HUNTER McCORQUODALE

the co-operators
A Better Place For You®

Acceptional Life™

Acceptional Life™ is insured and underwritten by Co-operators Life Insurance Company and is distributed by Hunter McCorquodale and its contracted sales advisors.

APPLICATION FOR COVERAGE

(not available in Quebec)

TERM 10, NON-RENEWABLE, NON-CONVERTIBLE

Note: The words "you" and "your", wherever used in this application, shall refer to the Policy Owner and/or the proposed Life Insured, as appropriate.

CO-OPERATORS LIFE INSURANCE COMPANY CONSUMER PRIVACY NOTICE

THE UNDERWRITING PROCESS

Thank you for applying to Co-operators Life Insurance Company for your insurance coverage.

Your application will be evaluated to see if the proposed Life Insured is eligible for the Policy applied for. We begin by reviewing all of the information in the application. We will confirm or add to this information in the ways described in this notice. We process all applications uniformly and on a fair basis in order to determine the premium you should pay.

We will inform you if we cannot provide the coverage asked for, or if we can only provide it on a modified basis or at a premium different from that quoted or with applicable exclusions based on the information obtained during the application process. We will tell you, in general terms, of the reasons for our decision. Upon your request, more specific reasons will be given to you or your physician.

OUR INFORMATION PRACTICES

Information Collection - Your application is one source of information. However, we may also:

- Ask you to have a medical examination or other tests which may include, but are not limited to, an electrocardiogram, blood tests or urine tests.
- Ask physicians, hospitals or other medical care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you have signed. If you want a copy of this form, it will be given to you.
- Obtain a report from a consumer reporting agency. Information about this report and any rights you have under provincial law is noted below.
- Obtain information from MIB, Inc. This organization is described below.
- Conduct a telephone interview.
- Seek information from other companies where you have applied for insurance or submitted a claim.
- Seek information from any reinsurers who may have been involved in underwriting this or any other application for insurance or adjudicating any claim.

Information Use - We will use information regarding the insurance relationship you have with us only for business purposes. Your social insurance number, if provided, will be used for the purposes of tax reporting and the administration of any benefits, policies or contracts under which you are covered, and may be used to verify information provided as part of the underwriting process.

Access to Information - Upon written request, we will provide you with a copy of the relevant information we have obtained about you in connection with your application, subject to any restrictions authorized by law. If you feel that the information in our files is not correct or not complete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. This statement will be sent with any disclosures of the information which we make. We will not send you information we collect in connection with any claim or in connection with or in expectation of legal proceedings.

Retention of Information - We keep and use information provided by you for the duration of the Policy so that claims can be adjudicated appropriately. In the event you are declined for coverage, or do not proceed with the coverage applied for, we keep the information you have provided to us to access if you apply for insurance at a future date, and to confirm information that may be provided to us or to other insurers in respect of other applications for insurance that you may make.

CONSUMER REPORTS

In some situations, we will also ask an independent source to provide a Consumer Report to verify and add to the information that was provided as part of the application process. The Consumer Reporting agency will collect information about your health, lifestyle, employment, finances and personal characteristics. The agency may collect information by talking in person or by telephone to you or your business associates, financial sources, and other affiliates.

The Consumer Reporting agency that makes the report will be discreet and impartial. They may keep the information and provide it, to the extent permitted by law, to others who have a legitimate need for these reports. We will send you the name, address and phone number of any agency we ask to prepare a Consumer Report or an Investigative Consumer Report about you upon request. The Consumer Reporting agency will provide you with the information contained in their report upon request and presentation of proper identification.

MOTOR VEHICLE REPORT (M.V.R.) OR DRIVING ABSTRACT

In some situations, a copy of your driving record may be required to evaluate your insurability/mortality risk and will be requested through your provincial motor vehicle division.

MIB, INC. (MIB)

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at canada_disclosure@MIB.com.

