APP NO.

Face-to-Face **Life Insurance and Critical Illness Insurance**

Application Form

BMO Insurance

126E (2017/10/01)

Application for Life Insurance and Critical Illness Insurance – contents

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IMPORTANT INSTRUCTIONS FOR THE ADVISOR

A – FOR FASTER ISSUE

1. **Use this form only if you are completing it in person with the person(s) to be insured and the policy owner(s).**
2. Complete ALL questions on the application. Missed questions and/or incomplete answers will result in policy amendments and/or delay the issuance of coverage for your client.
3. PRINT all answers using black or dark blue ink.
4. DETACH the **Privacy and Personal Information – Section 16** and leave with the **Proposed Insured(s)**.
5. An ILLUSTRATION must accompany all applications for Universal Life.
6. If PAYOR WAIVER OF PREMIUM is applied for, complete the relevant sections of Section 11.
7. Make sure that all CHANGES to the application are initialled by the person ANSWERING the questions.
8. If there is insufficient space in any section, use the COMMENTS sections. If you require additional space, please attach a separate page with the Proposed Insured(s) signature and current date.
9. Please ensure that all appropriate SIGNATURES have been affixed.
10. With the exception of Section 16 and Section 19, DO NOT remove any Section(s) from this form.

B – MEDICAL QUESTIONS

Section 10 – Medical Information

If medical underwriting requires at least a paramedical, you may elect to NOT complete Section 10. Do not remove this section. Medical underwriting requirements are shown on all illustrations generated by The Wave illustration software.

*Medical underwriting requirements can be found in the **Underwriting Guidelines** (form **319E**) within the Wave Illustration system and on the Advisor Support internet site at bmoinsurance.com/advisorsupport.*

C – APPLYING FOR TEMPORARY INSURANCE

Section 18 and Section 19

All of the following conditions must be met before the **Temporary Insurance Agreement and Receipt – Section 19**, may be issued:

1. The Life Insured(s) must complete the questions in the **Application for Temporary Insurance – Section 18**.
2. The completed **Application for Temporary Insurance – Section 18** must be submitted with this Application.
3. The Proposed Life Insured(s) must NOT be over the age of 65.
4. The full premium or part of the premium as outlined in the **Temporary Insurance Agreement and Receipt – Section 19** is paid (post dated cheques are not acceptable).

ONLY COLLECT PREMIUM IF ALL OF THE ABOVE CONDITIONS ARE MET AND ALL QUESTIONS IN THE Application For Temporary Insurance – Section 18 ARE ANSWERED "NO".

We use the information in this application to determine whether or not you are eligible for the coverage and to establish the premium rates for the coverage you are applying for. If you misrepresent any facts or the information you provide is not current, correct and complete, we can cancel any policy we have issued on the basis of the information you provided.

POLICY LANGUAGE

Do all of the proposed insureds and the policy owner understand the language (English or French) in which this Application for Insurance is written? ◯ Yes ◯ No
If **No**, have the details of this Application been fully explained to all parties in your preferred language and are they completely understood? ◯ Yes ◯ No

If No, please do not proceed with this application.
If **"Yes"** please describe the steps that were taken to ensure all questions and authorizations in this Application for insurance were understood. The insurance policy you applied for will only be issued in one of Canada's official languages (English or French, as requested). It is your responsibility to take measures to fully understand the terms and conditions of the policy contract.

Language for policy and future correspondence: ◯ English ◯ French

Are all of the proposed insureds and the policy owner a resident of Canada for Canadian income tax purposes? ◯ Yes ◯ No
If No, please do not proceed with this application.

SECTION 1 – INFORMATION ABOUT THE LIVES TO BE INSURED

This Application is for:

◯ A new policy

◯ Replacement of BMO Insurance policy # _____

◯ Additional Proposed Insured's with Application # _____

◯ Additional coverage to an existing LifeProvider, policy # _____

1.1 – PROPOSED INSURED 1

First Name	**Last Name**	**Middle Initial**	**Maiden Name** (if applicable)

What is your citizenship? ◯ Canadian Citizen ◯ Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) DD/MMM/YYYY ◯ Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY) DD/MMM/YYYY

Date of Birth (DD/MMM/YYYY) DD/MMM/YYYY

Place of Birth (Province, Country)

Are you a resident of Canada for Canadian income tax purposes?
◯ Yes
◯ No
If No, please do not proceed with this application.

Required if you are applying for universal life insurance or whole life insurance and you are the policy owner

Are you a resident or a Citizen of the United States?
◯ Yes – TIN (Taxpayer Identification No.) _____
◯ No

Are you a resident of any country other than Canada or the U.S.?
◯ Yes – TIN (Taxpayer Identification No.) _____
Country _____
◯ No

Sex at birth
◯ Male
◯ Female

Smoking Class
◯ Smoker
◯ Non-smoker

Driver's Licence Number

Social Insurance No. (SIN) – Required if you are applying for universal life insurance or whole life insurance and you are the policy owner

Home Address (Street, Apt.)

Number of Years

Home Phone Number (000) 000-0000

City

Province

Postal Code

Preferred Contact Number (000) 000-0000

If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence

Occupation/Duties

Years with Current Employer

Employer's Name

Type of Business

Employer's Address (Street, Apt., R.R.)

City

Province

Postal Code

Required if you are applying for universal life insurance or whole life insurance and you are the policy owner
Are you an intermediary or "gatekeeper" such as a Lawyer, Accountant, Real Estate Broker or Certified Trust & Financial Advisor that holds accounts for clients? ◯ **Yes** ◯ **No**

I request that the policy be issued in ◯ **English** ◯ **French**

1.2 – PROPOSED INSURED 2

First Name | **Last Name** | **Middle Initial** | **Maiden Name** (if applicable)

Relationship to Proposed Insured 1

What is your citizenship? ◯ Canadian Citizen ◯ Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) DD/MMM/YYYY ◯ Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY) DD/MMM/YYYY

Date of Birth (DD/MMM/YYYY) DD/MMM/YYYY | **Place of Birth** (Province, Country)

Are you a resident of Canada for Canadian income tax purposes?
◯ Yes
◯ No
If No, please do not proceed with this application.

Required if you are applying for universal life insurance or whole life insurance and you are the policy owner

Are you a resident or a Citizen of the United States?
◯ Yes – TIN (Taxpayer Identification No.) _____
◯ No

Are you a resident of any country other than Canada or the U.S.?
◯ Yes – TIN (Taxpayer Identification No.) _____
Country _____
◯ No

Sex at birth
◯ Male
◯ Female

Smoking Class
◯ Smoker
◯ Non-smoker

Driver's Licence Number

Social Insurance No. (SIN) – Required if you are applying for universal life insurance or whole life insurance and you are the policy owner

Home Address (Street, Apt.) | **Number of Years** | **Home Phone Number** (000) 000-0000

City | **Province** | **Postal Code** | **Preferred Contact Number** (000) 000-0000

If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence

Occupation/Duties | **Years with Current Employer**

Employer's Name | **Type of Business**

Employer's Address (Street, Apt., R.R.) | **City** | **Province** | **Postal Code**

Required if you are applying for universal life insurance or whole life insurance and you are the policy owner
Are you an intermediary or "gatekeeper" such as a Lawyer, Accountant, Real Estate Broker or Certified Trust & Financial Advisor that holds accounts for clients? ◯ **Yes** ◯ **No**

I request that the policy be issued in ◯ **English** ◯ **French**

SECTION 2 – POLICY OWNERSHIP

- For a sole proprietorship, the Owner will be the individual, or the individual carrying on business as the company.
- If this policy will be owned by more than one person, the policy will be set up as joint ownership with the right of survivorship except in Quebec.

