500-5000 Yonge Street
Toronto, ON M2N 7J8
Fax: 1-877-767-0477

Application to Exercise Purchase Option Rider

Policy Number _____ Insured _____

Disability coverage in force: (include group, individual coverages, etc.)

COMPANY NAME	TYPE	MONTHLY AMOUNT	BENEFIT PERIOD	ELIMINATION PERIOD
				Days
				Days
				Days

THIS MUST BE COMPLETED FOR ALL CASES

Annual earned income (before taxes): $_____

Self-employed only: Business income: $_____

Expenses: (subtract): $_____

Net earned income: $_____

Unearned income: Source: $_____

Amount (Annually): $_____

PLEASE ATTACH A COPY OF YOUR TWO PREVIOUS INCOME TAX RETURNS*

* Your Social Insurance Number (SIN) will be used for following purposes only: tax reporting, record keeping and identification, when needed. The use of your SIN for identification purposes is optional. You may withdraw consent for use of your SIN for identification purposes at any time by contacting *ivari's* Client Services using the contact number listed on your policy. Further note: certain transactions requested under the universal life policy may require you to provide the SIN before processing. You have the option to provide your SIN now to avoid any future delays.

New policy _____ Benefit period _____ (no longer than base policy)

Amount applied for under option: $_____ Elimination period _____ days (not shorter than base policy)

I understand that my answers to the above questions will be relied on by *ivari* in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire (being part of the Application for Insurance) may be rendered void on the grounds of misrepresentation or fraud.

I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to *ivari*.

Signed at _____ this _____ day of _____ , 20 _____ .

Sign Here _____
Signature of Insured

Sign Here _____
Signature of Witness

Sign Here _____
Owner(s), if other than Insured

Sign Here _____
Signature of Witness