APPLICATION FOR DISABILITY INSURANCE 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: ☐ 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 ( ) Best time to Call: Best Place to Call:

9. Social Insurance Number:

10. Owner, if other than Proposed Insured (owner must sign on page 4):

11. Citizenship:

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 Employers 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

2. Duties:

a. Job Title:

b. Professional Designation/Degree:

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

		d. 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:

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Section C — PLAN INFORMATION

1. Plan Type and Details: (or enclose a signed, witnessed and dated quotation)

Type Of Coverage (check all applicable)	Elimination Period	-- Temporary Total Disability -- Monthly Benefit	Benefit Period	Principal (lump) Sum	Permanent Total Disability Principal (lump) Sum
☐ Income Replacement					
☐ Buy-Sell					
☐ Overhead Expense					
☐ Key Person					

2. Policy Term:_____ 3. Annual Premium: $_____ 4. Currency: ☐ CAD ☐ USD

5. Income Replacement Only:
   a. Are benefits to be taxable? ☐ Yes ☐ No
   b. Include Residual Disability and Recovery Benefit Rider? ☐ Yes ☐ No

6. Effective Date: ☐ Date of Approval ☐ Other (specify): _____

Section D — FINANCIAL INFORMATION

1. **Earned Income:**
a. This year to date $_____
b. Last year $_____
c. 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.**

NB: Appropriate financial documentation must accompany all applications.

Section E — GENERAL INFORMATION

	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 coverage?	☐	☐
c. Are you or will you become eligible for Group Disability coverage, not noted above, within the next year?	☐	☐
d. Are you eligible for Workers Compensation or other similar coverage?	☐	☐
2. Have you ever had an application for disability insurance declined, postponed, rated or modified in any way?	☐	☐
3. 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?	☐	☐
4. Have you ever received disciplinary action from your licensing body and/or been charged with or convicted of any criminal offence?	☐	☐
5. Do you have any intention of spending more that 1 month at a time outside Canada or the United States within the next 2 years?	☐	☐
6. Have you ever made a claim or received a pension, payments or compensation for any sickness or injury?	☐	☐

Give details of any "yes" answers in Section E (refer to question #):

Additional space is available on Page 4, or attach extra signed and dated sheets.

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Section F

HEALTH QUESTIONS

	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, gall bladder, 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 sought or received advice or treatment for the use of alcohol or drugs, prescribed or non-prescribed, or used cocaine, barbiturates, marijuana, or any narcotic or habit forming drug?	☐	☐
6. Have you ever 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 surgical operation?	☐	☐

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 #	

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, time off work and present status.

Additional space is available on the next page, or attach extra signed and dated sheets.

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Section G

ADDITIONAL INFORMATION

Please provide additional details of any "yes" answers in Section E or Section F , and/or any other information you feel is material to your insurance application:

Section H

DECLARATION AND AUTHORIZATION

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)

I understand and agree that any insurance issued pursuant to this application will take effect on the date set forth in the policy, provided that the first premium and any outstanding requirements are received by Hunter McCorquodale within 31 days of the effective date, and provided further that there have been no changes in the information in this application between the date of completion 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 any other organization, institution or person that has any records of me, my health or other information relevant to this application, to provide any such information to Hunter McCorquodale. 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 will not be disclosed to any other party EXCEPT Underwriters at Lloyd's or other persons or organizations 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 1/2 years from the date of completion. I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

Signed at_____ this _____ day of _____,_____

Signature of Proposed Insured_____

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

Print name and title of person signing for owner_____

Section I

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 that is not fully disclosed. I also certify that the Proposed Insured reads and understands English.

Signed at_____ this _____ day of _____,_____

Signature of Agent/Broker_____