2.1 – OWNER

Who will own this policy? (Select all that apply)

◯ **A. Proposed Insured 1**
◯ **B. Proposed Insured 2**
◯ **C. Jointly owned by Proposed Insured 1 and Proposed Insured 2**
◯ **D. Individual(s) other than Proposed Insured 1 or Proposed Insured 2**
◯ **E. Corporation, Trust or other Entity** (Complete Section 2.3 and complete **form 715E**)

If you have selected **A., B.** and/or **C**, proceed to **Section 2.2, "Verification of Identity"** as the required information will be taken from **Section 1**. For all others, complete the following applicable sections.

Complete if Owner is an individual and not Proposed Insured 1 and/or Proposed Insured 2.

First Name | **Last Name** | **Middle Initial** | **Maiden Name** (if applicable)

Relationship to Proposed insured | **Date of Birth** (DD/MMM/YYYY) DD/MMM/YYYY | **Place of Birth** (Province, Country)

Are you a resident of Canada for Canadian income tax purposes?
◯ Yes
◯ No
If No, please do not proceed with this application.

Required if you are applying for universal life insurance or whole life insurance for tax reporting

Are you a resident or a Citizen of the United States?
◯ Yes – TIN (Taxpayer Identification No.) _____
◯ No

Are you a resident of any country other than Canada or the U.S.?
◯ Yes – TIN (Taxpayer Identification No.) _____
Country _____
◯ No

Sex at birth
◯ Male
◯ Female

If applying for Payor Waiver of Premium Smoking Class
◯ Smoker ◯ Non-smoker

Social Insurance No. (SIN)
Required if you are applying for universal life insurance or whole life insurance.

2.1 – OWNER *(continued)*

Home Address (Street, Apt.)		**Number of Years**	**Home Phone Number** (000) 000-0000
City	**Province**	**Postal Code**	**Preferred Contact Number** (000) 000-0000

If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence

Occupation/Duties	**Years with Current Employer**
Employer's Name	**Type of Business**

Employer's Address (Street, Apt., R.R.)	**City**	**Province**	**Postal Code**

Required if you are applying for universal life insurance or whole life insurance and you are the policy owner

Are you an intermediary or "gatekeeper" such as a Lawyer, Accountant, Real Estate Broker or Certified Trust & Financial Advisor that holds accounts for clients? ◯ **Yes** ◯ **No**

I request that the policy be issued in ◯ **English** ◯ **French**

2.2 – VERIFICATION OF IDENTITY

Complete this section if this application is for universal life insurance or traditional whole life insurance and the Owner is an Individual.

The Advisor must verify the Owner(s) identity by reviewing the original of one of these **Photo ID** government issued documents.

◯ Passport ◯ Driver's Licence (with photo and signature) ◯ Provincial Health Card (except in PEI, ON, and MB)

◯ Other (specify) _____

Place of Issue (Country)	**Province of Issue**	**Document #**	**Expiry Date** (DD/MMM/YYYY) DD/MMM/YYYY

2.3 – COMPLETE IF OWNER IS A CORPORATION, TRUST OR OTHER ENTITY

If this application is for universal life insurance or whole life insurance, you must also complete the applicable sections of form 715E and submit it together with this application.

Legal Name	**Trade Name** (if applicable)
Relationship to Proposed Insured	

Business Address (Street, Apt., R.R.)	**City**	**Province**	**Postal Code**
Attention:			

2.4 – MAILING INFORMATION

We will mail all correspondence to the Owner indicated above unless otherwise directed below:

Attention:			
Address (Street, Apt., R.R.)	**City**	**Province**	**Postal Code**

2.5 – NAMING A CONTINGENT/SUBROGATED OWNER

If, after the death of the owner (sole remaining owner, if applicable), an insured person is still alive, you may name a contingent owner below to replace that owner. That person will become the contingent owner if alive at the owner's death.

To name a contingent owner (subrogated owner in Quebec), complete below:

Name (first, middle, last) **or legal name of Corporation/Entity**	**Date of Birth** (DD/MMM/YYYY) DD/MMM/YYYY

SECTION 3 – PLAN DETAILS

Please check one: ◯ **Illustration attached** ◯ **No Illustration Completed** *(You must submit a signed illustration with every application for Universal Life and BMO Insurance Whole Life Plan.)*

Please select a Policy Date: ◯ **Date to save age for:** ◯ **Proposed Insured 1** **OR** ◯ **Proposed Insured 2**
◯ **Current date**

3.1 – SINGLE LIFE OPTIONS

Complete this section if you want one (1) individual insurance policy or two (2) individual insurance policies.

Product Type	Proposed Insured 1		Proposed Insured 2	
	Plan Name	Face Amount	Plan Name	Face Amount
◯ **Universal Life**		$		$
◯ **Term Life**		$		$
◯ **Whole Life**		$		$
◯ **Critical Illness**		$		$

3.2 – JOINT PLANS/MULTI COVERAGE OPTIONS

Complete this section if you want one insurance policy that covers two or more individuals.

Product Type	Plan Name	Coverage Type	Face Amount
◯ **Universal Life**		◯ Joint First-to-Die ◯ Joint Last-to-Die ◯ Multi-Coverage	$
◯ **Term Life**		Joint First-to-Die	$
◯ **Pure Term 100**		◯ Joint First-to-Die ◯ Joint Last-to-Die	$
◯ **BMO Insurance Whole Life Plan**		◯ Joint Last-to-Die	$

3.3 – ADDITIONAL BENEFITS AND RIDERS

Rider	Proposed Insured 1	Face Amount	Proposed Insured 2	Face Amount
Waiver of Premium Benefit	◯	$	◯	$
Term Rider	◯	$	◯	$
Accidental Death Benefit	◯	$	◯	$
Children's Term Rider	◯	$	◯	$
Critical Illness Rider	◯ LB10 ◯ LB20 ◯ LB75 ◯ LB100	$	◯ LB10 ◯ LB20 ◯ LB75 ◯ LB100	$
Other (specify)	◯	$	◯	$

3.4 – REQUEST FOR OPTIONAL POLICY

◯ **Proposed Insured 1** ◯ **Required illustration attached**

◯ **Proposed Insured 2** ◯ **Required illustration attached**

SECTION 4 – BENEFICIARY INFORMATION

If you are applying for life insurance coverage

- Complete all applicable sections.

If you are applying for critical illness insurance coverage

- Proceeds from any critical illness living benefit, including Critical Illness Benefit, Early Discovery Benefit, Return of Premium on Surrender Benefit Rider, if applied for and the Return of Premium on Expiry Benefit Rider, if applied for, will be paid to the owner of the policy unless a beneficiary has been named or a direction to pay has been completed and is on file.
  - Beneficiaries may be designated in Section 4.1, 4.2 and 4.3 for applications signed and the policy issued in any of the following provinces: Alberta, British Columbia, Manitoba, Ontario or Quebec.
  - The Direction to Pay for Critical Illness Policies form 630E can be completed for applications signed and policies issued in any other province or territory in Canada.
- Proceeds from any critical illness death benefit, including Return of Premium on Death Benefit (ROPD) Rider will be paid to the Insured's estate unless a beneficiary has been designated in Section 4.3.

Revocable and irrevocable beneficiaries

There are two types of beneficiaries: revocable and irrevocable

- A beneficiary designation is considered revocable, unless you make it irrevocable. This will allow the policy owner to change their beneficiary designation at any time without the current beneficiary(ies) consent.
- If you name a beneficiary as irrevocable, your ability to deal with the policy is limited. For example, you cannot change the beneficiary without their consent, unless permitted by law. You may also need the irrevocable beneficiary's consent to deal with the policy, e.g., surrender, assign, and transfer ownership.
- In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless otherwise stated.
- A minor child or your estate cannot give consent to make any changes on the policy if they are designated as an irrevocable beneficiary.
- A minor irrevocable beneficiary cannot consent to change of beneficiary and a parent guardian may not sign on behalf of a minor child for this purpose.

