

Policy number _____

General Information

Product type

- Individual Disability Plan
 Individual Disability Plan - Truckers

Nature of application

- Modification (complete sections 1, 2, 5 and 11)
 Cancellation (complete sections 1, 2, 6 and 11)
 Reinstatement (complete sections 1, 2 and the other applicable sections)

Section 1: Insured

First Name _____ Last Name _____
 _____ | Y , Y , Y , Y | M , M | D , D | _____ Sex _____
 Name at birth (if different) _____ Date of birth _____ Age _____ Female Male

Address _____ Apt. _____ City _____
 _____ Smoker Yes No
 Province _____ Postal Code _____ Telephone (home) _____ Preferred Language English French

Occupation (position) _____ Telephone (work) _____
 \$ _____
 Employer _____ Number of months worked per year _____ Gross income per year _____

Work from home Yes No If yes, percentage of time worked from home _____ %
 How long have you been working from home? _____
 Do you have a contract with one or two companies in particular? Yes No
 Bankruptcy Yes No Date of discharge _____ | Y , Y , Y , Y | M , M | D , D | _____

Section 2: Policyowner (complete if the policyowner is not the insured)

First Name _____ Last Name _____
 _____ | Y , Y , Y , Y | M , M | D , D | _____
 Name at birth (if different) _____ Date of birth _____ Relationship to insured _____

Address _____ Apt. _____ City _____
 Province _____ Postal Code _____ Telephone _____

Subsidiary policyowner (if applicable)

First Name _____ Last Name _____
 _____ | Y , Y , Y , Y | M , M | D , D | _____
 Date of birth _____ Relationship to insured _____

Section 3: Other In Force Insurance Policies (Individual and Group)

Insert a check mark in the box if none

Company's Name	Year of Issue	Disability: Monthly Income	Critical Illness: Face Amount

Section 4: Replacement

Does this request replace any policy in force?

 Yes No

If yes, the prior notice(s) of replacement must be completed and submitted, in accordance with the terms applicable to each province, with the present request or in the delay prescribed by each province.

Section 5: Modification of Benefit

Name of Benefit	Decrease of Benefit Period	Increase of Waiting Period	Decrease of Indemnity	New Premium
	From: to:	From: to:	From: to:	\$
	From: to:	From: to:	From: to:	\$
	From: to:	From: to:	From: to:	\$
	From: to:	From: to:	From: to:	\$

Section 6: Cancellation of Benefit or Policy

Policy Number	Total	Partial, Specific Benefit to Cancel
	<input type="checkbox"/>	<input type="checkbox"/>

Section 9: Business Overhead Expense Benefits

To complete for business overhead expense benefits

During the last five (5) years:

Yes No

1. Have you been or are you presently self-employed?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> sole proprietorship <input type="checkbox"/> corporation <input type="checkbox"/> partnership		
2. Company's name and address:	_____	
3. Number of associates/partners, including yourself:	_____	
4. Percentage of shares:	_____ %	_____ %
5. Number of full-time employees (except the owner)?	_____	Number of part-time employees? _____
6. Have you been working in the same type of company before that?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for how long? _____		
7. Does your company operate all year long or seasonally? _____		
Specify the number of months per year: _____		
8. What is the monthly amount of expenses in the last twelve (12) months?	Total	Your share
a) rent or interest on commercial mortgage:	_____	_____
b) salaries:	_____	_____
c) public utilities (heating, electricity, gas, etc.):	_____	_____
d) telephone:	_____	_____
e) office equipment renting:	_____	_____
f) equipment depreciation:	_____	_____
g) taxes:	_____	_____
h) association fees:	_____	_____
i) accounting and legal departments:	_____	_____
j) other fixed expenses:	_____	_____
Give details, if total exceeds 10%: _____		

Total:		
9. As written in your last tax statement, what were:	_____	_____
a) your gross annual income:	_____	_____
b) the operating expenses:	_____	_____
c) your net income:	_____	_____

