Equitable Life of Canada®

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DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE

☐ **Reinstatement of Final Protection policies: complete sections 1, 6 and 8.**
☐ **Reinstatement of Living Protection policies: complete sections 1, 7 and 8.**
☐ **Reinstatement of all other policies: complete sections 1, 2, 3, 4, 5 and 8**

1. TERMINATED/LAPSED POLICY

Terminated/Lapsed Policy Number:

LIFE 1: First name	Last Name	Date of birth (dd/mm/yyyy)
LIFE 2: First name	Last Name	Date of birth (dd/mm/yyyy)

Please Note: if policy reinstatement is approved, all premiums overdue will be required to reinstate the policy at the time of approval.
☐ Please resume pre-authorized chequing withdrawals using <u>new</u> banking particulars. A VOID sample cheque is attached.
☐ Please resume pre-authorized chequing withdrawals using banking particulars already on file.

2. GENERAL INFORMATION (TO BE COMPLETED FOR ALL LIVES TO BE INSURED)

If "YES" answer to any questions 2.1 to 2.5, complete "Details" below.

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
2.1 Have you made any flights (within the last 2 years) or do you intend to make any flights other than as a fare-paying passenger on a scheduled airline?	☐	☐	☐	☐
2.2 Have you engaged (within the last 2 years) or do you intend to engage in any hazardous sport or hobby e.g. scuba diving, hang-gliding, skydiving, etc?	☐	☐	☐	☐
2.3 Has your driver's licence been suspended within the last 10 years, and/or have you had any driving offences (excluding parking tickets) in within the last 3 years? (If "YES", provide driver's licence no.)	☐	☐	☐	☐
2.4 Do you intend to travel outside of North America for longer than a total of 6 weeks or change your Country of residence, in the next 12 months?	☐	☐	☐	☐
2.5 Have you ever had any application for **Life, Disability, Group** or **Critical Illness** insurance on your life postponed, declined, rated or modified in any way? (If yes, provide date, name of company and reason.)	☐	☐	☐	☐

Details of all "Yes" answers.

Question #	Life #	Date	Details

3. SMOKING DECLARATION (TO BE COMPLETED BY ALL LIVES TO BE INSURED)

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
3.1 Have you smoked any cigarettes or used any form of marijuana or hashish within the last 12 months?	☐	☐	☐	☐
3.2 Have you used any other tobacco or nicotine based products, or smoking cessation aids within the last 12 months? (If yes, specify types and frequency):	☐	☐	☐	☐

Life #	Type	Frequency	Dates last used

4. STATEMENT OF HEALTH – NON MEDICAL (TO BE COMPLETED FOR ALL LIVES TO BE INSURED OVER EXACT AGE 16 FOR LIFE COVERAGE AND ALL AGES FOR CRITICAL ILLNESS COVERAGE)

Person to be insured – Life 1

First name	Last Name	Height ☐ ft/in ☐ cm	Weight ☐ lbs ☐ kg

Weight changes in the past year? ☐ Yes ☐ No	Gain ☐ lbs ☐ kg	Loss ☐ lbs ☐ kg	Reason for weight changes:

Name & address of your usual medical advisor
(If none, state last consult)

Date last consulted	Reason/symptoms	Any diagnosis and treatment? ☐ Yes ☐ No (If "Yes" provide details)

Duration of illness	Any follow-up advised? (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If "Yes" provide details)

Person to be insured – Life 2

First name	Last Name	Height ☐ ft/in ☐ cm	Weight ☐ lbs ☐ kg

Weight changes in the past year? ☐ Yes ☐ No	Gain ☐ lbs ☐ kg	Loss ☐ lbs ☐ kg	Reason for weight changes:

Name & address of your usual medical advisor
(If none, state last consult)

Date last consulted	Reason/symptoms	Any diagnosis and treatment? ☐ Yes ☐ No (If "Yes" provide details)

Duration of illness	Any follow-up advised? (e.g. tests, surgery, hospitalization) ☐ Yes ☐ No (If "Yes" provide details)

Family History

Has any family member (whether living or deceased) ever suffered from, or is suffering from High Blood Pressure, Heart Disease, Stroke, Cancer (specify type), Diabetes (specify type), Kidney Disease, Mental Illness, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Motor Neuron Disease, Multiple Sclerosis, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease?