Payment of benefits when the beneficiary is a minor

- Except where Quebec law applies, we will pay benefits to the trustee for the minor beneficiary, if you have named one. If no trustee is named, we will make the payment as the law requires.
- Where Quebec law applies, we will pay the parent(s) of the minor beneficiary or Tutor duly appointed in law.

Multiple and contingent beneficiaries

- You can name a beneficiary "primary" or "contingent" ("subrogated" in Quebec).
- If you name more than one beneficiary, indicate the share of each beneficiary; otherwise they will share the benefit equally.
- Benefits will first be paid to all living primary beneficiaries. If a primary beneficiary dies before you, their share of the benefits will be paid equally to the surviving primary beneficiaries unless you state otherwise.
- If all primary beneficiaries die before you, the benefits will be paid equally to the contingent beneficiary(ies) unless you state otherwise.
- If no beneficiary is alive when the benefits become payable, the benefits will be paid to the policy owner if other than the life insured, otherwise the policy owner's estate.
- If a beneficiary is disqualified from receiving the benefits for any reason, that beneficiary will be treated as if he/she died before you and the benefits will be dealt with in accordance with the law.

4.1 PRIMARY BENEFICIARIES (SHARE OF BENEFITS MUST ADD UP TO 100%)

- **If not completed, any beneficiary will be the proposed owner or the estate of the proposed owner**

Legal Name (first, middle initial, last or Corporate/entity name)	**Relationship to Proposed Insured 1** (in Quebec, relationship to the Proposed Owner)	**Date of Birth for Minor Beneficiary** (DD/MMM/YYYY)	**Beneficiary designation**	**% share of benefits to be paid**
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%

Legal Name (first, middle initial, last or Corporate/entity name)	**Relationship to Proposed Insured 2** (in Quebec, relationship to the Proposed Owner)	**Date of Birth for Minor Beneficiary** (DD/MMM/YYYY)	**Beneficiary designation**	**% share of benefits to be paid**
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%

4.2 – CONTINGENT BENEFICIARIES

Legal Name (first, middle initial, last or Corporate/entity name)	**Relationship to Proposed Insured 1** (in Quebec, relationship to the Proposed Owner)	**Date of Birth for Minor Beneficiary** (DD/MMM/YYYY)	**Beneficiary designation**	**% share of benefits to be paid**
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%

Legal Name (first, middle initial, last or Corporate/entity name)	**Relationship to Proposed Insured 2** (in Quebec, relationship to the Proposed Owner)	**Date of Birth for Minor Beneficiary** (DD/MMM/YYYY)	**Beneficiary designation**	**% share of benefits to be paid**
		DD/MMM/YYYY	◯ Revocable ◯ Irrevocable	%

4.3 – CRITICAL ILLNESS RETURN OF PREMIUM RIDERS AND OTHER RIDERS

	Legal Name (first, middle initial, last or Corporate/entity name)	**Relationship to proposed life insured** (in Quebec, relationship to the Proposed Owner)	**% share of benefits to be paid**
Critical Illness Return of Premium on Surrender Benefit Rider (ROPS)			%
Critical Illness Return of Premium on Expiry Benefit Rider (ROPX)			%
Critical Illness Return of Premium on Death Benefit Rider (ROPD)			%
Other, Please Specify _____			%

4.4 – TRUSTEE FOR MINOR BENEFICIARY DESIGNATIONS

- Complete when a minor beneficiary has been named (Under the age of 18)
- In all provinces other than Quebec, if you designate minor children as beneficiaries, you should also name a trustee to receive funds on their behalf.
- In Quebec, any amount payable to a minor beneficiary during their minority will be paid to the parent(s) or a Tutor duly appointed in law.

Primary beneficiaries: I appoint	
Contingent beneficiaries: I appoint	
Return of premium on death benefit payee: I appoint	

as a trustee to receive any payments on behalf of any named minor beneficiary during their minority.

SECTION 5 – PURPOSE OF INSURANCE AND SOURCE OF PAYMENT

5.1 – PURPOSE OF INSURANCE – COMPLETION IS **MANDATORY** ON ALL APPLICATIONS

1. Purpose of Insurance

◯ Income Replacement ◯ Key Person ◯ Buy Sell ◯ Personal ◯ Other (specify)

2. Is there an existing or planned agreement that provides for anyone other than Proposed Insured 1, Proposed Insured 2 or Owner identified in Section 2, (Third Party) to obtain any legal interest, pay the premiums or have an ownership interest in any policy resulting from this application?

◯ Yes ◯ No (If "Yes" provide details)

5.2 – SOURCE OF PAYMENT – COMPLETION IS **MANDATORY** ON ALL APPLICATIONS (SELECT **ALL** THAT APPLY)

◯ Self-employment income ◯ Employment income ◯ Retirement Income/Pension Income ◯ Grants/Scholarships

◯ Insurance Claim Payments ◯ Corporate ◯ Investment Income/Savings ◯ Sale of Assets

◯ Trust/Inheritance ◯ Gift ◯ Loan ◯ Lottery Winnings

◯ Proceeds from a legal case or action ◯ Other (specify)

If this application is for universal life insurance and a payment of $100,000 or more is made, you must complete Part 2 through 5 of form 715E and submit it together with this application.

SECTION 6 – FINANCIAL INFORMATION

6.1 – FINANCIAL DETAILS (COMPLETION IS **MANDATORY** ON ALL APPLICATIONS)

DESCRIPTION	PROPOSED INSURED 1	PROPOSED INSURED 2	**OWNER** (to be completed only if the Owner is not the Proposed Insured)
1. Total Assets	$	$	$
2. Total Liabilities	$	$	$
3. Net Worth	$	$	$
4. Annual Earned Income	$	$	$
5. Unearned Income	$	$	$
Specify source of unearned income			
6. If not gainfully employed, what is the gross amount of the family income?	$	$	$
7. If not gainfully employed, what is the amount of in force insurance on the working spouse?	$	$	$

6.2 – TO BE COMPLETED IF APPLYING FOR BUSINESS INSURANCE

1. Full Legal Name of Business (including Company, Limited, Inc., etc.)

2. Business Number	**3. Type of Business** ◯ Corporation ◯ Partnership ◯ Proprietorship	**4. Nature of the Business**

5. Fair Market Value	**6. Net Profit After Taxes**	**7. Net Profit After Taxes**	**8. Percentage Ownership of Business**
$	Last Year – $	Year Before – $	%

9. Details of Business Insurance on other members of business	**10. How was the amount of insurance determined?**

6.3 – TO BE COMPLETED IF THE PROPOSED INSURED IS UNDER THE AGE OF 16

1. Is the Proposed Insured under the age of 16?
(If "Yes" indicate the amount of in force Life and or Critical Illness Insurance on the parents and other siblings)

◯ Yes ◯ No (If "Yes" provide details)

SECTION 7 – INSURANCE HISTORY

Please complete questions 1, 2 and 3. Please provide details for "Yes" answers in space provided, and if necessary in Comments Section.		**Proposed Insured 1**	**Proposed Insured 2**
1	Do you have in force or pending any of the following: Life Insurance, Critical Illness Insurance, Disability Insurance or Long Term Care Insurance? (If "Yes" complete table below.)	◯ Yes ◯ No	◯ Yes ◯ No
2a	Is this Insurance intended to replace or change any existing Life Insurance or Critical Illness Insurance with BMO Insurance or any other Company? If "Yes" answer 2b. If Yes to 2a, **Life Insurance**, your advisor must provide you with a written analysis of the advantages and disadvantages of the proposed replacement. The Replacement Forms or Life Insurance Replacement Declaration (LIRD) must be submitted to Head Office with this application.	◯ Yes ◯ No	◯ Yes ◯ No
2b	If this insurance applied for will replace an existing BMO Insurance policy, does the owner instruct BMO Insurance to cancel such policy on issuance of the policy applied for herein? If "Yes" to 2b, include the policy number to be cancelled: _____	◯ Yes ◯ No	◯ Yes ◯ No
3	Has any Application or re-instatement for Life, Critical Illness, Long Term Care or Disability Insurance ever been declined, rated, postponed, cancelled, rescinded or modified in any way? (If "Yes" provide details in comments section below.)	◯ Yes ◯ No	◯ Yes ◯ No