If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction at: 330 University Avenue, Suite 501, Toronto, Ontario MSG 1R7. We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

REPLACEMENT

Please tell your financial advisor if you intend to discontinue current insurance coverage, surrender an existing policy or borrow from the cash value of an existing policy to pay premiums on the Policy applied for. Your financial advisor will furnish you with information to help you compare the Policy you have applied for with the existing policy you intend to use or replace.

THIS PAGE SHOULD BE DETACHED AND LEFT WITH THE APPLICANT.

CO-OPERATORS LIFE INSURANCE COMPANY CONSUMER PRIVACY NOTICE (CONTINUED)

Co-operators Life Insurance Company Privacy Statement

The Co-operators is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about The Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co-operators at Priory Square, Guelph, Ontario, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

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TERM 10, NON-RENEWABLE, NON-CONVERTIBLE

Note: The words "you" and "your", wherever used in this application, shall refer to the Policy Owner and/or the proposed Life Insured, as appropriate.

A. PROPOSED LIFE INSURED

For the purpose of this application, the term "Life Insured" shall mean the person whose life is proposed to be Insured.

1. Name _____ (First Name) _____ (Initial) _____ (Last Name)
2. Maiden Name (if applicable) _____ Policy Language: ☐ English ☐ French
3. Date of Birth _____ (MMM/DD/YYYY) Place of Birth _____
4. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law
5. Citizenship: ☐ Canadian ☐ Permanent Resident - Social insurance Number _____ ☐ Male ☐ Female
6. Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)
7. Number of years _____ Previous address, if less than 1 year _____
8. Residence Telephone Number (_____) _____ Business Telephone Number (_____) _____
9. Email _____
10. Occupation/ Duties _____ Length of Time _____
11. Employer's Name _____
12. Employer's Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

B. PROPOSED LIFE INSURED I.D. VERIFICATION

Please review 1 piece of identification to confirm address, photo and signature.

1. Driver's License Number _____ Province of Issue _____ Expiry Date _____ (MMM/DD/YYYY)

OR - One of the following:

☐ Passport Number _____ Place of Issue _____ Expiry Date _____ (MMM/DD/YYYY)

☐ Permanent Resident Card Number _____ Place of Issue _____ Expiry Date _____ (MMM/DD/YYYY)

C. INSURANCE APPLIED FOR

1. Face Amount (minimum $300,000, maximum $10,000,000) $ _____
2. Purpose of Coverage: ☐ Personal Reason _____ Annual Income $_____ Net Worth $_____
   ☐ Business Complete ***Business Financial Questionnaire***

D. OWNER

1. The Owner Will Be: ☐ The Life Insured (proceed to Beneficiary Designation on the next page)
   ☐ A person other than Life Insured (provide additional information below)
   ☐ A corporation or other entity (proceed to Business Owner section)
2. Name _____ (First Name) _____ (Initial) _____ (Last Name)
3. Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)
4. Residence Telephone Number (_____) _____ Business Telephone Number (_____) _____
5. Email _____
6. Employer's Name _____
7. Employer's Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

E. OWNER I.D. VERIFICATION (IF OTHER THAN LIFE INSURED) Please review 1 piece of identification to confirm address, photo and signature.

1. Driver's License Number _____ Province of Issue _____ Expiry Date _____ MMM/DD/YYYY

OR - One of the following:

☐ Passport Number _____ Place of Issue _____ Expiry Date _____ MMM/DD/YYYY

☐ Permanent Resident Card Number _____ Place of Issue _____ Expiry Date _____ MMM/DD/YYYY

F. BUSINESS OWNER

1. Legal name of corporation or other entity _____ Province of Registration _____
2. Address _____ Street _____ City _____ Province _____ Postal Code
3. Contact for Correspondence _____ Telephone (_____) _____

G. BENEFICIARY DESIGNATION If no beneficiary designation is provided, then the Owner [if living] or the owner's estate will be the beneficiary by default.