LIFE 1 ☐ Yes ☐ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age If Alive	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

LIFE 2 ☐ Yes ☐ No If "YES", please complete the chart below:

Family Member	Disease	Age at Diagnosis	Actual Age If Alive	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

4. STATEMENT OF HEALTH – NON MEDICAL (CONTINUED)

Personal History

If "YES" answer to any questions 4.1 to 4.18, complete "Details" below.

Have you ever had symptoms of, been treated for, or been advised to receive treatment for, or had or been advised to have any investigations or examinations with respect to questions 4.1 to 4.9 below?:

		LIFE 1		LIFE 2	
		YES	NO	YES	NO
4.1	Heart attack, angina, chest pain, rheumatic fever, stroke, TIA, elevated blood pressure (last reading and date), or cholesterol, murmur, or other heart or blood vessel disease or disorder?	☐	☐	☐	☐
4.2	Asthma, respiratory, sleep apnea or other lung disorder?	☐	☐	☐	☐
4.3	Hearing or visual impairments?	☐	☐	☐	☐
4.4	Diabetes, colitis, bowel disorder, hepatitis, or hepatitis carrier state, kidney, bladder, prostate, gout, or urinary disorder, blood or endocrine abnormality?	☐	☐	☐	☐
4.5	Thyroid or glandular disorder, lupus, MS, ALS, epilepsy, muscle or bone disorder?	☐	☐	☐	☐
4.6	Cancer, tumour, cyst, polyp, mole, lump or other growth, breast disorder or abnormal mammogram or ultrasond?	☐	☐	☐	☐
4.7	Anxiety, depression, fatigue, stress, attempted suicide, nervous breakdown, eating disorder, or other nervous system disorder?	☐	☐	☐	☐
4.8	Optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?	☐	☐	☐	☐
4.9	The skin, muscles, bones and joints, e.g. arthritis, back or neck pain, paralysis, deformity, unusual skin lesions, unexplained infections, or major organ transplantation? ...	☐	☐	☐	☐
4.10	a) Have you ever been diagnosed or had treatment for, or have had any indication of possible exposure to AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	☐	☐	☐	☐
	b) Have you ever had a positive test result indicating exposure to the AIDS virus?	☐	☐	☐	☐
	c) Within the past 5 years, have you had any indication of a sexually transmitted disease?	☐	☐	☐	☐
4.11	Have you ever had any: (If "YES", advise type(s), date(s), reason(s), result(s).)				
	a) Electrocardiograms	☐	☐	☐	☐
	b) X-Rays	☐	☐	☐	☐
	c) Other Diagnostic Tests	☐	☐	☐	☐
4.12	Have you ever had:				
	a) symptoms, illness, injury, surgery, treatment, examination or investigation;	☐	☐	☐	☐
	b) or been advised to receive surgery, treatment, examination or investigation;	☐	☐	☐	☐
	c) surgery, treatment, examination or investigation for which results are not yet known to you; which have not been disclosed in questions 4.1 to 4.11 above?	☐	☐	☐	☐
4.13	Do you regularly take any medication? (If "YES", specify type, dosage, when and by whom prescribed.)	☐	☐	☐	☐
4.14	Have you been absent from work as a result of illness or injury for 5 or more consecutive days within the past 5 years?	☐	☐	☐	☐
4.15	Have you consulted any physician within the past 5 years for anything not covered in the above questions or in this Application? (If "YES", give particulars)	☐	☐	☐	☐
4.16	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐	☐	☐	☐
4.17	Have you been advised to have surgery, treatment or testing, which has not been completed?	☐	☐	☐	☐
4.18	a) Do you drink alcoholic beverages? (If "YES", specify type and ounces per week.)	☐	☐	☐	☐
	b) Have you ever received advice, treatment or counselling pertaining to your use of alcohol?	☐	☐	☐	☐
	c) Have you ever used marijuana, cocaine or any illegal or addictive drugs?	☐	☐	☐	☐
	d) Have you ever received advice, treatment or counselling pertaining to your use of marijuana, cocaine or any illegal or addictive drugs?	☐	☐	☐	☐

DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE

Personal History – Details of all "Yes" answers.

