APPLICATION FOR SecureDI COVERAGE

RELIABLE LIFE INSURANCE COMPANY

Application for: ☐ New Coverage
☐ Reinstatement ☐ Exchange

Policy Number(s) to be changed: _____

When completed, send the application to the following agency address:

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

Section A — PERSONAL INFORMATION

1. Name of Proposed Insured: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr. ☐Title_____

First: Middle: Last: Maiden if Applicable:

2. Residence Address:
Street, Apt./Ste. # City/Town Prov. Postal Code

3. Date of Birth ____/____/____ (Day Month Year)

4. Age

5. Sex

6. Mailing Address (if different from residence address):
Street, Apt./Ste. # City/Town Prov. Postal Code

7. Place of Birth (Province/Country):

8. Telephone: Home ( ) Cell ( )
Work ( ) Email:

9. Social Insurance Number:

10. a) Owner, if other than Proposed Insured (owner must sign on page 6):

10. b) Owner Address:
Street, Apt./Ste. # City/Town Prov. Postal Code

12. ☐ Canadian Citizen
☐ Landed Immigrant

Section B — EMPLOYMENT INFORMATION

1. Employer (provide details for past 2 years):

a. Current Employer/Business Name:

e. Previous Employer/Business Name:

b. Dates Employed:
From: To:

f. Dates Employed:
From: To:

c. Address:
_____

g. Address:
_____

d. Nature of Employers Business:

h. Nature of Employer's Business:

i. Current Employment Status
☐ Employee: How paid? ……. ☐ Salary ☐ Commission ☐ Combination
☐ Unincorporated Business Owner/Partner
☐ Incorporated Business Owner (>10% ownership): Date Incorporated_____

j. If self-employed:
Length of time self-employed: _____ Percentage Ownership/Share: _____
No. of full-time employees (excluding owners): _____ Fiscal Year-End (Month/Day): _____

2. Duties

a. Job Title:

b. Professional Designation/Degree:

c. Breakdown of Duties (total = 100%):

		Description of Duties
Administrative/Office:	_____%	_____
Manual/Physical:	_____%	_____
Sales:	_____%	_____
Driving:	_____%	_____
Travel (outside North America):	_____%	_____
Supervision (outside office e.g. plant, jobsite):	_____%	_____

3. a. How many months a year do you usually work?

b. How many hours a week do you usually work?

c. How many hours a week do you usually work at home?

d. Length of time employed in current job:

e. Length of time employed in similar job:

f. Are you actively working at your full-time job? ☐ Yes ☐ No

g. Do you have a part-time or seasonal job? ☐ Yes ☐ No
If "yes", describe exact duties:

h. Do you plan to change your duties, occupation, or country of residence ☐ Yes ☐ No
If "yes", give details:

Section C

PLAN INFORMATION

1. Maximum Benefit Period: a) Sickness: □ 2 Years □ 5 Years □ 10 Years ("preferred" risks only)
b) Accident: □ same as Sickness □ to Age 65

2. Basic Monthly Benefit: $

3. Elimination Period □ 30 Day (only with 2 Year Benefit Period) □ 60 Day □ 90 Day □ 120 Day □ 180 Day

4. Benefits to be: □ Non-Taxable □ Taxable (must be part of a valid Wage Loss Replacement Plan)

5. Premium Refund Rider: □ Yes □ No

6. PREMIUM INFORMATION:
a. Mode: □ Annual □ Semi-Annual □ Monthly PAP (complete authorization on Page 6)
b. Modal Premium: $_____ c. Deposit with Application: $_____ (at least one month's premium)

7. Special Dating Request (must be the first of a month)

8. Beneficiary (if blank, the beneficiary is the owner or the estate of the owner):

Section D

FINANCIAL INFORMATION

1. **Earned Income**
a. This year to date $_____
b. Last year $_____
c. 2 years prior $_____

Earned Income Means:
Employee: salary plus bonus if consistent or commission less business 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.

2. Annual Unearned Income:
$_____ □ None

Unearned Income Means:
Income that would continue (net of expenses) in the event of disability e.g. rents, investment

3. Annual Income, other jobs:
$_____ □ None

NB: Appropriate financial documentation must accompany all applications.