Section 10: Critical Illness Benefit

To complete for critical illness benefit

Section A

Yes No

1. In the last two (2) years:		
a) Have you been or have you been advised to:		
– be hospitalized or undergo surgery for cardiovascular or cerebrovascular problems?	<input type="checkbox"/>	<input type="checkbox"/>
– be hospitalized, undergo surgery or be treated for cancer or malignant tumour?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you taken or has your physician advised you to take screening tests for cancer, whose result is not yet known or reveals the presence of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever suffered from or been advised by a physician that you suffer from any of the following diseases, affections or disorders: hepatitis, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or any other deficiency of the immune system, or have you had a positive test revealing the AIDS virus or antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>

Section 10: Critical Illness Benefit (Ctd.)

To complete for critical illness benefit

Section A (ctd.)

	Yes	No
3. Have you been or are you suffering from problems requiring the use of a respiratory device outside a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. During the last five (5) years, have you used or do you use narcotics, marijuana, cocaine, other drugs or have you ever received advice or treatment for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past three (3) years, have you been found guilty of two or more driving offences and/or has your driver's licence been suspended?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been requiring assistance by a third party to perform any of the following tasks: a) eating, b) dressing, c) using washrooms, d) washing and taking care of yourself, e) transferring from bed to a chair?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you suffer from any of the following diseases: a) liver cirrhosis, b) Alzheimer's disease, c) vascular dementia, d) Parkinson's disease, e) hepatitis for more than 12 months, f) epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you suffer from diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
If yes,		
a) have you been diagnosed by a doctor or an ophthalmologist for problems with vision and/or ocular globes, kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>
b) have you had an amputation in the last five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
c) are you insulin dependent?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "yes" to any question in Section A, you are not eligible for critical illness benefit.

Section B

	Yes	No
1. Have you ever suffered from or been advised by a physician that you suffer from any of the following diseases, afflictions or disorders:		
a) cancer, tumour, polyps, swollen glands, blood disorders, hemophilia or any other malignant disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) chest pain or angina, high blood pressure, abnormal EKG, cerebrovascular accident or transient ischemic accident, stroke, vertigo, peripheral vascular disorder or any other heart disease, including myocardial infarction (heart attack), as well as heart or blood vessels failures, cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
c) kidney disorder (other than kidney stones), including failures of the kidney, prostate and bladder?	<input type="checkbox"/>	<input type="checkbox"/>
d) intestinal or colon disorders such as: Crohn's disease, ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>
e) chronic pulmonary afflictions, chronic obstructive pulmonary disease (COPD), cystic fibrosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
f) permanent paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g) multiple sclerosis, amyotrophic lateral sclerosis or Huntington's Chorea?	<input type="checkbox"/>	<input type="checkbox"/>
h) vital organ transplant or failure?	<input type="checkbox"/>	<input type="checkbox"/>
i) systemic lupus erythematosus?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had or do you have any symptoms, signs or illnesses for which you have not yet consulted a doctor, or been advised to undergo any tests, treatments or surgeries which have not yet been performed?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been advised that the results of your blood analyses, X-rays, electrocardiogram or any other diagnosed tests were abnormal?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your current weight exceed the maximum weight as indicated in the table below?	<input type="checkbox"/>	<input type="checkbox"/>

Size		Men maximum weight		Women maximum weight	
Feet	Centimeters	Pounds	Kgs	Pounds	Kgs
5'0" - 5'3"	152 - 160	208	94	191	87
5'4" - 5'6"	163 - 168	230	104	213	97
5'7" - 5'9"	170 - 175	250	113	229	104
5'10" - 6'0"	178 - 183	270	122	249	113
> 6'0"	> 183	291	132	274	124

If you have answered "yes" to any question in Section B, you are not eligible for critical illness benefit.

Section 10: Critical Illness Benefit (Ctd.)