Question #	Life #	Date	Details

5. CHILDREN'S STATEMENT OF HEALTH – NON MEDICAL

Complete for: a) All children to be insured under Children's Protection Rider
b) LIFE 1 or LIFE 2 under the exact age of 16 (Section "4" also required for all ages when applying for Juvenile Critical Illness)
c) Signature of all children who have attained age 16, 18 in Quebec, is required in Section "8"

Full name of child to be insured	Sex	Date of birth (dd/mm/yyyy)	Nearest age	Current height	Current weight	Name and address of usual medical advisor
1.	☐ Male ☐ Female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
2.	☐ Male ☐ Female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
3.	☐ Male ☐ Female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
4.	☐ Male ☐ Female			☐ ft/in ☐ cm	☐ lbs ☐ kg	
5.	☐ Male ☐ Female			☐ ft/in ☐ cm	☐ lbs ☐ kg	

	YES	NO
5.1 Has any application for Insurance on any child been declined, postponed or modified in any way?	☐	☐
5.2 If the child is less than 2 years of age, was the birth premature by more than 4 weeks or is there any indication of failure to thrive or gain weight? (If Yes, provide details)	☐	☐
5.3 Do any of the children have any physical or mental impairment or have they had any illness, impairment or injury that has required treatment, surgery, and/or hospitalization?	☐	☐
5.4 Are any of the children on medication or has any treatment or diagnostic test been advised that has not been completed?	☐	☐
5.5 Is there any Family History of Huntington's Chorea, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease? (If YES provide relationship of family member, disease and age at diagnosis)	☐	☐
5.6 Do any of the children to be insured NOT live with the applicant? (Please state below the relationship to the children, date last seen and frequency of visits)	☐	☐

Details of all "Yes" answers.

Question #	Life #	Date	Details

6. FINAL PROTECTION – SMOKING DECLARATION AND PERSONAL HISTORY

Please Note: To qualify for reinstatement of Final Protection policies all questions 6.2 to 6.12 must be answered "NO".

		LIFE 1		LIFE 2	
		YES	NO	YES	NO
6.1	Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids, or smoked marijuana or hashish within the last 12 months?	☐	☐	☐	☐
6.2	In the past two (2) years, have you had an application for life insurance (other than group insurance or group mortgage insurance) rejected or postponed?	☐	☐	☐	☐
6.3	Are you presently hospitalized, in a nursing facility, bedridden or confined to a wheelchair, or have you been advised that this is required due to your present condition?	☐	☐	☐	☐
6.4	In the past two (2) years, have you had an amputation as a result of disease?	☐	☐	☐	☐
6.5	In the past two (2) years, have you been diagnosed, hospitalized, or treated (other than by medication) or presently under investigation for any of the following conditions:				
	a) Angina, heart attack, heart failure, or cardiomyopathy?	☐	☐	☐	☐
	b) Cancer (other than basal cell carcinoma)?	☐	☐	☐	☐
	c) Leukemia?	☐	☐	☐	☐
	d) Lymphoma?	☐	☐	☐	☐
	e) Chronic kidney disease?	☐	☐	☐	☐
6.6	In the past two (2) years, have you been prescribed a new medication or required an increase in your medication for any of the following conditions:				
	a) Angina, heart attack, heart failure, or cardiomyopathy?	☐	☐	☐	☐
	b) Cancer (other than basal cell carcinoma)?	☐	☐	☐	☐
	c) Leukemia?	☐	☐	☐	☐
	d) Lymphoma?	☐	☐	☐	☐
	e) Chronic kidney disease?	☐	☐	☐	☐
6.7	In the past two (2) years have you been diagnosed or hospitalized for:				
	a) Chronic respiratory condition that required the administration of oxygen	☐	☐	☐	☐
	b) Liver disease (other than fatty liver)?	☐	☐	☐	☐
	c) Diabetic coma or insulin shock?	☐	☐	☐	☐
	d) Cerebrovascular accident (stroke)?	☐	☐	☐	☐
6.8	In the past five (5) years have you received an organ transplant or bone marrow transplant or were you advised that one was required due to your condition?	☐	☐	☐	☐
6.9	In the past five (5) years have you had a cancer reoccurrence or cancer diagnosed in more than one location?	☐	☐	☐	☐
6.10	Have you ever tested positive for HIV or undergone treatments (including medication) for AIDS or AIDS-related complex?	☐	☐	☐	☐
6.11	Have you ever been diagnosed or undergone treatments (including medication) for any of the following conditions: amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease or dementia?	☐	☐	☐	☐
6.12	Have you been diagnosed or treated for any incurable terminal illness (for which you have been advised that you have less than 12 months' life expectancy)?	☐	☐	☐	☐