Section E

GENERAL INFORMATION

Important: Please give details of any **"yes"** answers in the spaces provided or in section **"H".**

YES NO

1.a. Do you have any disability insurance coverage in force or pending (include group, individual, mortgage, etc)? If "yes" give details: …… □ □

Company Name	Group?	Plan Type	Year Issued	Monthly Benefit	Benefit Period	Elimination Period	Taxable?	To be replaced or reduced?
i)	□ Yes □ No	□ Personal □ Business					□ Yes □ No	□ Yes □ No
II)	□ Yes □ No	□ Personal □ Business					□ Yes □ No	□ Yes □ No

b. Are you eligible for Employment Insurance (E.I.) sickness benefits? …….. □ □

2. Are you or will you become eligible for Group Disability coverage, not noted above, within the next year? if "yes", give details _____ □ □

3. Have you ever had an application for disability income, life or critical illness insurance declined, postponed, rated or modified in any way? If "yes", give details including company, date and specific nature of decision _____ □ □

_____

4. During the past 3 years have you:
a. flown as a pilot, student pilot or crew member, or do you contemplate doing so? …….. □ □
b. participated in any form of motorized racing, scuba diving, sky diving, hang gliding, bungee jumping, mountain or rock climbing, heli- or cat-skiing or skiing outside regularly marked trails at ski resorts or any other similarly hazardous sport or avocation, or do you contemplate doing so? □ □
c. had your driver's license suspended or revoked, been charged with 3 or more moving violations, or been convicted of driving while under the influence of drugs or alcohol? …… □ □
If "yes", driver's license # _____ Province _____
d. been unemployed for more than 30 days? …… □ □
e. filed for personal or business bankruptcy? …… □ □
f. had a license to practice your occupation suspended or revoked? …… □ □
g. been convicted of a criminal offense or are any criminal charges currently pending or before the courts? □ □

If "yes" to any of 4.a to 4.g give details _____

_____

5. Have you spent any time outside Canada, the United States, Western Europe, Australia or New Zealand in the past 2 years or do you intend to do so in the future? If "yes" give details □ □

_____

6. Have you ever made a claim or received a pension, payments or compensation for any sickness or injury? If "yes" give details _____ □ □

Section F

HEALTH QUESTIONS

Important: Please give details of any **"Yes"** answers in the spaces provided or in section **"H".**

	YES	NO
1. Height _____ □ cm □ ft' in" Weight _____ □ kg. □ lbs. Has your weight changed more than 10 lbs. (5kg) in the last year? Gain _____kg./lbs. Loss _____kg./lbs.	□	□
2. Within the past 12 months, have you used any form of tobacco, marijuana, nicotine products or nicotine substitutes? ……..	□	□
3. Have you taken any prescribed medication in the past 3 months? ……	□	□
4. In the past 10 years, have you had any known indication of, or received treatment or advice for:		
a. dizziness, fainting, convulsions, numbness, chronic headache, epilepsy, stroke, or other disorder of the brain or nervous system? ……..	□	□
b. anxiety, depression, stress, burnout, chronic fatigue or other emotional, nervous or mental disorder? ….	□	□
c. asthma, bronchitis, sleep disorder, tuberculosis, pleurisy, emphysema, blood spitting, persistent cough, or other disorder of the lungs or respiratory system? ……..	□	□
d. high blood pressure, high cholesterol, chest pain, palpitations, heart murmur, heart attack or other disorder of the heart or blood vessels? ……..	□	□
e. ulcer, gastritis, intestinal bleeding, colitis, jaundice, hepatitis, hemorrhoids, hernia, or other disorder of the stomach, intestines, rectum, gallbladder, liver or pancreas? ……	□	□
f. sugar, protein, albumin, pus or blood in the urine, nephritis, kidney stone or other disorder of the kidney or bladder? ……...	□	□
g. diabetes (please complete Section G), cancer, tumour, gout, venereal disease, or disorder of the prostate or reproductive organs? ……	□	□
h. backache, rheumatic fever, rheumatism, arthritis, fibromyalgia, paralysis, or other disorder of the muscles or bones, including joints and spine? ……..	□	□
i. thyroid disorder, enlarged lymph glands, anemia, allergies, or other disorder of the glands or blood? …..	□	□
j. disorder of the eyes, ears, nose, throat or skin? ……	□	□
5. In the past 10 years have you been advised to seek treatment for drug or alcohol use? ……..	□	□
6. Have you been medically diagnosed as having or been treated for AIDS or HIV infection, or any other immunological disorder? ……	□	□
7. Have you ever attempted to commit suicide? ……	□	□
8. Have your parents, brothers, or sisters ever had diabetes, high blood pressure, heart disease, kidney disease, cancer, stroke, Huntington's Chorea or any other hereditary disease? ……...	□	□
9. In the past 5 years, **other than as already disclosed,** have you:		
a. missed more than 15 consecutive days from work due to sickness or injury? ……..	□	□
b. been a patient in a hospital, clinic, sanatorium or other medical facility? ……	□	□
c. had an electrocardiogram, X-ray, blood or urine test or other diagnostic test? ……	□	□
d. had any other illness, surgery, injury or disease? ……	□	□
e. been examined by or consulted by a physician, chiropractor, psychologist, physiotherapist or other practitioner? ……	□	□
10. Are you totally disabled or on sick leave, medical leave, or hospitalized? ……..	□	□
11. Are you contemplating medical attention or a surgical operation? ……...	□	□
12. Have you been advised to have any diagnostic tests, treatment or surgery that has not yet been completed? ……	□	□

