Beneva Inc. The undersigned further agree to review such information upon receipt of the contract and to inform Beneva Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that all information that they divulged during a RECORDED telephone interview to a paramedical company or another authorized person representing or acting for Beneva Inc., including but not limited to, their medical history and state of health, is deemed to form part of this application and that this information shall be used to draw up a contract with Beneva Inc. The undersigned agree that any recording, transcription or other notation of such information by Beneva Inc. or on behalf of Beneva Inc. shall be considered to be accurate, complete and binding as if given in writing to you.
3. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the requested contract), the contract shall be void with respect to such insured.
4. Agree that, if a temporary insurance agreement has been drawn up for life insurance, the amount payable under the aforesaid temporary insurance agreement and such other temporary insurance agreement as may be drawn up by Beneva Inc. for each insured life shall be limited to the lesser of $500,000 or the total face amount requested in the insurance applications.
5. Agree that, if a conditional insurance policy is drawn up for critical illness insurance, the amount payable shall be the lesser of the face amount requested in this insurance application or $500,000 less all other face amounts under any critical illness insurance pending or in effect with Beneva Inc.
6. Agree that this application, as well as the attached temporary insurance agreement relating to life insurance and the attached conditional insurance policy relating to critical illness insurance, if any, are subject to the laws of the province where the policyowner resides when the policy is issued, subject to applicable laws.
7. Agree that, under the Term Plus product, the benefit payable in the event of a total disability, when the disability rider without guarantee – Proof of loan upon claim has been selected, or, when the monthly indemnity is more than $2,000, shall be based on the total amount of eligible monthly payments for all eligible loans in effect at the time of total disability, regardless of the monthly amount that is underwritten in the present application. The benefit payable shall not exceed the monthly amount that is underwritten in the present application, subject to the terms of the contract. When the disability rider without guarantee – Proof of loan upon claim has been selected, if there is no eligible monthly payment in effect at the time of total disability, the undersigned agree that the liability of Beneva Inc. shall be limited to the refund of premiums received since the loan or loans were discharged, on the understanding that this refund shall not exceed a period of eighteen (18) months prior to the date the total disability benefit was requested.
8. Agree that they have received the advisor's explanations concerning the possibility of a tax rule change that certain changes, which require evidence of insurability, may cause, if any. As such, the entire policy could be subject to the tax rules in effect as of January 1st 2017, if it is not already the case.
9. Declare having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applicants. This is the case for the electronic application, which is used to assess a person's risk profile in order to provide the best possible premium. The undersigned agree that submitting an application initiates this process.
10. Declare having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.
11. Declare that the information provided in this application with respect to universal life insurance (if applicable) concerning their contact information, identification information, occupation (including job title, field of activity, name of employer and employment status) and the purpose of insurance, is accurate, complete and has been correctly indicated, and they agree to promptly notify their financial security advisor/representative of any change in this information. The financial security advisor/representative will then forward the updated information to Beneva Inc. without delay.
12. Declare that the information provided in the Declaration of Tax Residence section is correct and complete and agree to provide Beneva Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to become incomplete or inaccurate.
13. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the insurance application with Beneva Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.
14. Declare having been made aware of the personal information protection notice as well as of all other notices sent to the applicant(s) and the owner(s) as well as having accepted the terms and conditions herein.

_____ This _____ day of _____ of year _____

Signed at (city and province) Date

X _____ **X** _____

Signature of insured 1 Signature of insured 2

X _____

Signature of the father, mother or legal guardian of the minor child (children's insurance)

X _____ **X** _____

Signature of policyowner 1 – only necessary if not an insured Signature of policyowner 2 – only necessary if not an insured

If the policyowner is a company or other type of entity:

_____ **X** _____

Name and Title of Authorized Signatory Signature

_____ **X** _____

Name and Title of Authorized Signatory Signature

N – Authorizations

Your authorizations are necessary in order to provide and administer your products and services.

1. Authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. Authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. Authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. Authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

Insured 1

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured 1 (please print)	X Signature of insured 1	Y Y Y Y M M D D Date
If a minor insured: Name of mother, father or legal guardian (please print)	X If a minor insured: Name of mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

Insured 2

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured 2 (please print)	X Signature of insured 2	Y Y Y Y M M D D Date
If a minor insured: Name of mother, father or legal guardian (please print)	X If a minor insured: Name of mother, father or legar guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

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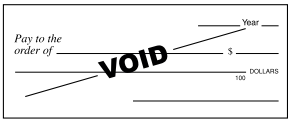
O – Pre-authorized debit agreement

1. I hereby authorize Beneva Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify Beneva Inc. before the renewal date of the contract of insurance.
3. I understand that depending on the product chosen, a monthly payment will result in a higher annualized premium.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), Beneva Inc., is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform Beneva Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month on the day selected in the insurance application or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. **I agree and understand that Beneva Inc. will not notify me before each withdrawal.**
9. In the event that I instruct Beneva Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing Beneva Inc. with thirty (30) days' notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
11. I understand that Beneva Inc. reserves the right to terminate this Agreement upon fifteen (15) days' notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with Beneva Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by Beneva Inc.
13. 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 Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Beneva Inc.
Premium Accounting
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a specimen cheque, on which you have written "VOID", for the account to be debited.