7. LIVING PROTECTION – SMOKING DECLARATION AND PERSONAL HISTORY

Please Note: To qualify for reinstatement of Living Protection policies all questions 7.2 to 7.6 must be answered "NO".

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
7.1 Have you smoked any cigarettes or used any other tobacco or nicotine based products or smoking cessation aids, or smoked marijuana or hashish within the last 12 months?	☐	☐	☐	☐
7.2 In the past two (2) years, have you had an application for critical illness insurance or life insurance declined or postponed or modified in any way?	☐	☐	☐	☐
7.3 Have you: i) ever been investigated for; ii) ever been advised to have an investigation for; iii) a pending investigation for; iv) ever been treated for; v) any symptoms, complaints or indication of; or, vii) ever had any symptom, complaints or indication of:				
a) Coronary artery disease, angina, shortness of breath, chest pain, angioplasty, bypass, heart surgery, heart attack, stroke, transient ischemic attack (TIA) or any other cerebrovascular disease or disease of the heart or the blood vessels?	☐	☐	☐	☐
b) Diabetes, abnormal blood sugar, abnormalities of the thyroid, pituitary, lymph or adrenal glands, chronic kidney disease or endocrine disorder?	☐	☐	☐	☐
c) Cancer or other malignant disease such as leukemia or lymphoma, or tumor, abnormal PAP test (without a follow up normal test), or recurrent colon polyps (without a follow up normal colonoscopy)?	☐	☐	☐	☐
d) Breast disease or disorder, breast mass, breast cyst, abnormal mammogram or breast biopsy or undiagnosed breast pain or prostate disorder, prostate nodule or abnormal PSA or ultrasound results?	☐	☐	☐	☐
e) AIDS, HIV or AIDS-related illness, persistently enlarged lymph glands, chronically abnormal blood work or any immunological disorder?	☐	☐	☐	☐
f) Hepatitis B or C (including hepatitis B carrier state), abnormal liver function tests, biopsy or ultrasound results or any form of liver disease?	☐	☐	☐	☐
g) Crohn's, ulcerative colitis, persistent, undiagnosed abdominal pain, rectal bleeding, or any other disorder of the colon, rectum, stomach or esophagus other than esophageal reflux or ulcer controlled with medication or irritable bowel syndrome?	☐	☐	☐	☐
7.4 In the last 5 years have you:				
a) been treated or counseled for alcohol or drug use, or joined or been advised to join an organization or program due to your alcohol or drug use?	☐	☐	☐	☐
b) used narcotics, cocaine, heroin, morphine, demerol, LSD, hashish, hallucinogens, amphetamines, barbiturates, tranquilizers, or anabolic steroids or any drugs not prescribed by a licensed physician, or methadone whether prescribed by a physician or not?	☐	☐	☐	☐
7.5 Have 2 or more of your immediate family members (mother, father, brother or sister) been diagnosed with or treated for, heart disease, aneurysm, stroke, polycystic kidney disease, or cancer prior to age 60.	☐	☐	☐	☐
7.6 Does your current weight exceed the weight indicated for your height in the tables below?	☐	☐	☐	☐

Height (in)	Weight (lbs)	Height (cm)	Weight (kgs)
56	174	142	79
57	180	145	82
58	186	147	84
59	196	150	88
60	199	152	90
61	206	155	93
62	213	157	97
63	220	160	100
64	227	163	103
65	234	165	106
66	241	168	109
67	249	170	113

Height (in)	Weight (lbs)	Height (cm)	Weight (kgs)
68	256	173	116
69	264	175	120
70	272	178	123
71	279	180	127
72	287	183	130
73	295	185	134
74	303	188	137
75	312	190	142
76	320	193	145
77	329	196	149
78	337	198	153

