

APPLICATION FOR PERSONAL ACCIDENT COVERAGE

Underwritten by certain Underwriters at Lloyd's, London, England through

Hunter McCorquodale
1200 - 145 Wellington St. W
Toronto, Ontario M5J 1H8

LLOYD'S

Section A PERSONAL INFORMATION	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) _____	2. Birthdate: ____/____/____ Day Month Year	3. Sex
	4. Residence Address: (Street, Apt/Suite #, City/Town, Province, Postal Code)		5. Daytime telephone #:
	6. Mailing Address (if different from residence address):	7. Email address:	
	8. Owner, if other than Proposed Insured (owner must sign page 2):	9. Citizenship: <input type="checkbox"/> Canadian <input type="checkbox"/> Other (specify): _____	

Section B EMPLOYMENT INFORMATION	1. Profession or Occupation:	
	2. Brief Description of Duties:	
	3. Employer Name:	
	4. Employer Address:	
	5. Current Employment Status: <input type="checkbox"/> Employee <input type="checkbox"/> Unincorporated Business Owner/Partner <input type="checkbox"/> Incorporated Business Owner/Partner	
	6. Do you anticipate any material changes in your occupation or duties in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details:	
	7. Earned Income: Estimated next 12 months \$ _____ This year to date: \$ _____ Last year: \$ _____ 2 years prior: \$ _____	Earned Income Means: Employee: Total salary, bonus and commission, less deductible employment expenses. Unincorporated Business Owner/Partner: Your share of net business income after normal and customary business expenses and before income tax. Incorporated Business Owner (>10%): Salary, bonus if consistent, and your share of corporate net profit before income tax. All amounts should be on a fiscal year basis.

Section C PLAN INFORMATION	1. Principal Sum Insured: \$	2. Currency: <input type="checkbox"/> CAD <input type="checkbox"/> USD
	3. Policy Term: <input type="checkbox"/> 12 months <input type="checkbox"/> Other (specify):	4. Premium: \$
	5. Beneficiary (if left blank, the beneficiary is the owner or the estate of the owner): Name: _____ Relationship to Proposed Insured: _____	
	6. Coverage Type: <input type="checkbox"/> Accidental Death only <input type="checkbox"/> Accidental Death and Dismemberment <input type="checkbox"/> Accidental Death, Dismemberment and Permanent Total Disability	
	7. Scope: <input type="checkbox"/> All risk, 24 hour <input type="checkbox"/> Other (specify):	
	8. Optional Coverages: <input type="checkbox"/> War and Terrorism <input type="checkbox"/> Joint 2 nd to die (Submit completed application on 2 nd life)	
	9. Effective Date: <input type="checkbox"/> Date of approval <input type="checkbox"/> Other (specify):	
	10.a. What is the purpose of this coverage?	
	b. How was the amount determined?	

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		Yes	No
<p>Section D</p> <p>GENERAL INFORMATION</p> <p>(Provide details of any "Yes" answers in Section F below)</p>	1. Approximate total of other insurance in force or pending on your life: \$ _____.		
	2. Have you ever had an application for life, disability, health, critical illness or personal accident coverage declined, accepted on special terms, cancelled or non-renewed?	<input type="checkbox"/>	<input type="checkbox"/>
	3. Have you made any claim(s) against an Insurer in respect of an accident?.....	<input type="checkbox"/>	<input type="checkbox"/>
	4. Do you intend to travel outside Canada or the U.S.A. during the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
	Give details in Section F, including countries to be visited, expected length of stay and purpose.		
	5. Have you ever flown as a pilot, or do you anticipate doing so in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
	6. a. Have you ever participated in motorized vehicle racing, scuba diving, sky diving, hang gliding, mountain, rock or ice climbing, heli-skiing, or any other hazardous sport or avocation?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you anticipate doing so in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of driving while under the influence of drugs or alcohol, or had your driver's license suspended or revoked for any reason, or is any such action pending?.....	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, Driver's license # _____ Province _____			

		Yes	No
<p>Section E</p> <p>HEALTH QUESTIONS</p> <p>(Provide details of "Yes" answers in Section F below)</p>	1. Height _____ <input type="checkbox"/> cm <input type="checkbox"/> ft'.in". Weight _____ <input type="checkbox"/> kg. <input type="checkbox"/> lbs.		
	2. In the past 10 years have you had, been medically diagnosed as having, or been treated for:		
	a. dizziness, fainting, seizures, stroke or other disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
	b. depression, burnout, chronic fatigue or other psychological, emotional or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	c. high blood pressure, a heart condition, or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
	d. backache, rheumatic fever, rheumatism, arthritis, fibromyalgia, paralysis or other disorder of the muscles or bones, including joints and spine?.....	<input type="checkbox"/>	<input type="checkbox"/>
	e. any disorder of the eyes or ears?.....	<input type="checkbox"/>	<input type="checkbox"/>
	3. In the past 10 years, have you sought or received advice or treatment for the use of alcohol or drugs, or used cocaine, barbiturates, or any other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been medically diagnosed as having, or been treated for AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever attempted to commit suicide?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are you totally disabled, or on sick leave, medical leave, or hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	
7. In the past 5 years, have you missed more than 15 consecutive days from work due to an injury?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are you contemplating medical attention or a surgical operation?.....	<input type="checkbox"/>	<input type="checkbox"/>	

<p>Section F</p> <p>ADDITIONAL INFORMATION</p>	<p>Please provide additional details of any "Yes" answers in Section D or Section E, and any other information you feel is material to your insurance application:</p>
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<p>Section G</p> <p>DECLARATION</p>	<p>I hereby warrant that all information recorded in this application is, to the best of my knowledge and belief, true 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 Underwriters in relation to acceptance of this application or the terms of coverage offered. If you are in doubt as to what constitutes a material fact you should consult Hunter McCorquodale).</p> <p>Signed at _____ this _____ day of _____, _____</p> <p>Signature of Proposed Insured:</p> <p>Signature of Owner, if other than Proposed Insured:</p> <p>If owner is corporation print name and title of person signing: _____</p> <p>Broker Declaration: I certify that I have no knowledge of information that is not fully disclosed.</p> <p>Signature of Agent/Broker:</p>
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For purposes of the Insurance Companies Act (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.