ivari™

Insured's Request for Living Benefits

CL1725 2/17

General information

ivari™

A Policy details

INSURED

Policy number(s)			Policy Face Amount/Sum Insured(s) $
Name of Insured *(First, middle and last name)*			Date of birth (DD/MM/YYYY) / /
Address			Apt./Suite
City		Province	Postal code
Telephone	Cell phone	Email address	

POLICY OWNER IF OTHER THAN INSURED

Name of Insured *(First, middle and last name)*			Date of birth (DD/MM/YYYY) / /
Address			Apt./Suite
City		Province	Postal code
Telephone	Cell phone	Email address	

B Benefit request details TO BE COMPLETED BY THE INSURED

Describe exact nature of your illness or injury:

Date you were first treated for your illness or injury? (DD/MM/YYYY) ____/____/________

Date of your most recent consultation with a medical professional regarding your illness or injury? (DD/MM/YYYY) ____/____/________

PRIOR ILLNESS OR INJURY:

a) Have you had the same kind of illness or injury before? yes no

b) If ***"yes,"***

i) When? ______________________

ii) By whom were you treated? ______________________

PROGNOSIS:

a) Has a medical professional diagnosed that your condition is terminal? yes no

b) If ***"yes,"*** what life expectancy have you been given? ____________________

NAME AND ADDRESS OF YOUR DOCTOR(S): **PLEASE PROVIDE INFORMATION FOR ALL THE DOCTORS YOU HAVE SEEN IN THE PAST 5 YEARS**

1.	Name			Date of last visit (DD/MM/YYYY) / /
	Address			Telephone
	City	Province	Postal code	Fax
2.	Name			Date of last visit (DD/MM/YYYY) / /
	Address			Telephone
	City	Province	Postal code	Fax
3.	Name			Date of last visit (DD/MM/YYYY) / /
	Address			Telephone
	City	Province	Postal code	Fax

Most recent hospitalization (if applicable):

a) From: (DD/MM/YYYY) ____/____/________ to: (DD/MM/YYYY) ____/____/________

b) Name and address of hospital: ____________________

C Claim request

I request to withdraw an amount from the fund value of my Universal Life insurance policy in accordance with the terms of my contract.

Amount requested $____________________ or maximum amount*____________________

*Maximum amount = Total account value minus 3 monthly deductions/premiums.

Note: If the policy has a Level Death Benefit, the Face Amount/Sum Insured will be reduced by the requested amount.

D Private notice

"I" and "we" means the Insured and Owner(s) of the Policy.

I/We understand that the information collected on this request form, and otherwise in connection with my/our request, is required by *ivari*, its reinsurers and authorized administrators (the "Insurer") for insurance purposes. Examples of insurance purposes include: determining whether there is insurance coverage, investigating and administering requests and claims, coordinating benefits with other insurers and fraud detection. For insurance purposes, the Insurer will consult its existing files, may collect additional information from and about me/us and, where required, exchange information about me/us with third parties. This collection, use and disclosure of personal information enable *ivari* to administer my/our request for living benefits.

Your personal information may be used, stored or accessed in other countries and may be subject to the laws of those countries. Information may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in these countries.

For more details about *ivari*'s Privacy Policy, please visit us at: ivari.ca

A person may refuse to consent to this collection, use and disclosure of personal information. However, in that event *ivari* may be unable to provide administration services and this may result in delays in processing, or denial, of requests.

E Declaration, acknowledgment, and authorization

I/We hereby declare and agree that the statements and answers given above are true, complete and correctly recorded to the best of my/our knowledge and belief and are the basis for the consideration of a Living Benefits claim.

I/We agree and understand that any misrepresentation of information on this request form may make me/us liable to *ivari* for any payment made by *ivari* as a result of this request.

I/We acknowledge that receipt of a Living Benefit may, depending on all of the facts, be a taxable event with respect to which I/we am/are advised by *ivari* to consult a tax advisor for more details.

Insurer Authorization: I/We authorize the Insurer to collect, use and disclose personal information (including personal health information) about me for insurance purposes.

Authorization to exchange personal information: I/We hereby authorize any person with relevant information about me, including but not limited to any physician or other healthcare provider, hospital or other healthcare institution or medically related facility, any insurance company or reinsurance company, to release and exchange with *ivari*, or a representative thereof, all personal information (including personal health information, benefit payment), about me in its possession that is requested by *ivari* for insurance purposes.

This authorization does not have any expiry date and it will remain valid for as long as I/we are claiming eligibility for benefits or services from *ivari*. I/We, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me/us will be as valid as the original.

I/We, the Insured/Owner acknowledge that the Policy will be amended to include the Living Benefit Amendment.

____
Signature of Insured

Date: (DD/MM/YYYY) ____/____/________

Address:

____

____

____
Witness

Date: (DD/MM/YYYY) ____/____/________

Address:

____

____

____
Signature of Irrevocable Beneficiary

Date: (DD/MM/YYYY) ____/____/________

Address:

____

____

____
Witness

Date: (DD/MM/YYYY) ____/____/________

Address:

____

____

____
Signature of Owner (if other than Insured)

Date: (DD/MM/YYYY) ____/____/________

Address:

____

____

____
Witness

Date: (DD/MM/YYYY) ____/____/________

Address:

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