Send the completed application to:

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

APPLICATION FOR TRANSITION L.T.D.
Long Term Disability Insurance for Outplaced Employees

RELIABLE LIFE INSURANCE COMPANY

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 other than residence address:

Street, Apt./Ste. # City/Town Prov. Postal Code

7. Place of Birth (Province/Country):

8. Telephone:

( )_____-_____ ( )_____-_____ _____

Daytime Evening Best Time to Call

9. Social Insurance Number:

Section B — EMPLOYMENT INFORMATION

1. Employer Name at Date of Job Termination:

2. Employer Address:

Street, Ste. # City/Town Province Postal Code

3. Start Date: _____ / _____ / _____ (Day / Month / Year)

4. Last Day Worked: _____ / _____ / _____ (Day / Month / Year)

5. Contact Name:

6. Telephone:

7. Occupation and Duties:

8. Previous Employment History Over the Past Three Years:

From Month/Year	To Month/Year	Employer Name	Occupation	Final Annual Salary

Section C — FINANCIAL INFORMATION

1. Annual Base Salary at Date of Job Termination:
$_____

2. Amount of Severance:
a. ☐ Lump Sum of $_____ and/or b. ☐ Salary Continuation for _____ months

3. Expiry Date of Group LTD Coverage
a. ☐ Last Day Worked or b. ☐ Other (specify) _____ / _____ / _____ (Day / Month / Year)

4. Do you have any other disability income insurance in force or applied for? ☐ Yes ☐ No (If "yes" give details)

Company Year Issued Monthly Benefit Benefit Period Elimination Period

_____

Section D — PLAN INFORMATION

1. Coverage Period (#months): ☐ 6 ☐ 9 ☐ 12 ☐ 15 ☐ 18 ☐ 21 ☐ 24

2. Monthly Benefit Amount: $_____

3. Benefit Period ☐ to age 60 ☐ to age 65

4. Indexing: ☐ Yes ☐ No

5. Premium to be Paid by: ☐ Proposed Insured ☐ Employer

APPLICATION FOR TRANSITION L.T.D. COVERAGE

Section E

GENERAL INFORMATION

	YES	NO
1.Have you ever had an application for disability income insurance declined, postponed, rated or modified in any way? If "yes", give details including company, date and specific nature of decision _____	☐	☐
_____		
2.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 racing (automobile, snowmobile, motorcycle, boat), scuba diving, sky diving, hang gliding, bungee jumping, mountain or rock climbing, or any other 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?	☐	☐
If "yes" to any of 2.a to 2.g give details _____		
_____		
3.Do you have any intention of spending more than 1 month at a time outside Canada or the United States within the next 2 years? If "yes" give details _____	☐	☐
4.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

(provide details of any "yes" answers on page 3)

	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, been medically diagnosed as having, or been treated 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 kidneys or bladder?	☐	☐
g. diabetes, 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 or kidney 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 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?	☐	☐

APPLICATION FOR TRANSITION L.T.D. COVERAGE

Section F (continued)

HEALTH QUESTIONS

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

(tear on dotted line)

RECEIPT FOR CASH PAYMENT

It is acknowledged that the sum of $_____has been paid to Reliable Life Insurance Company, in connection with an application for disability insurance for

_____
Print Name of 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 the insurability of the Proposed Insured subsequent to the completion of this application.

Signed at _____ this _____ day of _____,_____

Agent's Signature_____

APPLICATION FOR TRANSITION L.T.D. COVERAGE

Section G

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.

_____

To the best of my knowledge and belief, all statements and answers recorded on this application are true and complete.

I understand and agree that any policy issued on this Application takes effect only on delivery and on payment in full of the premium and then only if there has been no change in my insurability subsequent to the completion of this application. 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 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 or knowledge of me, my health or other personal information, to give to 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_____

Section H

AGENT/ BROKER STATEMENT
(if application is submitted by a licensed agent or broker)

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 understands English.

Name of Agent/Broker:

Signed at _____ this _____ day of _____,_____

Signature of Agent/Broker_____

IMPORTANT: Detach and retain this 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.