12. Personal Physician: a. Name	d. Date last consulted
b. Address: Number and Street	e. Reasons & results
City or Town Province Postal Code	
c. Telephone # Fax #	

If answer is "yes" to any questions give details:

Question #	Details as to diagnosis, treatment, duration, present status	Date(s)	Name and address of physician and/or hospital

Additional space is available in section "H".

Section G

DIABETES QUESTIONNAIRE

(must be completed if Proposed Insured is diabetic)

1. How old were you when first diagnosed? _____years old
2. Treatment: Diet only? □ Yes □ No
   Have you ever been on insulin or oral hypoglycemics? □ Yes □ No
   If yes, please indicate when, what medication, dosage and the circumstances:

_____

_____

3. a. Is a specialist treating you for your diabetes? □ Yes □ No
3. b. If "yes", please provide name, address, phone number and date of last visit.

_____

_____

4. a. Date of most recent diabetes blood test: _____/_____/_____ (DD/MM/YYYY).
4. b. Hemoglobin A1c result if known: _____

5. Have you ever been in a diabetic coma or ever had insulin shock or insulin reactions? □ Yes □ No
   If yes, please provide details including the date(s) and name(s) of hospitals:

_____

_____

_____

6. How frequently do you test your blood sugar levels? _____
   Please indicate the most recent values, whether random or fasting, and the dates:

_____

_____

_____

7. Do you have a history of, or have been diagnosed with any of the following:

□ Heart disease	□ Hypertension	□ Vision problems, incl. retinopathy
□ Stroke	□ Kidney disease	□ Numbness or tingling in arms, legs hands or feet
□ Chest pain	□ Protein in urine	
□ Neuritis	□ Peripheral vascular disease	□ None of the above.

   Details of checked items:_____

_____

_____

8. Do you drink alcoholic beverages? □ Yes □ No If yes, please indicate amount consumed:

_____

9. Have any of your parents or siblings ever been diagnosed as having diabetes or any of the above mentioned problems? □ Yes □ No If yes, please indicate who, the nature of the problem and the current health status:

_____

_____

_____

Section H

ADDITIONAL INFORMATION

Please provide additional details for any “Yes” answers in Sections “E” or “F” or any other information that is material to this insurance application.

Section I

DECLARATION AND AUTHORIZATION

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby apply for insurance. I understand that the insurance for which I am applying requires that I be actively at work 30 hours per week at the time my application for insurance is approved. The insurance will not be effective until the date such requirement is met. To the best of my knowledge and belief, all statements and answers recorded on this application are true and complete.

I understand that the insurance applied for will become effective on the date specified by Reliable Life Insurance Company ("the Company") only if this application is accepted by the Company and the first premium is paid during my lifetime, and only then if there has been no change in my insurability between the date I complete this application and the date the policy is delivered to me.