8. LEGAL INFORMATION

THE APPLICANT AND THE PERSON(S) TO BE INSURED DECLARE AND AGREE THAT:

1. The personal information willingly provided by me/us to the independent broker and/or the Company and collected on this Declaration and held in their files will be used by the Company for the purposes of underwriting, servicing, administration, determining Canadian or foreign tax payor status, and claims processing and adjudication related to this Declaration, any reinstated policy, if approved, and any supplementary documents. I/We understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by the Company, its sales distribution network, participating reinsurer(s), other companies, Canadian or foreign tax authorities, and any other person or party whom I/we authorize.
2. The statements and answers in this Declaration are true, complete and correctly recorded, and these statements and answers, the statements and answers made in the original Application for the policy and any additional evidence of insurability provided by me/us, shall together be used to determine insurability.
3. The insurance being applied for reinstatement in this Declaration or such insurance approved by the Company shall not take effect unless:
   (i) a Notice of Reinstatement is issued by the Company;
   (ii) I/we have paid all premiums in arrears with interest; and
   (iii) no change has taken place in the insurability of the lives to be insured since completion of this Declaration and the date the Company's Notice of Reinstatement is delivered to me.
4. I/We know of nothing not disclosed in this Declaration, the original Application and any other evidence of insurability provided by me/us, affecting the insurability of the person(s) to be insured.
5. I/we have received the Notice Regarding the MIB, and authorize any physician, practitioner, hospital, clinic or other medical related facility, insurance company, MIB, or any other organization, institution or person that has any MIB records or knowledge of the person(s) to be insured or their health, to give full particulars of such information, including any prior medical history, to The Equitable Life Insurance Company of Canada or its reinsurers. A photostatic copy of this authorization will be as valid as the original.
6. This Declaration may be transmitted to the Company electronically and received by the Company as the Applicant/Owner's application for policy reinstatement.
7. I/We consent to the obtaining of a consumer report containing personal and/or credit information.

FAILURE TO DISCLOSE EVERY FACT WITHIN THE APPLICANT/OWNER AND PERSON(S) TO BE INSURED KNOWLEDGE THAT IS MATERIAL TO THE INSURANCE BEING APPLIED FOR REINSTATEMENT, OR MATERIAL TO THE INSURABILITY OF THE PERSON(S) TO BE INSURED, OR, ANY MISREPRESENTATION OR MISSTATEMENT OF ANY FACTS, STATEMENTS, INFORMATION OR ANSWERS GIVEN AND CONTAINED IN THIS DECLARATION, THE ORIGINAL APPLICATION INCLUDING ANY PART II, AND ANY WRITTEN STATEMENT GIVEN AS EVIDENCE OF INSURABILITY PROVIDED BY ME/US SHALL RENDER ANY INSURANCE REINSTATED IN CONNECTION WITH THIS DECLARATION VOIDABLE BY THE COMPANY.

DECLARATION OF INSURABILITY FOR APPLICATION TO REINSTATE

Signed at _____ (city) _____ (province) this _____ (day) of _____ (month) 20 _____.

Signature(s) of Applicant(s)/Owner(s)	

(If Applicant/Owner is a corporation, affix Corporate Seal if available and have Authorizing Office(s) sign and indicate title(s) - if other than Person to be Insured)

LIFE 1		LIFE 2	
	* Signature of Person to be Insured		* Signature of Person to be Insured

Other		
	** Signature of Person to be Insured	Witness to all Signatures

* Signature required for each Person to be Insured who has attained their 16th, (18th in Quebec) birthday at the date hereof.
* Signature of parent/legal guardian of children under attained age 16, 18 in Quebec

** If other than Life 1 or Life 2

NOTICE REGARDING THE MIB INC

Information regarding the insurability of the Person(s) to be Insured will be treated as confidential. We or our reinsurer 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 the Person(s) to be Insured apply(ies) to another MIB member company for life, critical illness or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information Office is 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone number (416) 597-0590. We or our reinsurer(s) may also release information in our files to other life insurance companies to whom the Proposed Life Insured mayapply for life, critical illness 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

Please note: Equitable Life® cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.668.4095.