1. PRIMARY BENEFICIARY(IES) If beneficiary is to be irrevocable, please complete the Irrevocable Beneficiary form.

Full Name	Relationship of Beneficiary to Life Insured	Relationship of Beneficiary to Owner (if other than Life Insured)	Beneficiary Date of Birth (MMM/DD/YYYY)	% Share (must total 100%)

2. CONTINGENT BENEFICIARY(IES) If beneficiary is to be irrevocable, please complete the Irrevocable Beneficiary form.

Full Name	Relationship of Beneficiary to Life Insured	Relationship of Beneficiary to Owner (if other than Life Insured)	Beneficiary Date of Birth (MMM/DD/YYYY)	% Share (must total 100%)

3. TRUSTEE FOR MINOR CHILDREN

Name of Trustee	Relationship of Trustee to Life Insured	In Trust to Age

H. OWNER BANKING INFORMATION

1. Modal Premium $ _____ Premium Mode: ☐ Monthly PAD ☐ Annual ☐ Semi-Annual
2. Premium Payor: ☐ Life Insured

   ☐ Other _____ First Name _____ Initial _____ Last Name

   ☐ Joint Account - Holder's Name _____ First Name _____ Initial _____ Last Name

   ☐ Company - Name _____
3. Withdrawal Date: ☐ Draw on Issue Date **OR** ☐ Specify Date _____

   Note: Draw date cannot be the 29th, 30th or 31st of each month.

I. AUTHORIZATION FOR A PRE-AUTHORIZED DEBIT PLAN Attach a void cheque.

1. The Owner authorizes Co-operators Life Insurance Company to make withdrawals from their financial institution to pay premiums for policies issued pursuant to the application.

   ☐ Establish a new PAD account

   ☐ Use existing PAD

J. BANKRUPTCY

1. Has any Owner or Life Insured ever declared bankruptcy or made a voluntary assignment in bankruptcy, or is currently in an undischarged bankruptcy? ... ☐ Yes ☐ No

   If yes, please provide details (including date of discharge and whether business or personal) _____

K. INSURANCE HISTORY (PROPOSED LIFE INSURED)

1. Do you have any life insurance pending or in force? ☐ Yes ☐ No

Company Name	Personal/ Business	In-force/Pending	Coverage Amount	Date Issued/Pending

2. Will this insurance replace or substantially change any other individual life insurance policy in force anywhere? ☐ Yes ☐ No

   If yes, please complete ***Life Insurance Replacement Declaration.***

3. Have you ever had an application for life, health, critical illness or disability income insurance declined, postponed, modified or rated? ☐ Yes ☐ No

   If yes, provide full details (including insurer, decision and approximate date) _____

   _____

   _____

   _____

L. NON-MEDICAL SECTION (PROPOSED LIFE INSURED)

1. HAZARDOUS ACTIVITIES

a. During the past two years, have you flown as a pilot, student or crew member? ☐ Yes ☐ No

b. During the past two years, have you participated in any hazardous activities such as motor vehicle racing, snowmobile racing, mountain or rock climbing, hang gliding/para-sailing, parachute jumping, scuba-diving, etc. ☐ Yes ☐ No

If yes to A or B, complete the appropriate Questionnaire.

c. Is any such activity planned? ☐ Yes ☐ No

If yes, provide details in Remarks Section (Page 6).

2. TRAVEL

a. Have you travelled outside of Canada or the United States within the last two years? ☐ Yes ☐ No

b. Do you intend to do so within the next 12 months? ☐ Yes ☐ No

If yes to A or B, complete the Foreign Travel Questionnaire.

3. DRUG USE

a. Have you ever used any drugs not prescribed by a physician, including but not limited to narcotics, cocaine, steroids, amphetamines, hallucinogens and/or marijuana? ☐ Yes ☐ No

b. Have you ever been requested to take or received advice, counselling or treatment for drug use? ☐ Yes ☐ No

If yes to A or B, complete the Drug Questionnaire.

4. LEGAL

a. Have you ever been convicted of any criminal offence, including refusal of breathalyzer or driving while impaired? ☐ Yes ☐ No

b. Are any criminal charges pending? ☐ Yes ☐ No

If yes to A or B, provide dates and details in Remarks Section (Page 6).

c. Have you had any driving convictions in the past three years or ever had your license suspended? ☐ Yes ☐ No

If yes, in Remarks Section (Page 6), give date(s) and type of violations; date, length and reason for suspension(s).