I hereby authorize any physician, medical or health practitioner, hospital, clinic or medically related facility, insurance company, employer or former employer, the Medical Information Bureau, Inc., or any other organization, institution, or person which has any records of knowledge of me, my health or other personal information, to give Hunter McCorquodale, Reliable Life Insurance Company or its reinsurers all such information to use to determine eligibility for insurance or for benefits under an existing policy. This authorization shall be valid for 26 months, and a copy shall be as valid as the original. I may receive a copy upon request. I have received and read the Disclosure Notice.

Signed at _____ this _____ day of _____,_____

Signature of Proposed Insured _____

Signature of owner, if other than Proposed Insured _____

(Important: if a corporation, must be signing officer of the corporation, other than the Proposed Insured)

Print name and title of person signing for owner _____

Section J

AGENT/ BROKER STATEMENT

AGENT/BROKER STATEMENT

I certify that I have asked all questions and have accurately recorded on the application all information supplied by the Proposed Insured, and I have no knowledge of information which is not fully disclosed. I also certify that the Proposed Insured reads and understand English

Name of Agent/Broker:

Signed at _____ this _____ day of _____,_____

Signature of Agent/Broker _____

RELIABLE LIFE INSURANCE COMPANY

Box 557, 100 King Street West
Hamilton, Ontario L8N 3K9
Phone: 800.465.0661

Policy No: _____

These services are for (please check one): Personal ❑ Business ❑

Pre-Authorized Debit (PAD) Agreement

INSTRUCTIONS:

1. Sign the authorization using the signature(s) on file at your financial institution.
2. Attach a voided sample cheque

I/we authorize Reliable Life Insurance Company, and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for monthly premium payments. Regular monthly payments for the amount of premium will be debited to my/our specified account. Reliable Life Insurance Company will provide ten (10) days written notice of any change in the amount of each regular debit.

This authority is to remain in effect until Reliable Life Insurance Company has received signed written notification from me/us of its change or termination. This notification must be received at least ten (10) days before the next debit is scheduled at the address provided. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we 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/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

DEPOSITOR(S)

_____
Name of Accountholder(s) listed on the Account ***(Please print)***

_____

X_____
Signature of Accountholder Date

X_____
Signature of Joint Accountholder *(if applicable)*

_____
Name of Financial Institution

_____
Address of Financial Institution

_____
City Province Postal Code

_____
Financial Institution Phone Number

_____
Chequing Account Number you wish to debit

❑❑❑ - ❑❑❑❑❑
Financial Institution Transit Number

--- Attach a voided sample cheque *(no deposit slips, please)* ---

TO: THE FINANCIAL INSTITUTION NAMED ABOVE

So that you may comply with your depositor's request, this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any cheque / electronic debit, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such cheque / electronic debit shall be dishonoured whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss through dishonour results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositors or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.
4. That this agreement may be cancelled by any one of the Insurance Company, the Financial Institution or the Depositor by giving written notice to the other two parties. Such notice shall be effective as to each receiving party upon its receipt except that it shall not affect cheques / electronic debits drawn prior to receipt of the notice and then outstanding.

This form is to be sent to Reliable Life Insurance Company at the address shown above.

DETACH THIS PAGE AND LEAVE WITH APPLICANT

RECEIPT FOR CASH PAYMENT

It is acknowledged that the sum of (an amount equal to at least one monthly premium) $_____ has been paid to Reliable Life Insurance Company.

Name of Proposed Insured _____

Name of Owner (if other than Proposed Insured) _____

It is expressly understood and agreed that the payment evidenced by this receipt does not put the proposed insurance in effect. Any policy issued based on this application takes effect only on delivery to the Owner and only if there has been no change in insurability of the Proposed Insured subsequent to the completion of this application.

Signed at _____ this _____ day of _____, _____

Agent's Signature _____

IMPORTANT DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Reliable Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Under some circumstances, medical information will be disclosed only to your attending physician. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7 – (416) 597-0590.

Reliable Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

INFORMATION PROCEDURES: Personal information about you obtained by the Company will not be disclosed to any other party without your consent, except to public health authorities or where otherwise required by law. You have a right to access and to seek correction with respect to personal information gathered. Details on these procedures will be furnished on request.