Important notice: In the absence of completing the information below and a specimen cheque, Beneva Inc. will withdraw the pre-authorized debits from the bank account of the cheque provided with this application.

Name of financial institution

Address, city, province and postal code of the branch

Branch | Financial institution number | Account number

Authorization

Is the account joint? ☐ **Yes** ☐ **No**

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of account holder or authorized person (please print) | **X** Signature | Y Y Y Y M M D D Date

Name of account holder or authorized person (please print) | **X** Signature | Y Y Y Y M M D D Date

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P – Financial security advisor's / representative's report

1. Source

☐ From insured ☐ Referred ☐ Associate ☐ Life customer ☐ P&C customer ☐ Other (specify): _____

2. Relationship with insured

☐ Personal friend ☐ Relative (specify): _____ ☐ Other (specify): _____

How long have you known each insured? Insured 1: Y Y Y Y M M D D Insured 2: Y Y Y Y M M D D

3. Do you have doubts about the insurability of one of the insureds?

☐ Yes ☐ No If yes, specify: _____

4. Are you personally aware of the habits of the insured(s)?

☐ Yes ☐ No If yes, give details: _____

5. Which language(s) has (have) been used to complete the application? _____

6. Has (have) the individual(s) told you he/she (they) understood the language used to complete the application?

☐ Yes ☐ No

7. If a language other than English has been used, name the person who explained the application to the individual(s) to be insured. The person cannot be the beneficiary or a family member of the person(s) to be insured.

_____

P1 – Underwriting requirements

Evidence of insurability ordered from	Ordered requirements
☐ Dynacare Insurance Solutions ☐ Other ☐ ExamOne Y Y Y Y M M D D Date of request of evidence of insurability _____ Order number	☐ Paramedical ☐ Resting electrocardiogram ☐ Blood profile including urinalysis ☐ Other (specify): _____ **The Inspection Report is ordered by Beneva Inc. when required.**

P2 – Financial security advisor / representative certification

I confirm that I have provided an *Advisor Disclosure Statement* to the policyowner(s) disclosing the following:

- the name of the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and critical illness insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflict of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this application has been signed.

I hereby declare that all information in this application is true and complete to the best of my knowledge.

If I am not the service advisor for this policy, I declare that I have informed the policyowner(s) of that fact and of the identity of his/her (their) service advisor as it appears in Section P3.

Identity verification of the policyowner(s) (applicable for universal life insurance)

I have verified the identity of the person(s) who signed this form as policyowner(s) using a method permitted in accordance with the requirements of the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations.

Third party determination (applicable for universal life insurance)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, I have taken reasonable measures to determine if the policyowner(s) is (are) acting on behalf of a third party.

Ongoing monitoring of business relationships (applicable for universal life insurance)

When the person(s) who has(have) signed this application as policyowner(s) notifies(notify) me of an update to their contact information, identification information, occupation (including job title, field of activity, name of employer and employment status), or the purpose of insurance, I agree to inform Beneva Inc. without delay.

_____ _____

Name of financial security advisor / representative (please print) Code of financial security advisor / representative

X _____ Y Y Y Y M M D D

Signature of financial security advisor / representative Date

P3 – Information about financial security advisor / representative

The following information is necessary for the application to be processed and for commissions to be paid.

Name of service advisor (please print) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

Name of other advisor sharing commission, if applicable (please print) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

Name of other advisor sharing commission, if applicable (please print) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

☐ **I do not have an advisor's code with Beneva Inc. This is my first application.**

Comments and details from financial security advisor / representative

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Q – Notices and agreements

Q1 – Conditional insurance policy – critical illness insurance

Instructions for the financial security advisor / representative

If ALL proposed insureds are 30 days old or more and less than 66 years old on the nearest birthday when the application is signed, please detach this conditional insurance policy and give it to the policyowner.

Regardless of whether any premium has been collected with the application, no guarantee is provided with regard to this conditional insurance policy unless all the conditions set out below and on the reverse are met.

Conditional insurance policy – critical illness insurance

Beneva Inc. provides free temporary CONDITIONAL critical illness insurance in accordance with the conditions set out below and on the reverse. This conditional insurance policy, subject to the usual terms of the policy applied for, will take effect:

- on the date on which sufficient evidence of insurability for all individuals to be insured is received ("effective date"); and
- if all individuals to be insured represented a regular risk at the effective date, in accordance with the rules and common practice applied by Beneva Inc. as far as risk selection is concerned; and
- if a payment for the amount of the first monthly premium or more was both received and cashable on the date the insurance application has been signed by all proposed insureds and by the financial security advisor / representative, or before this date; and
- if the aforementioned payment was made to Beneva Inc. and was honoured by the financial institution the first time it has been presented.