If yes to A, B or C, please provide: License Number(s) _____

Province(s) _____

5. SMOKING

a. Have you ever used cigarettes (including e-cigarettes), cigarillos, cigars, pipe, chewing tobacco, nicotine gum, nicotine patch, nicotine substitute or tobacco in any other form? ☐ Yes ☐ No

If yes, in Remarks Section (Page 6), specify type(s), amount and frequency of use.

Date of Last Use _____
MMM/YYYY

L. NON-MEDICAL SECTION (CONTINUED)

6. ALCOHOL USE

a. Do you presently consume alcoholic beverages? ☐ Yes ☐ No

If yes, specify number of drinks per: ☐ Day _____ ☐ Week _____ ☐ Month _____ ☐ Year _____

If no, Date of Last Use _____
MMM/YYYY

b. Did you ever consume more alcohol than you do currently? ☐ Yes ☐ No

If yes, in Remarks Section (Page 6), specify for how long, number of drinks consumed and how often.

c. Have you ever been requested to take or have you ever received advice, counselling or treatment because of alcohol use or attended a support group such as Alcoholics Anonymous? ☐ Yes ☐ No

If yes, in Remarks Section (Page 6), provide dates, details, etc.

If yes, have you used alcohol since? ☐ Yes ☐ No

If yes, in Remarks Section (Page 6), provide dates used, amount consumed, etc.

M. REMARKS

Question Number	Details

N. MEDICAL SECTION (PROPOSED LIFE INSURED)

1. Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ Kg

2. Weight change in the last 12 months: ☐ None ☐ Loss: Specify Amount _____ ☐ Gain: Specify Amount _____

3. Reason for Loss/Gain _____

4. Do you have a regular physician? ☐ Yes ☐ No

   If yes, complete the following information. If no, provide the name of the clinic you attend and complete the information below:

   Name _____ Date of Last Visit _____ (MMM/YYYY)

   Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

   Phone (_____) _____ Reason for Visit _____

   Results/Diagnosis _____ Treatment/Medication _____

5. Are you pregnant? ☐ Yes ☐ No

   If yes, due date _____ (MMM/YYYY)

6. Have any of your immediate family members (father, mother, siblings) ever had: heart disease, stroke, high blood pressure, elevated cholesterol, cancer (specify type), diabetes, mental illness, Alzheimer's Disease, Huntington's Disease, Multiple Sclerosis, Parkinson's Disease, Motor Neuron Disease, hereditary kidney disease or any other hereditary disease? ☐ Yes ☐ No

Family Member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death	Type of Cancer

7. Are you now under observation or receiving advice or treatment from any physician or any Alternative Health Care Provider (AHCP) or taking medication for any ailment or condition? (ACHP includes herbalist, acupuncturist, chiropractor, practitioner of homeopathy or naturopathy, etc.) ☐ Yes ☐ No
   If yes, in Remarks Section (Page 8) provide details, names of medications, etc.

8. Do you have any mental or physical impairment or disease, or any symptoms or complaints for which you have not consulted a physician or received treatment? ☐ Yes ☐ No
   If yes, provide details in Remarks Section (Page 8).

9. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), had a positive test for HIV, ever been advised to have HIV testing or ever had any other disorder of the immune system? ☐ Yes ☐ No
   If yes, provide dates and details in Remarks Section (Page 8).

10. Are you contemplating any surgical operation or are you planning to have, or been advised to have, any tests or investigations that have not yet been completed? ☐ Yes ☐ No
    If yes, provide dates and details in Remarks Section (Page 8).