	Company	**Type of Insurance Plan**	**Personal Amount**	**Business Amount**	**Yr. Issued** (if in force) **or Yr. submitted** (if pending)
Proposed Insured 1			$	$	
			$	$	
			$	$	
Proposed Insured 2			$	$	
			$	$	
			$	$	

SECTION 8 – PERSONAL INFORMATION

Please provide details for "Yes" answers in space provided, and if necessary Comments Section below.
For Quebec and British Columbia residents, include an MVR Authorization if required due to Underwriting Requirements.

		Proposed Insured 1	Proposed Insured 2
1	Have you used any form of tobacco, marijuana, hash, nicotine products or nicotine substitutes:		
	a) in the past 12 months?	◯ Yes ◯ No	◯ Yes ◯ No
	b) in the past 24 months?	◯ Yes ◯ No	◯ Yes ◯ No
	c) in the past 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
2	Have you within the past 5 years flown as a pilot, student pilot, crew member or intend to do so? (If Yes, complete the Aviation Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
3	Have you within the past 5 years participated in motor vehicle or power boat racing, scuba diving, skydiving, hang gliding, ultra light flying, ballooning, rock climbing, mountaineering, heli-skiing, back country skiing or any other similar sports or avocations or intend to do so? (If "Yes" complete the appropriate Avocation Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
4	Have you traveled, resided, or worked outside North America in the past 12 months or have any plans to do so in the next 12 months? (If "Yes" provide details in Comments Section including length of time outside of North America, dates and purpose of trips.) _____	◯ Yes ◯ No	◯ Yes ◯ No
5	Have you had:		
	a) more than two moving violations in the past 3 years? (If "Yes" give details including dates and type of violation.)	◯ Yes ◯ No	◯ Yes ◯ No
	b) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
	c) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 10 years?	◯ Yes ◯ No	◯ Yes ◯ No
	If you answered "Yes" to a, b, or c please provide your Driver's Licence number: _____		
6	Have you ever been arrested, charged or convicted of any criminal offense? (If "Yes" provide details.)	◯ Yes ◯ No	◯ Yes ◯ No
7	Have you ever declared personal or corporate bankruptcy? (If "Yes" when was it discharged? [DD/MMM/YYYY]) DD/MMM/YYYY	◯ Yes ◯ No	◯ Yes ◯ No

SECTION 9 – COMMENTS

(If additional space is required, please attach a separate page with the Proposed Insured's signature and current date.)

SECTION 10 – MEDICAL INFORMATION

10.1 – PHYSICIAN

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.
If you need more space use the Comments Section on page 8.

Details	Proposed Insured 1	Proposed Insured 2
1. Name of Personal Physician and any specialist consulted and/or referred to		
2. Physician's Address		
3. Physician's Phone Number	(000) 000-0000	(000) 000-0000
4. Date of last consultation (DD/MMM/YYYY)	DD/MMM/YYYY	DD/MMM/YYYY
5. Reason for last consultation		
6. Treatment or Medication prescribed		
7. Results		

10.2 – HEIGHT AND WEIGHT

Details	Proposed Insured 1	Proposed Insured 2
1. Height	_____ ◯ cm ◯ ft/in	_____ ◯ cm ◯ ft/in
2. Weight	_____ ◯ kg ◯ lbs	_____ ◯ kg ◯ lbs
a) In the past year	◯ Same ◯ Gain ◯ Loss	◯ Same ◯ Gain ◯ Loss
b) How much weight change?		
c) Reason for change		
3. If insured is less than 6 months old, weight at birth	_____ ◯ kg ◯ lbs	_____ ◯ kg ◯ lbs

10.3 – MEDICAL HISTORY

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.
If additional space is required, please attach a separate page with the proposed insured's signature and current date.
Please circle the applicable disorder if any. Please provide details for "Yes" answers in space provided below.

		Proposed Insured 1	Proposed Insured 2
1	Are you now under medical observation or are you receiving or been recommended to receive any type of medication, treatment or therapy, or have you ever been advised to have, any pending test, investigation, hospitalization or surgery, which was not completed?	◯ Yes ◯ No	◯ Yes ◯ No
2	Have you ever had or been told you had, or are you aware of any symptoms or complaints or had any known indication of, disease or disorder of, or received treatment or advice for:		
	a) Elevated cholesterol, high blood pressure, chest pain, heart murmur, palpitations, rheumatic fever, phlebitis, varicose veins or other disorders of the heart and blood vessels, abnormal ECG, Angina, cerebrovascular disease (CVA), coronary bypass surgery, transient ischemic attack (TIA), stroke, peripheral vascular disorder, any cardiac procedure, heart attack?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Epilepsy, fainting, dizziness, convulsions, optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Paralysis, Cerebral Palsy, Down's Syndrome and any other neurological disease?	◯ Yes ◯ No	◯ Yes ◯ No
	c) Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	◯ Yes ◯ No	◯ Yes ◯ No
	d) Chronic Kidney Disease, Diabetes, Cancer, tumour or other growth?	◯ Yes ◯ No	◯ Yes ◯ No
	e) Arthritis, neuritis, sciatica, fibromyalgia, lupus or other disorder of the back, muscles, bones or joints?	◯ Yes ◯ No	◯ Yes ◯ No
	f) Anemia, gout, lymph glands, allergies, skin disorders, thyroid, unusual bleeding or other endocrine disorders?	◯ Yes ◯ No	◯ Yes ◯ No
	g) Ulcer, hernia, colitis, gallstones, jaundice, hepatitis (including hepatitis carrier), Crohn's disease or other disorders of the stomach, liver, pancreas, or intestines?	◯ Yes ◯ No	◯ Yes ◯ No
	h) Kidneys, bladder, genitals, including sugar, blood, pus or protein in urine, kidney stones, prostate, venereal disease, reproductive disorders, any disease or disorders of the breasts - including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	◯ Yes ◯ No	◯ Yes ◯ No
	i) Asthma, bronchitis, emphysema, pleurisy, pneumonia, tuberculosis, sleep apnea, shortness of breath, chronic cough or other disorders of the nose, throat or lungs?	◯ Yes ◯ No	◯ Yes ◯ No
	j) Anxiety, stress, "burnout", depression, fatigue, chronic fatigue, suicide ideation or an emotional, behavioral, mental or nervous disorder?	◯ Yes ◯ No	◯ Yes ◯ No
	k) The eyes, ears or throat including loss of speech?	◯ Yes ◯ No	◯ Yes ◯ No
3	Have you ever had or been recommended to have a Computer Tomography Scan (CT Scan) including a coronary calcium scan or Magnetic Resonance Imaging (MRI) and/or any other diagnostic testing not mentioned above?	◯ Yes ◯ No	◯ Yes ◯ No

10.3 – MEDICAL HISTORY *(continued)*

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.
If additional space is required, please attach a separate page with the proposed insured's signature and current date.
Please circle the applicable disorder if any. Please provide details for "Yes" answers in space provided below.