The conditional insurance policy will terminate at the effective date of the requested contract.

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Q2 – Receipt – temporary insurance agreement – life insurance

Received from _____ $ _____ the sum of

Instructions for the financial security advisor / representative

If ALL proposed insureds are 15 days old or more and less than 66 years old on the nearest birthday when the application is signed, please detach this temporary insurance agreement and give it to the policyowner.

- The amount paid to the financial security advisor / representative must equal the first monthly premium or one-twelfth ($^{1}/_{12}$) of the annual modal premium and must be cashable on the date the insurance application is signed by the proposed insured(s).
- No insurance will be effective unless the payment is honoured the first time it is presented.
- No one may waive or change any of the terms of this temporary insurance agreement.
- **See Provisions and Conditions on reverse.**

Signed at (city and province) _____

X _____ Y Y Y Y M M D D
Signature of financial security advisor / representative — Date

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This notice must always be given to the policyowner.

Q3 – Notice to proposed insured(s) and policyowner(s)

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including Beneva Inc. (Beneva), work with an organization called the « MIB, LLC (MIB) ».

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing **Canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva or its reinsurers, may also release information in 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 may be obtained on its website at **www.mib.com**.

Conditional insurance policy – Critical illness insurance (ctd.)

The face amount for a critical illness insurance for a proposed insured as defined by this conditional insurance policy will be limited to the lesser of:

- the face amount requested in this application on the proposed insured; or
- $500,000 less all other face amount for any critical illness insurance payable by Beneva Inc. to the proposed insured.

If any proposed insured is diagnosed with cancer, no payment will be made according to this conditional insurance policy.

If any proposed insured dies 30 days following the diagnosis of a covered critical illness, no payment will be made according to this conditional insurance policy.

If any proposed insured is less than 30 days old or 66 years old or more, no payment will be made according to this conditional insurance policy.

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Provisions and conditions – temporary insurance agreement – life insurance

1. AMOUNT OF INSURANCE AND LIMITS
In consideration for payment of the premium indicated in Section D, Beneva Inc. agrees to provide a temporary insurance benefit, up to $500,000 on each of the insureds according to the Provisions and Conditions attached to this temporary insurance agreement. If the face amount as indicated in Section C is less than $500,000 the amount indicated in Section C will represent the face amount for the temporary insurance agreement. If the face amount as indicated in Section C is equal to or more than $500,000, the face amount for the temporary insurance agreement will be $500,000. In case of death of any insured while the temporary insurance agreement is in force, all the premiums paid in excess of the required premium of $500,000 coverage will be reimbursed. The maximum of $500,000 includes any other temporary insurance agreements issued by Beneva Inc., as mentioned in Section M (article 4).

2. EFFECTIVE DATE
The temporary insurance agreement becomes effective when the temporary insurance agreement's receipt has been signed, provided the premiums required from all insureds have been paid and that the questions 1 to 6 of the temporary insurance agreement questionnaire in Section G of the application have been answered "No".

3. END OF COVERAGE
The temporary insurance agreement will end on the earliest of:

a) 90 days from the date of this application;
b) the date a counter offer has been presented to your financial security advisor / representative;
c) the date the policy applied for comes into force;
d) the date Beneva Inc. notifies the policyowner(s) of the termination of the temporary insurance agreement;
e) the date Beneva Inc. refuses this application.

Beneva Inc. may terminate this temporary insurance agreement at any time provided the policyowner(s) is (are) notified. When the temporary insurance agreement ends in accordance with 3 a), b), c) or d) listed above, Beneva Inc. shall retain the received premium in order to apply it towards the coming into effect of the insurance contract.

4. EXCLUSIONS AND PARTICULARS
a) Any additional benefits applied for under Section C5 of the application are excluded from the temporary insurance agreement.
b) The Total Disability Rider pertaining to the Term Plus product is excluded from the temporary insurance agreement.
c) In case of suicide, fraud or misrepresentation, the temporary insurance agreement shall become void and the liability of Beneva Inc. shall be limited to refunding the premium paid to the policyowner(s).
d) The financial security advisor / representative is not authorized to offer the temporary insurance agreement to an insured under the age of 15 days or age 66 or over.
e) The temporary insurance agreement does not apply to critical illness products.

Policy number	Application number
	T 574 305 768

Authorizations

1. I authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. I authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. I authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. I authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

I achnowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured (please print)	X Signature of insured	Y Y Y Y M M D D Date
If a minor insured: Name of the mother, father or legal guardian (please print)	X If a minor insured: Signature of the mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

Policy number	Application number
	T 574 305 768

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1. I authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
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Name of insured (please print)	X Signature of insured	Y Y Y Y M M D D Date
If a minor insured: Name of the mother, father or legal guardian (please print)	X If a minor insured: Signature of the mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date