11. Have you ever been diagnosed with, or received treatment or advice for:
    a. Cancer, tumour, abnormal growth or cyst, or unusual skin lesion? ☐ Yes ☐ No
    b. Chest pain, high blood pressure, elevated cholesterol, heart murmur, rheumatic fever, heart attack, stroke, transient ischemic attack (TIA), or other disorder of the heart or blood vessels? ☐ Yes ☐ No
    c. Diabetes, sugar in the urine or elevated sugar in the blood? ☐ Yes ☐ No
    d. Anxiety, depression, suicide thoughts or attempts, or any other mental or nervous disorder? ☐ Yes ☐ No
    e. Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or Motor Neuron Disease? ☐ Yes ☐ No
    f. Epilepsy, seizures, loss of consciousness or any other disorder of the brain or nervous system? ☐ Yes ☐ No
    g. Asthma, bronchitis, tuberculosis, emphysema, or other disorder of the lungs or respiratory system? ☐ Yes ☐ No
    h. Hepatitis A, B, C or type unknown, hepatitis carrier, or any other disorder of the liver? ☐ Yes ☐ No
    i. Intestinal bleeding, colitis, Crohn's disease, disorder of the pancreas, gallbladder, stomach or intestines, including colon and rectum, or any other disorder of the digestive system? ☐ Yes ☐ No
    j. Protein, pus or blood in the urine, kidney stone, or other disorder of the bladder or kidneys? ☐ Yes ☐ No
    k. Disorder of the breast, prostate, reproductive organs or sexually transmitted disease? ☐ Yes ☐ No
    l. Arthritis, paralysis, fibromyalgia, chronic fatigue syndrome or any other disorder of the bones, muscles, joints or spine? ☐ Yes ☐ No
    m. Leukemia, anemia, hemophilia, or any other disorder or abnormality of the blood? ☐ Yes ☐ No
    n. Disorder of the thyroid, pituitary, adrenals or other glands? ☐ Yes ☐ No
    o. Disorder of the eyes or ears, or impairment of vision or hearing? ☐ Yes ☐ No

    If ANY question is answered 'Yes', in Remarks Section (Page 8), provide date(s), diagnosis/results, treatment/medication, frequency/duration and physician's name and hospital.

N. MEDICAL SECTION (CONTINUED)

12. Other than as listed in the answers above, in the past 5 years have you:

a. Seen a physician for any other illness, condition, check-up, consultation or treatment not previously mentioned? ☐ Yes ☐ No

b. Had any other illness, condition, check-up, consultation or treatment from an Alternative Health Care Provider or any other practitioner? ☐ Yes ☐ No

c. Missed more than 15 consecutive working days due to sickness, disability or injury? ☐ Yes ☐ No

d. Applied for or received disability benefits? ☐ Yes ☐ No

e. Been a patient in a hospital, clinic or other medical facility? ☐ Yes ☐ No

f. Had an electrocardiogram, X-ray, blood tests or other diagnostic tests? ☐ Yes ☐ No

If ANY question is answered 'Yes', in Remarks Section (Page 8), provide date(s), diagnosis/results, treatment/medication, frequency/duration and physician's name and hospital.

O. REMARKS

Question Number	Details

P. DECLARATION, AGREEMENT AND AUTHORIZATION

In this Declaration, Agreement, and Authorization:

1. "Applicant" means both the proposed Life Insured and Owner, if different.
2. "Application" means all application forms and any information the Company requires to underwrite the insurance risk, and includes this initial application form, any amended application form, an application for change, the telephone interview (where applicable), the medical or paramedical examination, and any supplemental or amended information submitted to the Company.
3. "The Company" means Co-operators Life Insurance Company and its authorized representative Hunter McCorquodale.

DECLARATION

The Applicant confirms that he/she was present when this initial application form was completed, he/she had an opportunity to review the answers and statements recorded in this initial application form, and all the answers and statements recorded are true and complete.

DECLARATION AND AGREEMENT

The Applicant declares and agrees that:

1. In completing the Application, the Applicant has a duty to disclose to the Company every fact within his or her knowledge and therefore must answer all questions in the Application truthfully, completely and accurately.
2. No person has the authority to waive any question or modify the Application in any way.
3. If the Company issues a Policy as a result of the Application, the Policy issued is based upon the answers and statements recorded in the Application.
4. If any Applicant misrepresents or fails to disclose any facts that are material to the insurance risk, the Company may void the insurance. Facts are material when they affect the Company's decision to issue a Policy on the terms proposed and for the premium charged.
5. No death benefit is payable if the Life Insured dies from suicide or self destruction by the Life Insured, while sane or insane, including euthanasia of the Life Insured assisted by another person including a licensed physician.
6. Once this Application has been signed, the information cannot be changed without the Applicant's consent.
7. By accepting the Policy offered by the Company, the Applicant confirms that: (a) all answers and statements recorded in the Application are true, complete and accurate, and (b) he/she agrees that the terms and conditions of coverage contained within the Policy exclude, and no death benefit will be paid, in the event of death of the Life Insured for which an Excluded Cause as defined in the Policy is the Immediate Cause, an Antecedent Cause or an Underlying Cause of death.
8. If a telephone interview will be conducted as part of the Application, the Company will be relying on the responses given during the telephone interview to assess whether the proposed Life Insured is insurable. The Applicant understands that he or she will be bound by these responses and that any untruthful, incorrect, or inaccurate information provided may render the coverage voidable at the time of claim or otherwise. The Applicant may correct any information given in the telephone interview or any other part of the Application by advising the Company in writing.
9. The Company will not be considered to have knowledge of any facts that are not recorded in the Application.
10. The Company will have no liability under this Application until the Policy takes effect (in accordance with the laws of the jurisdiction of which the initial application form has been completed) and there has been no change in insurability of the Life Insured between the date the initial application form has been signed and the Policy Effective Date.

AUTHORIZATION

The Applicant understands that, when he/she applies for insurance coverage, the Company will collect personal information about the Applicant. The Company collects this personal information for the purposes of underwriting the Application, administering coverage under any Policy issued by the Company, and adjudicating any claim submitted to the Company.

The Applicant hereby authorizes:

1. Any licensed physician, medical practitioner, hospital, clinic, paramedical firm, or other medical or medically-related facility or service provider to release any information about the Applicant or the Applicant's health status to the Company or the Company's authorized representative Hunter McCorquodale, the Company's reinsurers, or the Company's external suppliers and service providers. A facsimile, photocopy, scan or other electronically imaged copy of this Authorization is as valid as the original.
2. Any insurance company, MIB, Inc. or any other organization, institution, or person to release any information relating to the Applicant's insurability, including information about the Applicant's health status, to the Company or the Company's authorized representative Hunter McCorquodale, the Company's reinsurers, or the Company's external suppliers and service providers; and
3. The motor vehicle division in any province to release the Applicant's driving records to the Company or the Company's authorized representative Hunter McCorquodale, the Company's reinsurers, or the Company's external suppliers and service providers.

The Applicant hereby authorizes the Company, its reinsurers or authorized external suppliers and service providers:

1. To make a brief report of the Applicant's personal health information to MIB,
2. To use any information it has on record about the Applicant for the purpose of underwriting the Application, including information contained in closed files,
3. To perform any examinations, x-rays, electrocardiograms, blood profiles and tests (including an HIV antibody test), as the Company may require for the purpose of underwriting the Application,
4. To release any information obtained during the underwriting process to any of the Applicant, the Applicant's family physician, and to Public Health authorities, when required,
5. To use a Consumer Reporting Agency to obtain personal lifestyle and financial information about the Applicant,
6. To use the Applicant's social insurance number (SIN) for the purposes of tax reporting, underwriting the Application, and administering benefits, policies or contracts under which the Applicant is covered.
7. In the event that the Applicant makes an Application for coverage to another insurer, to release to the other insurer any information the Company has on record about the Applicant's insurability.
8. To obtain, for the purpose of underwriting, any information from any other insurer, or reinsurer, for which the Applicant has made Application for coverage.

P. DECLARATION, AGREEMENT AND AUTHORIZATION (CONTINUED)

In providing these authorizations, the Applicant understands and agrees that:

1. If the Application is for coverage that is intended to replace the coverage under an existing policy, your Financial Advisor will release the Replacement Disclosure Forms to the insurer of the existing policy and the Company.
2. A facsimile, photocopy, scan or other electronically imaged copy of this Authorization is as valid as the original.
3. The Authorization is valid for one year from the date the Authorization form was signed.
4. The Applicant may rescind the Authorization by notification in writing to the Company at any time, but the Applicant understands that such rescission may result in the Company being unable to complete the underwriting of the Application or offer a policy of insurance.
5. The Company will not provide any information to any party not specifically included in the Authorization unless the Company receives written consent from the Applicant or the information is provided in accordance with the "Co-operators Life Insurance Company Privacy Statement" section of the Consumer Privacy Notice.