		Proposed Insured 1	Proposed Insured 2
4	a) Have you had any symptoms of or treatment for any medical condition that resulted in hospitalization (other than normal childbirth) within the past 2 years?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Have you been absent from work for more than 7 days within the last 6 months because of sickness or injury? (If Yes, state reason and duration) _____	◯ Yes ◯ No	◯ Yes ◯ No
	c) Have you been absent from work for more than a two week period due to disability within the past two years? (If Yes, state reason and duration) _____	◯ Yes ◯ No	◯ Yes ◯ No
5	Do you drink alcoholic beverages? (If Yes, indicate type and frequency) _____	◯ Yes ◯ No	◯ Yes ◯ No
6	Have you received treatment or been advised to seek treatment or medical advice due to the use of drugs or alcohol? (If Yes, complete the appropriate Drug Usage or Alcohol Usage Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
7	Have you used any habit forming drugs (including but not limited to marijuana, LSD, cocaine, barbiturates, hash, excitants, hallucinogens or other narcotics) except as prescribed by a Physician? (If Yes, complete the Drug Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
8	Other than as already disclosed, within the past five years, have you:		
	a) Consulted a Physician, Chiropractor, Therapist or Health Care Worker?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Been a patient in a hospital, clinic or other medical facility?	◯ Yes ◯ No	◯ Yes ◯ No
	c) Had, or been advised to have, any hospitalization or pending test or investigation or surgery which was not completed?	◯ Yes ◯ No	◯ Yes ◯ No
	d) Had an electrocardiogram, x-ray, blood test or other diagnostic test?	◯ Yes ◯ No	◯ Yes ◯ No
	e) Had any mental or physical diseases or disorders not listed above?	◯ Yes ◯ No	◯ Yes ◯ No
	f) Been aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	◯ Yes ◯ No	◯ Yes ◯ No

9 Provide details below for **MEDICAL HISTORY** question(s) (1-8) to which you answered "Yes".

Question no.	Name of Proposed Insured	Name of Physician (if Different from Section 10.1)	Details (Including relevant dates, treatments, symptoms, referrals and results)

10.4 – FAMILY HISTORY

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.		Proposed Insured 1	Proposed Insured 2
1	Have your parents, brothers or sisters had cancer, high blood pressure, heart or kidney disease, polycystic kidney disease, diabetes, mental or nervous disorder (including Alzheimer's Disease), stroke, multiple sclerosis, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Parkinsons' Disease or any other hereditary disorders?	◯ Yes ◯ No	◯ Yes ◯ No

2 Provide details below of **FAMILY HISTORY** for all parents, brothers and sisters. If diagnosis or cause of death was cancer or cancer related, please specify the type(s) of cancer.

Proposed Insured 1	Proposed Insured 2	Relationship to Proposed Insured	Disease or disorder, if any	Age if Living	Age at Onset	Cause of Death	Age at Death
◯	◯						
◯	◯						
◯	◯						
◯	◯						
◯	◯						
◯	◯						

SECTION 11 – CHILDREN'S TERM RIDER AND PAYOR WAIVER OF PREMIUM

◯ Children's Term Rider* ◯ Payor Waiver of Premium

*To be completed on behalf of all children applying for Term Insurance, who are between 15 days and up to and including 17 years old.
The Beneficiary of this rider is the Owner unless stated otherwise.
Complete a separate Section 11 if both Children's Term Rider and Payor Waiver of Premium are applied for.

Proposed Life Insured

First and Last Name	Relationship to Life Insured	Date of Birth (DD/MMM/YYYY)	Height	Weight
		DD/MMM/YYYY	◯ cm ◯ ft/in	◯ kg ◯ lbs
		DD/MMM/YYYY	◯ cm ◯ ft/in	◯ kg ◯ lbs
		DD/MMM/YYYY	◯ cm ◯ ft/in	◯ kg ◯ lbs
		DD/MMM/YYYY	◯ cm ◯ ft/in	◯ kg ◯ lbs

1	Has anyone proposed for coverage above, within the past five years:	
	a) Consulted a physician for any reason; had an electrocardiogram or other diagnostic tests; been in a clinic, hospital or medical facility for observation or treatment?	◯ Yes ◯ No
	b) Been advised to have any diagnostic test, hospitalization or surgery which was not done?	◯ Yes ◯ No
2	Has anyone proposed for coverage above ever had or had indication of:	
	a) Cancer, stroke, heart attack or heart disease?	◯ Yes ◯ No
	b) Diabetes, glandular or thyroid disorder, enlarged lymph nodes, epilepsy, or any mental, nervous or neurological disorder?	◯ Yes ◯ No
	c) Chest pain, angina, high blood pressure, heart murmur or other circulatory or blood disorders?	◯ Yes ◯ No
	d) Kidney, urinary or reproductive disorder, or sexually transmitted disease?	◯ Yes ◯ No
	e) Liver or gastrointestinal disorder, hepatitis or hepatitis carrier state?	◯ Yes ◯ No
	f) Asthma, emphysema, or other respiratory disorder?	◯ Yes ◯ No
	g) Loss of vision, amputation, deformity, arthritis or other musculo-skeletal disorder?	◯ Yes ◯ No
3	Has anyone proposed for coverage above ever had or been told they have:	
	Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	◯ Yes ◯ No
4	Is anyone proposed for coverage above presently taking any medication?	◯ Yes ◯ No
5	Has anyone proposed for coverage above:	
	a) Ever had a request for life or disability insurance declined, postponed, rated, or restricted in any way?	◯ Yes ◯ No
	b) Within the past two years flown or taken instruction as a pilot or engaged in any kind of racing, scuba or sky diving, hang gliding or other hazardous activities or intend to do so?	◯ Yes ◯ No
	c) Within the past five years used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol use?	◯ Yes ◯ No
	d) Ever had their driver's licence restricted, revoked or had three or more moving violations within the past three years? If yes, provide drivers licence #_____	◯ Yes ◯ No
	e) Intend to reside or travel outside of Canada for more than four consecutive weeks?	◯ Yes ◯ No

Give full details for all "Yes" answers to questions 1 to 5. Give dates, treatment, duration of illness, and names and addresses of all attending physicians and medical facilities.

Question No.	First and Last Name	Details

SECTION 12 – PAYMENTS & AUTHORIZATIONS

12.1 – METHOD OF PAYMENT

- BMO Life Assurance Company (Company, We) does not accept cash
- All payments must be in Canadian funds drawn on a Canadian financial institution and be payable to BMO Life Assurance Company.
- If a method of payment is not selected, We will proceed on a payment on delivery basis
- Payments will not be taken from the payor's account until the policy is in effect unless the initial payment has been selected in the authorization.

Initial Payment of $_____ Paid by:

◯	Pre-authorized Debit (PAD) when payment submitted with the application **(TIA is available with this option)** • Complete Section 12.2, Pre-Authorized Debit (PAD) Authorization section
◯	Pre-authorized Debit (PAD) when the policy has been accepted and delivery requirements received by us **(TIA is NOT available with this option)** • Complete Section 12.2, Pre-Authorized Debit (PAD) Authorization section
◯	Cheque when payment submitted with the application **(TIA is available with this option)**
◯	Cheque when the policy has been accepted and delivery requirements received by us **(TIA is NOT available with this option)**
◯	Credit Card - First ANNUAL Payment only when payment submitted with this application **(TIA is available with this option)**
◯	Credit Card - First ANNUAL Payment only when the policy has been accepted and delivery requirements received by us **(TIA is NOT available with this option)**

Subsequent Payments Paid by:

◯	Monthly Pre-Authorized Debit (PAD) • Complete **Section 12.2, Pre-Authorized Debit (PAD) Authorization** section
◯	Annual Billing

12.2 – PRE-AUTHORIZED DEBIT (PAD) AUTHORIZATION

All payors must agree to all of the following terms in order to use the PAD payment option.

