

Distributed By:

HUNTER
McCORQUODALE INC.

Send completed application to:

Hunter McCorquodale Inc.
480 University Ave.
Suite 1100
Toronto, ON M5G 1V2

Underwritten By:



ace life

<p>Section A PERSONAL INFORMATION</p>	1. Name of Proposed Insured: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other (specify) _____				
	First	Middle	Last	Maiden, if applicable	
	2. Residence Address:				
	Street, Apt/Suite #		City/Town	Province	Postal Code
	3. Date of Birth:	4. Birthplace:	5. Gender	6. Citizenship	
	____/____/____ Day Month Year		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Canadian <input type="checkbox"/> Other (specify): _____	
	7. Telephone:		8. Email address:		
Home		Work			
9. Employer:					
10. Occupation/Duties:					
11. Average Annual Earned Income:			12. Estimated Total Net Worth:		

<p>Section B OWNER INFORMATION</p>	1. Name of Owner, if other than Proposed Insured:			
	2. Address:			
	Street, Apt/Suite #		City/Town	Province
3. Relationship to Proposed Insured:				

<p>Section C BENEFICIARY INFORMATION</p>	Name of Beneficiary	Type	Relationship to Proposed Life Insured	% Share	Status*	
		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

*The beneficiary will be revocable unless otherwise specified. In Quebec, a spouse designated as beneficiary will be deemed irrevocable unless otherwise specified.

<p style="text-align: center;">Section D</p> <p style="text-align: center;">PLAN INFORMATION</p>	<p>1. Sum Insured (minimum \$50,000, maximum \$500,000): \$ _____</p>
<p>2. Return of Premium Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>3. Monthly Premium: \$ _____</p>

<p style="text-align: center;">Section E</p> <p style="text-align: center;">GENERAL INFORMATION to be completed by the Proposed Insured</p>	<p>1. Do you have any life insurance in force or pending (include individual, group, mortgage, creditor, etc.)?... Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the following chart:</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width:30%;">Company Name</th> <th style="width:15%;">Year Issued</th> <th style="width:15%;">Life Insurance Amount</th> <th style="width:20%;">Purpose</th> <th style="width:20%;">Accidental Death Benefit Amount</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td></td> <td></td> <td><input type="checkbox"/> Personal <input type="checkbox"/> Business</td> <td></td> </tr> <tr> <td>b.</td> <td></td> <td></td> <td><input type="checkbox"/> Personal <input type="checkbox"/> Business</td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> <td><input type="checkbox"/> Personal <input type="checkbox"/> Business</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td><input type="checkbox"/> Personal <input type="checkbox"/> Business</td> <td></td> </tr> </tbody> </table> <p>2. Is this insurance intended to replace or change any existing life insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete replacement disclosure form.</p> <p>3. Have you had any company cancel, decline to issue or reinstate, rate, modify, postpone, or rescind any life, disability or critical illness insurance on your life? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>4. Have you ever applied for or received a pension, disability benefit or compensation for any accident or sickness, or had any premium waived under any insurance contract? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5. Within the last 2 years, have you engaged in flying (as a pilot, student pilot or crew member), motorized vehicle racing, parachuting, hang-gliding, scuba diving, bungee jumping, mountain, rock or ice climbing, heli-skiing, or other hazardous activities; or do you intend to do so? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete appropriate questionnaire(s).</p> <p>6. a) Have you traveled outside Canada, the United States, or the Caribbean within the last 2 years? Yes <input type="checkbox"/> No <input type="checkbox"/> b) Do you intend to do so within the next 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide details below, including specific countries visited, duration of trips and reason for travel.</p> <p>7. Have you had a driver's license suspended or had three or more moving violations in the past 2 years? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide: Driver's license number: _____ Province: _____</p> <p>8. Have you ever been charged with, or convicted of any criminal offence? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide details below, including dates.</p> <hr/> <p>IMPORTANT: Give details of any "Yes" answers in Section E (refer to Question #):</p>	Company Name	Year Issued	Life Insurance Amount	Purpose	Accidental Death Benefit Amount	a.			<input type="checkbox"/> Personal <input type="checkbox"/> Business		b.			<input type="checkbox"/> Personal <input type="checkbox"/> Business		c.			<input type="checkbox"/> Personal <input type="checkbox"/> Business		d.			<input type="checkbox"/> Personal <input type="checkbox"/> Business	
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c.			<input type="checkbox"/> Personal <input type="checkbox"/> Business																							
d.			<input type="checkbox"/> Personal <input type="checkbox"/> Business																							

Section F

HEALTH
QUESTIONS
(Cont'd.)

Important: Give details of any "Yes" answers in Section F. Refer to the applicable question number, and be sure to provide details as to symptoms, diagnosis, treatment, name of treating physician and/or hospital, duration, present status, and prognosis.

Section G

DECLARATION AND AUTHORIZATION

I declare that all information and statements recorded in this application and any questionnaire or declaration of insurability made in connection with this application are, to the best of my knowledge and belief, true, accurate and complete. 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 ACE INA Life Insurance's decision to approve this application for insurance and includes, but is not limited to, information about smoking habits).