CONFIRMATION

The Applicant confirms that they have been given a copy of the Consumer Privacy Notice.

PAYMENT AUTHORIZATION DEBIT AGREEMENT

The Applicant authorizes the Company to make withdrawals from their financial institution to pay premiums for any Policy issued pursuant to the Application by Pre-Authorized Debit (PAD).

The Applicant has waived their right to receive pre-notification of the amount of the PAD and agreed that they do not require advance notice of the amount of PADS before the debit is processed.

The Applicant has certain recourse rights if any debit does not comply with this agreement. For example, they have the right to receive reimbursement for any PAD that is not authorized or is not consistent with the terms of this PAD Agreement. To obtain more information on the Applicant's recourse rights, the Applicant may contact their financial institution or visit www.cdnpay.ca.

Your PAD Agreement may be cancelled provided notice is received by the Company 14 days before the next scheduled PAD. If any of the above details are incorrect, please contact us immediately at 1-800-454-8061 Option 3. If the details are correct, you do not need to do anything further and your PAD'S will be processed and start on the Payment Start Date indicated on Page 4.

Language: The Policy Owner and proposed Life Insured understand the language in which this Application is written ☐ Yes ☐ No

The parties expressly agree to enter into a contract written in the ☐ English ☐ French language.

Signed at _____ this _____ day of _____ 20 ____
City, Province

Proposed Life Insured _____ Signature of Proposed Life Insured _____

Witness _____ Signature of Witness _____

Owner(s) _____ Signature(s) of Owner(s) _____
(if other than the proposed Life Insured)

Witness _____ Signature of Witness _____

If Owner is a Business:

Name of person signing on behalf of business _____

Title of person signing on behalf of business _____

I have the authority to bind the business ☐ Yes ☐ No

Q. FINANCIAL 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 initialed by the Applicant answering the question, and that the Application is signed and dated.
2. Do not collect a premium with the Application. For monthly PAD premium mode, please submit a void cheque along with the completed Application.
3. The Acknowledgement page from a sales illustration must be signed and submitted with this Application.
4. Do not request or order any medical evidence. All requirements will be obtained by Hunter McCorquodale. You will be advised what requirements are being arranged after the initial underwriting review.
5. Please advise the Applicant that the underwriter may conduct a telephone interview.
6. 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 the 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. Did the Owner or proposed Life Insured approach you for this coverage? ☐ Yes ☐ No
2. To the best of your knowledge will any existing insurance be cancelled or changed if this Application is approved? ☐ Yes ☐ No
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 declare and confirm that:

1. 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.
2. I have reviewed and explained all important provisions of the proposed coverage, including the exclusions in the standard policy and the possibility of additional policy-specific exclusions, to the Applicant.
3. I have verified the identity of the proposed Life Insured, Owner(s) and premium payor by examining the original and valid identification documents for each of them, and have captured the reference numbers of those documents where required in this Application.
4. I hold all necessary licenses and certificates required to solicit the sale of this proposed insurance, and that I am covered by a current valid errors and omissions insurance policy.
5. I have disclosed the following to the Applicant:
   a. The insurance company or insurance companies that I represent;
   b. That I may receive compensation (such as commissions) for the sale of life insurance company products;
   c. That I may receive additional compensation or other things of value in the form of a bonus, conference program or other incentive;
   d. That there is no conflict of interest regarding the Application being considered by Co-operators Life Insurance Company, and my overall recommendation to the Applicant takes into consideration, and is based on my analysis and assessment of the Applicant's insurance needs.

Licensed Insurance Advisor _____ Signature of Licensed Insurance Advisor _____

Date _____
MMM/DD/YYYY