- BMO Life Assurance Company (Company) may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from the bank account indicated in this application for insurance;
- For the purpose of this agreement, all pre-authorized debits will be treated as Personal under the Canadian Payments Association rules (this means having 90 calendar days from the date any payment is processed to claim reimbursement for any unauthorized payment);
- The withdrawal amount is considered to be variable under the Canadian Payment Association rules;
- Any notices to be sent under this agreement may be sent to the proposed owner/owner's most recent address that the company has on record at the time the notice is sent;
- The company may charge a fee and may cancel the PAD for any withdrawal that is not honoured;
- This authorization may be cancelled at any time upon the Company's receipt of written notice by the payor;
- Any cancellation of this pre-authorized withdrawal will not affect the agreement between them and the Company whatsoever with respect to any insurance coverage so long as payment is provided by an alternate acceptable method.
- All persons whose signatures are required to sign on this account have signed below, including any required joint account holder.
- **To waive the requirement that BMO Life Assurance Company notify them of:**
  - **This authorization before the first payment is processed,**
  - **Any subsequent payments, and**
  - **Any changes to the amount or date of the payment initiated by them or the Company.**

◯	**Add to existing PAD Agreement for BMO Insurance Policy #**_____
◯	**Create a new PAD Agreement using:**
◯	The Account information on the first cheque provided with this application
◯	The Account information shown on a bank Letter of Direction. (A line of credit account cannot be used)
◯	the VOID cheque attached (cheque must have accountholder name preprinted)
◯	**Withdraw funds to pay the initial payment**

Withdrawal Information

If a pre-authorized payment is returned due to non-sufficient funds (NSF), BMO Life Assurance Company is authorized to retry the payment within ten (10) business days. The payor is responsible for any NSF charges incurred by their financial institution.

◯	**Match Policy Date**
◯	**Preferred Withdrawal Day*** (choose from the 1st to the 28th)

*Not available for Universal Life policies.

12.2 – PRE-AUTHORIZED DEBIT (PAD) AUTHORIZATION *(continued)*

- Payors have certain recourse rights in the event that a debit does not comply with this agreement. Payors have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. Payors may obtain a sample cancellation form or more information on rights to cancel this Authorization by contacting their financial institution or by visiting **www.cdnpay.ca**.

Contact us at any time:
BMO Life Assurance Company
60 Yonge Street
Toronto, ON M5E 1H5
1-877-742-5244 Fax 416-596-0348

Date (DD/MMM/YYYY)	**Signature(s)** (for a joint account, all depositors must sign)
DD/MMM/YYYY	X
	X

12.3 – CREDIT CARD AUTHORIZATION

(FOR FIRST ANNUAL PAYMENT ONLY, UP TO A MAXIMUM OF $50,000)

Name as it appears on the card:

◯ MasterCard ◯ VISA	**Card Number**	**Expiry Date (MM/YY)** MM/YY

I authorize BMO Life Assurance Company (BMO Insurance) to charge $_____ to the above account in respect to this Application for Insurance.

Upon receipt of this form, BMO Insurance will request necessary authorization from the issuer of your credit card. If necessary authorization is obtained from the issuer, your account will be debited accordingly. Payment to BMO Insurance by the issuer pursuant to the above will constitute and represent "an amount paid" and, as such, is governed by the provisions of this Application.

Date (DD/MMM/YYYY)	**Signature**	**Cardholder's Name** (please print)
DD/MMM/YYYY	X	

SECTION 13 – GENERAL COMMENTS

SECTION 14 – NOTICE, REPRESENTATIONS, ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURES

14.1 – IMPORTANT NOTICE: The information contained in this application and other information BMO Insurance may collect in connection with the application is required by BMO Insurance for insurance purposes, including activities, such as: considering and processing the application and administering any policy if issued and investigating coverage and claims (the "Insurance Purposes"). Further information about the Insurance Purposes and BMO Insurance's privacy practices are set out in the notice on *Privacy and Personal Information and MIB Inc. Notice* provided at the time of Application.

14.2 – REPRESENTATIONS AND ACKNOWLEDGEMENTS: "I" (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below represent and confirm that:

1. I have read and understood all of the questions in this application form, and in any supplemental questionnaires, submitted to BMO Life Assurance Company (BMO Insurance) as part of this application for life insurance (the "Application") and that I intend to submit the Application for insurance.
2. I have reviewed all of my answers and statements recorded in the Application and the answers provided are true and complete and were provided by me to my advisor (or some other authorized person acting on behalf of my advisor) for the Insurance Purposes. In addition, I understand that any statements that I make during a telephone conversation or visit with a medical professional or other representative are also part of my Application and will also be used for the Insurance Purposes.
3. I understand that the information and answers provided in the Application will be relied upon by BMO Insurance in assessing the Application, and issuing any policy. I was present when the answers to the questions related to me were collected and I provided the answers.
4. BMO Insurance may void any policy it issues based on the Application if any of the information or answers provided in the Application is incomplete or incorrect.
5. I will notify BMO Insurance immediately if any of the answers or information provided in the Application is discovered to be untrue or changes in the period before approval of the issuance of and delivery of the policy applied for. I will notify BMO Insurance if there is a change in my residency status for tax purposes.
6. I have received sufficient and satisfactory information concerning the product(s) I am applying for before signing this Application, and I understand that the life insurance advisor may be paid on a commission basis.
7. I also understand that there are variables (e.g., type and performance of investments, cost of insurance, policy loans, payments and withdrawals, etc.) that can affect the policy's performance and that changes in these variables can affect the policy's non-guaranteed benefits and values, and I further understand that benefits and values set out in any illustration are not guaranteed and are based on assumptions that are likely to change.
8. I (being the proposed policy owner) will be deemed to have accepted any policy issued based on this Application if I do not return the policy to BMO Insurance with 10 days of delivery.

14.3 – AUTHORIZATIONS AND SIGNATURES: "I" (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below indicate that:

1. I consent to the collection, use and disclosure of my personal information by BMO Insurance and its sub-contractors for the Insurance Purposes.
2. I consent to BMO Insurance obtaining a credit bureau report, conducting a criminal records check and obtaining information relating to my driving history, as required, for the Insurance Purposes
3. I authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, and insurance company, advisor or broker or its affiliate, the MIB Inc., and any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide and exchange all such information and records with BMO Insurance or its reinsurers.
4. I consent to the testing of specimens(s) provided by me, which may include AIDS Virus (HIV) antibody/antigen testing, unless I expressly revoke this consent.
5. I consent to BMO Insurance releasing the results of any tests, reports and personal information gathered about me to its reinsurers and other authorized insurers, to my personal physician, and to the MIB Inc.
6. I understand that if the proposed life insured is not the only proposed life insured or is different than a proposed policy owner(s), that the personal information (including health information) of the proposed life insured will be shared with any additional proposed life insured or policy owner and I consent to this.
7. I have read, understood and agree to the collection, use and disclosure of my personal information as set out in the *Privacy and Personal Information and MIB Inc. Notice* provided to me at the time of Application.
8. Acceptance of any policy issued on the Application constitutes approval of the provisions of the policy and ratification of any additions or endorsements or amendments.

By signing below I understand and agree to the statements in the section above and consent to the disclosure of my personal information as described.

Province Signed	**Date** (DD/MMM/YYYY)	**Signature**
	DD/MMM/YYYY	**Proposed Owner** (indicate title of signing officers if applicable) X
	DD/MMM/YYYY	**Proposed Owner** (indicate title of signing officers if applicable) X
	DD/MMM/YYYY	**Proposed Insured** (if other than proposed owner or if under 16 (18 in Quebec) signature of parent or guardian) X
	DD/MMM/YYYY	**Proposed Insured** (if other than proposed owner) X
	DD/MMM/YYYY	**PAD Payor** (if other than proposed owner or proposed insured) X
	DD/MMM/YYYY	**PAD Payor** (if other than proposed owner or proposed insured) X

A copy of this authorization is as valid as the original.