NOTICE ABOUT YOUR PERSONAL INFORMATION: The information requested on and in respect of this application is required by ACE INA Life Insurance, its reinsurers, agents and authorized administrators ("ACE") for insurance purposes including processing this application and administering any policy, if issued, and investigating coverage and claims. ACE will establish a financial services file for these purposes. From time to time ACE may wish to use or disclose to another member company of the ACE group of companies, information for the optional purpose of offering additional products and services. Consent to such use or disclosure of personal information may be declined or revoked at any time by writing to: ACE INA Life Insurance or by calling 1-877-534-3655. For more information about ACE and privacy, please review ACE's Privacy Policy at www.ace-ina-canada.com/pdf/Main/Privacy%20Policy.pdf or call 1-877-534-3655 to request a copy.

I understand and agree that any insurance issued pursuant to this application will take effect on the date set forth in the policy, on the condition that the information provided herein remains true and complete on the date the Policy is delivered, and provided the initial premium is paid during the lifetime of the Proposed Insured and when due. I understand that I will have a 10 day period after delivery of the policy during which I may cancel it for any reason and receive a full refund of any premium paid.

I authorize any physician, medical or health practitioner, hospital, clinic or medically related facility, insurance company, or any other organization, institution or person that has any records or knowledge of me, my health or other information relevant to this application, to provide any such information to ACE or ACE's authorized administrator, 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. A photocopy of this authorization is as valid as the original.

Pre-Authorized Debit (PAD) Authorization

I have attached a void cheque.

I authorize ACE INA Life Insurance and the financial institution designated to begin deduction of premium for SecureLife in the amount of _____ (Your monthly premium) to be charged on or about the first business day of each month to the account shown on the attached void cheque.

Signature: _____ Date: _____

Signature: _____ Date: _____

Secondary signature required on joint account.

I have waived the right to pre-notification at least 10 days before my first PAD; however ACE INA Life insurance will send me written notice identifying the new amount at least 10 days before each and any change in the amount of my PAD, with the exception of a reduction in tax rate. I may revoke my authorization at any time in writing or by phone, subject to a 30 day notice. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any PAD does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

I hereby certify that I read and understand the English language.
 Je déclare par la présente que je sais lire et comprendre la langue anglaise.
 I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.
 Je confirme par les présentes ma demande que le présent document et tous autres documents et correspondance se rapportant à la présente assurance soient dans la langue anglaise.

Signed at _____ this _____ day of _____,

Signature of Proposed Insured _____

Signature of Owner, if other than Proposed Insured _____

Print name and title of person signing for owner _____

Section H

INSURANCE ADVISOR'S REPORT AND DECLARATION

Instructions and information for Insurance Advisor:

1. Before submitting this application, please ensure that all questions are answered clearly and completely, that any changes are initiated **by the person answering the question**, and that the application is signed and dated.
2. Please **submit a void cheque** along with the completed application. Do **NOT** collect a premium deposit with the application. Premiums will be deducted by ACE from the designated account commencing from the effective date of coverage. Note that all policies are issued on a pre-authorized chequing basis (PAC). No other payment method is available.
3. Note that all policy effective dates are the 1st of the month and all PAC withdrawals are on the 1st of the month.
4. **A signed sales illustration must be submitted along with the application.**
5. **DO NOT** request or order any medical evidence. All requirements will be obtained by Hunter McCorquodale Inc. You will be advised what requirements are being arranged after the initial underwriting review.
6. Please advise the applicant that the underwriter may conduct a telephone interview.
7. If replacement is indicated ensure that the proper Comparison Disclosure Statement is completed and applicable provincial guidelines are followed. A copy of the Comparison Disclosure Statement must be sent in with the application. Failure to do so will delay processing.

Name of Insurance Advisor: _____
(person/entity to which commissions are payable)

Name of individual signing this Report, if other than above: _____

Contact Information: Telephone _____ Email: _____

Name of MGA or National Account, if applicable: _____

1. To the best of your knowledge will any existing insurance be cancelled or changed if this application is approved?
 Yes No
2. a. What is the purpose of this insurance? Personal Business
b. If business : Key Person Buy/Sell Collateral Other (Specify): _____
3. If this applicant has been underwritten for life or living benefits insurance by another insurer within the past 6 months please advise what medical requirements were obtained, and by which insurer:

4. Is there any other information that would be helpful in assessing this application?

By Signing below:

- I hereby declare that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief, and that I am not aware of additional information material to the assessment of this application.
- I confirm that I hold all necessary licenses and certificates required to negotiate the sale of this insurance, and that I am covered by a current valid errors and omissions insurance policy.
- I hereby confirm that I have disclosed the following to my client:
 - The company or companies I represent;
 - That I may receive compensation (such as commissions) for the sale of life insurance company products;
 - That I may receive additional compensation in the form of a bonus, conference program or other incentive; and
 - That there is no conflict of interest regarding the proposed sales transaction being considered with ACE INA Life Insurance, and my overall recommendation takes into consideration and is based on my analysis and assessment of my client's insurance needs.

Signed at _____ this _____ day of _____, _____

Signature of Licensed Insurance Advisor _____