To complete for critical illness benefit

Section C

Yes No

1. Have you ever used tobacco, in any form (cigarette, cigar, pipe, cigarillos)?
If yes, when did you quit? _____

2. Height: _____ ft _____ m Weight: _____ lb _____ kg
Have you lost or gained weight during the last twelve (12) months?
If yes, how much? + : _____ - : _____
If yes, specify the cause of the variation: _____

3. Has any member of your immediate family (father, mother, brother, sister) had before the age of 60:
cancer (specify the type), heart attack or stroke, diabetes, kidney disease, Huntington's Chorea, motoneuron diseases or any other hereditary disease?
If you have answered "Yes", please complete the following table:

Relationship	Condition	Age at Diagnosis	Current Age	Age at Death	Cause of Death

4. Have you ever had an insurance application or reinstatement declined, rated, postponed or otherwise modified?
If you have answered "Yes", please give details:

Section 11: Declarations, Authorizations and Signatures

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor/representative, during a RECORDED telephone conversation with a health care professional, or during a personal meeting with a health care professional. The undersigned agree that the additional questionnaire shall be deemed to form part of this modification and that the information it contains shall be used to draw up a contract with Beneva Inc. The undersigned further agree to review such information upon receipt of the rider and/or the confirmation of the modification and to inform Beneva Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the contract), the contract shall be void with respect to such insured.
3. Authorize any health care professional, hospital or private or public health or social services facility, insurance company, reinsurer or other institution or person holding any files or information about them or their health to release such files or information to Beneva Inc. or its reinsurers, and such information shall be treated as confidential and confined in the file mentioned in the **Notice regarding personal files and personal information** which they have read.
4. Authorize Beneva Inc. and its reinsurers, for the purposes of underwriting, appraisal of risk, setting of premiums, insurance administration and loss settlement only, to hold, collect from and exchange with any individuals or corporate bodies holding any personal information about them such personal information as is needed in accordance with the object of the file as aforesaid and only such information, which individuals and corporate bodies shall include any other insurance company, medical practitioner or medical facility, the Medical Information Bureau (MIB), any credit rating or investigative agency and any individual or corporate body likely to be holding any such personal information about them, to disclose to the aforesaid individuals and corporate bodies only such personal information as is necessary, and to request an investigative report about them. This authorization shall be valid for the period required to achieve the purposes for which it was requested. The undersigned have read the **Notice to proposed insured(s) and policyowner(s)** regarding the Medical Information Bureau and regarding personal files and personal information and understand that the information shall be treated as confidential and confined in the insured's file as mentioned in the latter notice.
5. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the present **Policy change** form with Beneva Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.

Signed at (city and province)

| Y , Y , Y , Y | M , M | D , D |

Date

X

Signature of insured or signature of the father, mother or legal representative, if a minor insured

X

Signature of policyowner or authorized person

Amendment to be sent to Advisor Policyowner Amount of cheque \$

Section 12: Pre-Authorized Debit Agreement

1. I hereby authorize Beneva Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify Beneva Inc. before the renewal date of the contract of insurance.
3. I understand that a financing charge may be applicable and spread over the instalments.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), Beneva Inc. is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform Beneva Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month on the day selected in the insurance application or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. I agree and understand that Beneva Inc. will not notify me before each withdrawal.
9. In the event that I instruct Beneva Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing Beneva Inc. with thirty (30) days notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnipay.ca for a sample cancellation form.
11. I understand that Beneva Inc. reserves the right to terminate this Agreement upon fifteen (15) days notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with Beneva Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by Beneva Inc.
13. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnipay.ca.

Beneva Inc.

Premium Accounting

1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a cheque specimen, on which you have written "CANCELLED", for the account to be debited.