SECTION 15 – AUTHORIZATION TO SHARE INFORMATION

Authorization to Share information - PLEASE COMPLETE ON ALL APPLICATIONS - Do not detach

You and *your* refer to the people to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *Us* and *our* refer to BMO Life Assurance Company (BMO Insurance). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, public or private health or social services establishments, clinics and other medically related facilities, insurance companies, MIB, Inc., your advisor or its affiliate and any other organization, institution, association or person that has information, records or knowledge of you or your health or of your children or their health (if applicable), to share or exchange information with us or our reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal information to MIB, Inc. Note: A parent or legal guardian signing on behalf of a minor must indicate relationship. A copy of this authorization shall be as valid as the original.

Province Signed	**Date** (DD/MMM/YYYY)	**Signature**	**Print Name**
	DD/MMM/YYYY	**Proposed Insured 1** X	
	DD/MMM/YYYY	**Proposed Insured 2** X	
	DD/MMM/YYYY	**Parent or Guardian and Relationship** (if Proposed Insured is under 16 [18 in Quebec]) X	

SECTION 16 – PRIVACY AND PERSONAL INFORMATION AND MIB INC. NOTICE

PLEASE DETACH AND GIVE TO PROPOSED INSURED(S)

In this Privacy and Personal Information Authorization, "You" and "Your" mean either the policy owner, proposed life insured, or payor of the policy either individually or collectively. "We" and "Our" mean BMO Life Assurance Company.

When We receive Your Application (which includes the application for insurance and any supplemental forms), We will establish and maintain a confidential file which will contain Your personal information including any health information and Your Application and any related contracts for insurance.

We maintain this file in order to:

(1) determine your eligibility for our products and services;
(2) confirm the accuracy of the information that You have provided to Us;
(3) issue, service, and administer Your contract of insurance, even after Your contract has ended;
(4) assess any claim for benefits under Your contract;
(5) comply with legal and regulatory requirements.

If You are the owner of a permanent life or universal life policy, then We will collect Your social insurance number for income tax reporting purposes.
As part of Our underwriting process, We may request a consumer report or conduct a personal investigation in connection with this Application.
Access to Your file, and Your personal information, is limited to:

(1) BMO Insurance employees;
(2) Your insurance advisor and the managing general agent that Your advisor is associated or connected to;
(3) Our reinsurers;
(4) Our third party service providers related to the administration, processing and servicing of your contract;
(5) Those other third parties that You authorize or those authorized by laws;
(6) Where necessary, Your named beneficiary(ies) in the event of a claim.

You may access Your file and request corrections to Your personal information by sending a written request to Privacy Officer, BMO Insurance, 60 Yonge St, Toronto, ON M5E 1H5.

For more information, or to review our Privacy Code, please visit www.bmoinsurance.com

MIB Inc. Notice:
Except as required by law, information regarding Your insurability will be treated as confidential. BMO Insurance or its reinsurers may however, make a brief report to the MIB Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If a person named in this Application applies to another MIB Inc. member for life or health insurance, or a claim for benefits is submitted to such a company, MIB Inc. will, upon request, supply that insurance company with the information in its file.

BMO Insurance or its reinsurers may also release information in its 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.

Upon receipt of a request from You, MIB Inc. will arrange disclosure of any information it may have in Your file. If You question the accuracy of information in the MIB Inc.'s file, you may contact MIB Inc. and seek a correction.

The address of MIB Inc.'s information office is:
MIB Inc.
330 University Avenue, Suite 501, Toronto ON M5G 1R7
Telephone (416) 597-0590
Web site www.mib.com

BMO Insurance

BMO Life Assurance Company
60 Yonge Street
Toronto, Ontario
Canada M5E 1H5

Tel 416-596-3900
Fax 416-596-4143
Toll Free 1-877-742-5244

BMO Insurance

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Toronto, Ontario
Canada M5E 1H5

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Toll Free 1-877-742-5244

SECTION 17 – ADVISOR REPORT

17.1 – GENERAL INFORMATION

1 **How long have you known the Proposed Life Insured(s)?** _____

Relationship to the Proposed Life Insured(s)? ◯ Know well ◯ Know slightly ◯ Just met

If related: ◯ Spouse ◯ Parent ◯ Child/Dependent ◯ Sibling ◯ Other _____

2 **Who solicited this Application?** ◯ Advisor ◯ Proposed Life Insured ◯ Owner

3 **Did you personally meet with the person(s) to be insured and the policy owner(s)?** ◯ Yes ◯ No
If No, do not submit this application. You must use form 431 (Non Face-to-Face Application for Life and Critical Illness Insurance) and submit to your MGA.

4 **Underwriting requirements ordered:** ◯ Urine-HIV ◯ Para-Medical ◯ Resting E.C.G. ◯ Saliva-HIV ◯ Doctor's Medical ◯ Stress E.C.G. ◯ Blood Profile ◯ APS ◯ Inspection Report ◯ Other _____

APS (if ordered, name of Physician) Dr.

Name of Paramedical facility or Medical Examiner

17.2 – THIRD PARTY DETERMINATION – **MANDATORY** COMPLETION IF THIS APPLICATION IS FOR UNIVERSAL LIFE INSURANCE

For the purpose of this section a "Third Party" is a person (Individual or company or organization) other than the proposed owner(s) of this contract that pays for the contract, have use of, or access to, the contract value. Example of a Third Party: Payor, Executor, Power of Attorney

1 Is the policy owner(s) acting on behalf of or at the instruction of a Third Party ◯ Yes ◯ No

2 Is someone other than the policy owner contributing funds to the policy, or now has or will in the future have use of the policy or access to its values ◯ Yes ◯ No

3 **If you answered "Yes" to either of the above questions, complete the following:**

Is the Third Party an ◯ Individual OR ◯ Company, Trust or other Entity (Complete form 715E)

Name of Third Party (individual, company, trust or other entity)	**If individual, date of birth** (DD/MMM/YYYY) DD/MMM/YYYY	**Relationship of Third Party to the Owner of this policy**	
Type of identification	**Identification Number**	**Province of Issue**	**Country of Issue**
Address of Third party		**Principal Business and Occupation of Third party**	

4 ◯ I am unable to determine Third Party Ownership, however I have reasonable grounds to suspect there is a Third Party

17.3 – ADVISOR CERTIFICATION

The foregoing answers are correct to the best of my knowledge. By signing here I confirm that:

- I am the soliciting Advisor and I am duly licensed to write this Application in the jurisdiction where the transaction occurred, and
- at the time of the application I met with Proposed Insured 1, Proposed Insured 2 (if applicable) and the Owners, and
- I have seen the original valid government issued document presented by Proposed Insured 1, Proposed Insured 2 (if applicable) and the Owners, for identification purposes.
- I used reasonable efforts to determine if the policy owner(s) is/are acting on behalf of a third party, and
- I have provided an Advisor Disclosure Statement to the Owner, advising:
  - about the company(ies) that I currently represent;
  - that I 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; or
  - of any conflicts of interest I may have with respect to this transaction.

Soliciting Advisor's Name (please print)	**Soliciting Advisor's Signature**	**Date** (DD/MMM/YYYY)
	X	DD/MMM/YYYY

17.4 ADVISOR INFORMATION

1	**Full Name** (please print) **(Servicing Advisor)**	**Advisor Code No.**	**Percentage Split**	**Print Name of MGA and MGA code# here**
2	**Full Name** (please print)	**Advisor Code No.**	**Percentage Split**	
3	**Full Name** (please print)	**Advisor Code No.**	**Percentage Split**	

17.5 – LICENSED ADMINISTRATIVE ASSISTANT'S DECLARATION

To be completed if a licensed administrative assistant completed this application.

