

Application for Renewal of Disability Insurance Coverage

Underwritten by certain Underwriters at Lloyd's, London, England
through **Hunter McCorquodale Inc.**
Yonge-Eglinton Centre

#2910 - 2300 Yonge Street, P.O. Box 2396, Toronto, ON M4P 1E4



Policy Number:

Person Insured:

Policy Owner:

Effective Date:

Renewal Date:

I hereby apply for renewal of this policy. I hereby declare that all answers and information disclosed on my original application, dated _____, continue to be complete and accurate, except as follows:

Section	Question No.	New Information

I understand that non-disclosure or misrepresentation of a material fact will render this insurance null and void. (A material fact is one likely to influence Underwriters in relation to acceptance of the application or the terms of coverage offered. If you are in doubt as to what constitutes a material fact you should consult Hunter McCorquodale Inc.)

Application for Renewal of Disability Insurance Coverage (cont.)

Policy Number:

Person Insured:

I hereby authorize any physician, medical or health practitioner, hospital, clinic or medically related facility, insurance company, employer, or any other organization, institution or person that has any records of me, my health or other information relevant to this application, to provide such information to Hunter McCorquodale Inc. I understand that the purpose of this authorization is to allow determination of eligibility for the insurance applied for or a claim for benefits under such insurance. Any information obtained by Hunter McCorquodale Inc. will not be disclosed to any other party EXCEPT Underwriters at Lloyd's or other organizations or persons performing business or legal services in connection with my application or claim, OR as may be otherwise lawfully required or as I may further authorize. I agree that this authorization shall be valid for 2 ½ years from the date of completion. I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____, _____

Signature of Person Insured

Signature of Owner, if other than Person Insured*

* If owner is a corporation, signatory should be a signing officer of the corporation other than the Person Insured.

Print Name and title of person signing for owner: _____