Name of financial institution

Address, city, province and postal code of the branch

Branch

Financial institution number

Account number

Authorization

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of account holder or authorized person
(in capital letters)

X
Signature

| Y , Y , Y , Y | M , M | D , D |

Date

Name of account holder or authorized person
(in capital letters)

X
Signature

| Y , Y , Y , Y | M , M | D , D |

Date

Section 13: Representative's / Financial Security Advisor's Report

1. Source
 From insured Referred Associate Life customer P&C customer Other: _____

2. Relationship with the insured person
 Personal friend Relative (please specify): _____
 How long have you known the insured person? _____

3. Do you have doubts about the insurability of the insured person?
 Yes No
 If yes, please specify: _____

4. Are you personally aware of the habits of the insured person?
 Yes No
 If yes, please specify: _____

5. Which language(s) has (have) been used to complete the request? _____

6. Has the insured person told you he/she understood the language used to complete the request?
 Yes No

7. If a language other than English has been used, please name the person who explained the request to the insured person:

Section 14: Information About Representative / Financial Security Advisor

I confirm that I have provided an "Advisor Disclosure Statement" to the policyowner disclosing the following:

- the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and health insurance products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflict of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this application has been signed.
 I hereby declare that all information in this application is true and complete to the best of my knowledge.

Name of representative / financial security advisor
 (in capital letters)

X

Signature of representative / financial security advisor

| Y | Y | Y | Y | M | M | D | D |

 Date

Name of representative / financial security advisor (in capital letters)	Agency	Code of representative / financial security advisor	Share %	Telephone number
Service advisor				
Other advisor to be paid (if applicable)				

Comments and details of representative / financial security advisor

Policy number _____

Section 15: Authorization

I hereby authorize any doctor, hospital, clinic, insurance company, the Medical Information Bureau or any other institution or organization holding information about me, including specific information about my state of health, my family medical history, my lifestyle, my finances and my reputation, to communicate this information to Beneva Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present application with other insurers, financial security advisors/representatives, financial institution or anyone else I have designated, and to make inquiries with them about for the purposes of risk selection, premium calculation or in the event of a claim.

In case of my death, the beneficiary, legal heir or executor of my estate is expressly authorized to communicate to the insurer, when required by it, any and all information or authorizations required for the settlement of the death claim and to obtain any justification requested. As well, Beneva Inc. is permitted to obtain information about me or my state of health and I am willing to undergo any tests, X-rays, electrocardiograms, blood or urine tests which Beneva Inc. may request in order to underwrite my insurance application. Furthermore, I authorize Beneva Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the Medical Information Bureau. In addition, I authorize Beneva Inc. to include all personal information contained in the Company's existing or future files.

A photocopy or an electronic copy of this authorization shall be valid as the original.

Name of insured _____ **X** _____
(in capital letters) Signature of insured Date | Y | Y | Y | Y | M | M | D | D |
If a minor, name (in capital letters) and signature of the mother, father or legal representative
(indicate relationship to the insured)

This notice must always be given to the policyowner.

Policy number _____

Section 16: Notice to Proposed Insured(s) and Policyowner(s)

Notice regarding the Medical Information Bureau (MIB Inc.)

Information regarding each proposed insured will be treated as confidential and will be confined in the file mentioned in the Notice regarding personal files and personal information. Beneva Inc. or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as Medical Information Bureau, 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, disability or critical illness insurance coverage, or a claim for benefits is submitted to a member company, the Bureau will, upon request, 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. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. Here is the address of the Bureau:

Medical Information Bureau, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, Telephone: (416) 597-0590.

Beneva Inc. or its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life, disability or critical illness insurance coverage, or to whom a claim for benefits may be submitted. By signing the authorization clause, the insureds agree to the release of the information to the Medical Information Bureau.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice regarding personal files and personal information

Beneva Inc. advises the insureds that all information obtained from them or from a third party, as mentioned in this application, for the risk assessment, premium calculations and claims is stored in a file referred to as "Life and Health Insurance". Only the employees, representatives or agents of Beneva Inc. and the people authorized by the insured have access to this file when needed to exercise their duties, execute their mandates or as authorized by the insured. This file is maintained at the office of Beneva Inc. The insured is entitled to have access to the personal information in this file and, if applicable, to rectify any inconsistencies. To do so, a written request must be sent to the attention of the Access Officer, Beneva Inc. at 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9. By signing the authorization form at the end of this application, the insureds agree to the gathering of information which will be confined in the above-mentioned file.