Did a licensed administrative assistant complete the application (excluding any Verification of Identity)? ◯ Yes ◯ No

I, the licensed administrative assistant confirm that:

- I have reviewed with each proposed owner, proposed insured and PAD payor, all information in this application and, to the best of my knowledge, this information is complete and true, and has all the facts material to the insurance applied for, and
- I saw every person sign this application.

Licensed administrative assistant's full name (please print)	**Licensed administrative assistant's signature**	**Date** (DD/MMM/YYYY)
	X	DD/MMM/YYYY

SECTION 18 – APPLICATION FOR TEMPORARY INSURANCE

The following questions are to be answered by Proposed Insured 1 and Proposed Insured 2, if applicable. If applying for life insurance only, complete question 1 and questions 2 a) through e). If applying for critical illness insurance, complete questions 1, 2 and 3.		**Proposed Insured 1**	**Proposed Insured 2**
1	Are you over the age of 65?	◯ Yes ◯ No	◯ Yes ◯ No
2	Have you		
	a) Ever been treated for or had any indication, signs or symptoms of Alzheimer's, Parkinson's, Huntington's Chorea, heart or circulatory disease, heart attack, chest pain, abnormal ECG, elevated blood pressure, loss of speech, severe burns, diabetes, cancer or tumours, stroke, transient ischemic attacks (TIA), chronic kidney, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, AIDS or HIV infections?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Been unable to perform regular activities for more than 7 consecutive days within the last 6 months because of a sickness or injury or currently under any treatment?	◯ Yes ◯ No	◯ Yes ◯ No
	c) Within the past 2 months,other than pregnancy or childbirth, been admitted to a hospital or other medical facility or been advised to do so?	◯ Yes ◯ No	◯ Yes ◯ No
	d) Been advised to have any tests, investigation or surgery not yet done?	◯ Yes ◯ No	◯ Yes ◯ No
	e) Been advised that you are not eligible for life insurance or been offered such insurance with extra premium or modified in any way?	◯ Yes ◯ No	◯ Yes ◯ No
3	Have you been advised that you are not eligible for health or critical illness insurance or been offered such insurance with extra premium or modified in anyway?	◯ Yes ◯ No	◯ Yes ◯ No

If any of the above questions are answered "Yes" for Proposed Insured 1 and/or Proposed Insured 2, DO NOT accept payment or detach the receipt. Payment remitted in an invalid TIA will be returned. The Temporary Insurance will only be provided if all of the above questions are answered "No" and will only be valid and enforceable if such answers are true.

Payment must be dated the same day as the Application for Temporary Insurance.

Amount paid with Application $_____

In addition to the acknowledgements on the Notice, Representations, Acknowledgements, Authorizations & Signatures section, we specifically acknowledge that we have read and received the Temporary Insurance Agreement and Receipt.

Province Signed	**Date** (DD/MMM/YYYY)	**Signature**
	DD/MMM/YYYY	**Proposed Insured 1** (or if under 16 [18 in Quebec] signature of parent or guardian) X
	DD/MMM/YYYY	**Proposed Insured 2** X
	DD/MMM/YYYY	**Proposed Owner** (if other than Proposed Life Insured) X

SECTION 19 – TEMPORARY INSURANCE AGREEMENT AND RECEIPT

PLEASE DETACH AND LEAVE WITH OWNER ONLY IF TEMPORARY INSURANCE HAS BEEN APPLIED FOR.

Important: No Temporary Insurance coverage shall take effect except as stated in the Temporary Insurance Agreement.

Received from	**The amount of**
	$

for Life and/or Critical Illness Insurance on the life of **Proposed Life Insured**

with an application dated **Date** (DD/MMM/YYYY) DD/MMM/YYYY

This Receipt is issued on the condition that any cheque or other order for the payment of money is honoured upon first presentation for payment.

Banking information provided and Pre-Authorized Debit (PAD) Authorization signed to take initial payment by Pre-Authorized Debit (PAD) ◯ Yes ◯ No

ALL CHEQUES MUST BE MADE PAYABLE TO BMO LIFE ASSURANCE COMPANY. DO NOT MAKE THE CHEQUE PAYABLE TO THE ADVISOR OR LEAVE THE PAYEE BLANK. NO PERSON IS AUTHORIZED TO CHANGE OR WAIVE ANY CONDITIONS IN THIS AGREEMENT.

Signed at	**Date** (DD/MMM/YYYY) DD/MMM/YYYY
Signature of Advisor X	**Date** (DD/MMM/YYYY) DD/MMM/YYYY

This temporary insurance is to provide limited coverage (temporary insurance amount) as described below while your Application is being processed. Coverage under this temporary insurance does not guarantee approval of your Application. Any change in insurability while your Application is being processed may also affect whether or not your Application is approved.

In the event of death of a life to be insured while this temporary insurance is in force, who qualifies for temporary insurance coverage, BMO Life Assurance Company (BMO Insurance) will pay the temporary insurance amount. Payment will be made in accordance with the beneficiary designation(s) in the Application and, in cases of joint lives to be insured, the plan for which application has been made.

Where an amount equal to at least one twelfth of the annual premium for the policy(ies) applied for has been paid, BMO Life Assurance Company (BMO Insurance) agrees to provide Temporary Insurance to the Proposed Life Insured(s) subject to the conditions, terms, limitations and other provisions set forth below:

Conditions for Termination

1. Termination date is the 90th day after the date this application is signed.
2. This Agreement terminates automatically when the policy(ies) applied for become(s) effective, a counteroffer is tendered to your representative, or on the termination date, whichever comes first.
3. BMO Insurance may terminate this Agreement at any time prior to the above indicated termination date. Notice will be mailed to the Owner with a refund of any money paid, to the mailing address designated on this Application. The termination date is the day following the mailing of the notice by BMO Insurance.

No representative of BMO Insurance is authorized to modify this Agreement.

Effective date

Temporary coverage under this Agreement is effective when this Application has been fully completed and signed and an amount equal to at least one twelfth of the annual premium has been paid.

Temporary Insurance Coverage

1. The maximum amount of insurance on the Proposed Life Insured(s) under this and any other Temporary Insurance Agreement with BMO Insurance is limited to the lesser of:
   a) The amount of insurance applied for, or
   b) $1,000,000 on each life for life insurance (regardless of the amount of money submitted with this Application), or
   c) $500,000 on each life for critical illness insurance;
2. No insurance is provided for any accidental death benefit rider, waiver of premium benefit or Children's Term Rider and Payor Waiver of premium.
3. If any Proposed Insured dies by his or her own intentional act, whether sane or insane, BMO Insurance's only liability is to refund any payment received.

Limitations

No insurance will be in effect under this Agreement unless:

1. The Proposed Insured is at least 15 days of age for life insurance and 30 days of age for critical illness insurance and is not over 65 years of age on the date of this agreement.
2. Any payment given for premium is payable to BMO Life Assurance Company and is honoured upon first presentation for payment.
3. No Critical Illness Benefit will be paid under this Agreement for any diagnosis of cancer.
4. No Critical Illness Benefit will be paid under this Agreement if death occurs within thirty days of the diagnosis of a defined critical illness.
5. Our standard Critical Illness policy provisions and exclusions shall govern the Critical Illness Insurance provided under this Agreement.

APP NO.

BMO Life Assurance Company
60 Yonge Street
Toronto, Ontario, Canada M5E 1H5

Tel 416-596-3900
Fax 416-596-4143
Toll Free 1-877-742-5244

www.bmoinsurance.com

BMO Insurance

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