Canada Life

The Canada Life Assurance Company

Home Office:
8515 E. Orchard Road
Greenwood Village, CO
80111

Mailing Address:
PO Box 174392
Denver, CO
80217-4392

POLICY CHANGE APPLICATION

USE THIS FORM FOR THE FOLLOWING:	SECTION
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MISCELLANEOUS POLICY CHANGES	2
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NOTE:

PART B - Smoking Questionnaire and Statement of Health - MUST BE COMPLETED for the following requests: Reinstatement, Review of Extra Rating, Non-Smoker Discount, Increase in Face Amount, Addition to Benefit/Rider , or any other change that would result in extra risk to the Company.

INSTRUCTIONS:

- Mark the box for each change or service you are requesting.
- This form and all signatures MUST be in ink.
- For Addition of Child Rider, copmlete Form No. 59.
- For Child POlicy, complete Form No. 17, Juvenile Non-Medical Form.
- SIGNATURE REQUIREMENTS:
  - The owner's signature is required for all requests. If a Corporation is Owner, signatures and titles of two officers, or of one officer under Corporate Seal are required. Witness must be of majority age with no interest in the contract.
  - If the policy has a total death benefit of $1,000,000.00 or more, signatures on the form must be notarized or guaranteed and the original documents must be received. We cannot accept faxes.
  - The signatures of Irrevocable Beneficiary(ies) and Assignee(s), if applicable, are required for all requests.

POLICY INFORMATION - Please Complete

Policy No.: _____

OWNER INFORMATION:

Name
Address
Social Security or Tax ID Number
Phone Number with Area Code

❑ Check here if new address

INSURED INFORMATION:

Name	
Address	
Social Security Number	
Date of Birth	Place of Birth
Phone Number with Area Code	

❑ Check here if new address

PART A

1. REINSTATEMENT

❑ Please reinstate this policy according to its terms.

❑ Please reinstate this policy on the basis of changing the policy year's date so that the arrears of premium payable on reinstatement will be the minimum acceptable to the Company. A fee will be charged.

2. POLICY CHANGE/INCREASE

Request is hereby made to ❑ change or ❑ increase existing policy to that specified below:

For UNIVERSAL LIFE Plans Only

Change to Option: ❑ A (Increasing) ❑ B (Level) ❑ New Specified Amount $ _____

New Billed Amount (or minimum required, if greater): $ _____ ❑ Lump Sum Amount: $ _____

Automatic Payment: $ _____ ❑ Add ❑ Remove ❑ Increase ❑ Remain the same

For NON-UNIVERSAL LIFE Plans Only

New Face Amount: (Base Policy Only): $ _____ ❑ ECO Face Amt. (or max available, if less) $ _____

ABR Annual Prem: $ _____ ❑ Add ❑ Remove ABR Single Prem: $ _____ ❑ Add ❑ Remove

Waiver of Premium: ❑ Add ❑ Remove

Please Add or Remove the Following Benefit(s)/Rider(s):

❑ Accidental Death Benefit: $ _____ ❑ Add ❑ Remove

❑ Term Rider (Specify Type): $ _____ ❑ Add ❑ Remove Type:

❑ Guaranteed Insurability Rider - No. of Units: _____ ❑ Add ❑ Remove

❑ Other Insured Rider or ❑ Spouse Rider to age _____ $ _____ ❑ Add ❑ Remove

❑ Other (Please Specify):

Please change Premium Mode to: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ PAC/EFT

❑ Add to existing PAC/EFT under Policy No. ❑ New PAC/EFT Form Attached

3. REVIEW OF EXTRA RATING

❑ Please reinstate this policy according to its terms.

4. DIVIDEND OPTION

Please ❑ change to or ❑ include the following dividend option:

❑ Paid-Up Additions ❑ Cash ❑ Reduce Premium (Not avail. with PAC/EFT)

❑ Accumulate at Interest ❑ Repay Policy Loan ❑ Purchase One-Yr. Term (bal. of div. to be _____)

❑ Other (Specify) _____

❑ Please apply existing dividend credits to this option ❑ Withdraw existing dividend credits

❑ Leave dividend credits under existing option ❑ Other _____

5. REMARKS (Not applicable in West Virginia)

PART B

6. SMOKING QUESTIONNAIRE (Specimen may be required)

A Do you currently use tobacco? ❑ Yes ❑ No

If 'YES', give type: ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Other (Specify): _____

How long have you been using tobacco? _____ Quantity per day: _____

B If you are not currently smoking cigarettes, have you ever smoked them? ❑ Yes ❑ No

If 'YES', date on which you stopped smoking: _____

Length of time you smoked: _____ Why did you stop? _____

If on the advice of a physician, provide full name and address: _____

7. STATEMENT OF HEALTH (The Company may require additional Evidence of Insurability)

Proposed Insured:	Occupation:	Relationship to Owner:

Date of Birth (mm/dd/yyyy): ____ / ____ / ____ Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs

Weight Gain/Loss in last year? ❑ Yes ❑ No If "YES", how much? _____ lbs

Reason: _____

		Y	N
A.	During the last two years have you been absent from work for a continuous period of two weeks or more because of illness or injury? If 'YES', give details in Section 8.	❑	❑
B.	Is any other application for insurance on your life pending at this time? If 'YES', give details in Section 8. INDICATE TOTAL LIFE and ACCIDENTAL DEATH & DISMEMBERMENT CURRENTLY IN FORCE.	❑	❑
C.	Do you participate in any type of flying or gliding, other than as a fare-paying passenger? If 'YES', please complete an Aviation Questionnaire (Form 24).	❑	❑
D.	Do you participate in sky or scuba diving, or racing of any kind? If 'YES', please complete an Avocation Questionnaire (Form 56).	❑	❑
E.	Do you travel or have you made plans to travel outside the USA and Canada within the next year? If 'YES' where: _____ , how long: _____ , and why: _____	❑	❑
F.	Do you now or have you ever used alcohol? If 'YES', have you received treatment or belonged to an organization because of alcohol use? If 'YES', give details in Section 8. Alcohol Use: Amount per week: _____ Type: _____	❑	❑
G.	Have you ever had your driver's license restricted, revoked or suspended in the last three years? If 'YES', give details in Section 8.	❑	❑
H.	During the past 5 years, have you used heroin or other narcotics, hallucinogenic or other habit forming drugs, including cocaine and marijuana? If 'YES', give details in Section 8.	❑	❑
I.	Have you ever had an application for life or disability insurance declined, postponed, rated or modified? If 'YES', give details in Section 8.	❑	❑
J.	To the best of your knowledge and belief, have you:		
1.	Ever been diagnosed or treated by a medical professional for heart disorder, high blood pressure, stroke, cancer, diabetes, alcoholism, or liver or kidney disease?	❑	❑
2.	Ever been diagnosed or treated by a medical professional for a respiratory disorder, gastrointestinal disorder, nervous disorder, sexually transmitted disease, elevated cholesterol or triglycerides, arthritis, or bone or joint disorders?	❑	❑
3.	Ever been treated by a medical professional for significant weight loss, fever, night sweats, persistent diarrhea or swollen lymph nodes?	❑	❑
4.	Ever been diagnosed as having or treated by a medical professional for any disease or disorder of the immune system?	❑	❑
5.	Had medical or surgical treatment during the past five years for any ailment, injury or sickness not named in connection with your prior answers?	❑	❑

PART B (Continued from Previous Page)

8. DETAILS of 'YES' Answers. Identify Question Number. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

AGREEMENT

The undersigned hereby declare(s) that to the best of his/her knowledge and belief the foregoing statements and answers are complete and true. I/We agree that this application and any evidence of insurability required by the Company in connection with the change requested will be considered an amendment and supplement to the original application and will form a part of the policy. I/We also agree that the change or reinstatement requested will not take effect until it has been approved at the Home Office and any required premium has been paid while the facts concerning the insurability of the Proposed Insured are the same as described in this application. No agent can modify this agreement or waive any of the Company's rights or requirements. I have received a copy of: 1) the Medical Information Bureau Notice; and 2) the Notice required by the Federal Fair Credit Reporting Act.

AUTHORIZATION: I understand and authorize the following:

A. to determine eligibility for insurance for the Proposed Insured, I authorize the release of information concerning:
   1. the diagnosis, treatment or prognosis of any past or present physical, mental, drug, or alcohol condition; and
   2. any non-medical data which relates to insurability;

B. the parties authorized to release such information are:
   1. any physician or medical practitioner;
   2. any hospital, clinic, or other medical related facility;
   3. any insurance or reinsurance company;
   4. the Medical Information Bureau or any consumer reporting agency; and
   5. any employer of the Proposed Insured.

C. the information may be released to:
   1. the Canada Life Assurance Company (Canada Life);
   2. the reinsurers of Canada Life; and
   3. the legal representative of Canada Life; and

D. any data obtained will not be released by Canada Life to any person or organization except:
   1. to reinsuring companies;
   2. to the Medical Information Bureau;
   3. to persons performing business or legal services in connection with my application;
   4. to any physician named in my medical declarations (as required for my medical care);
   5. as required by law; or
   6. as I further authorize.

I agree that a photocopy of this authorization will be as valid as the original. I know that I may request a copy of this authorization. I agree that this authorization will be valid for two and one-half years from the date shown below. I know that I may revoke this authorization at any time except to the extent that action is taken in reliance to it.

If the undersigned is signing in a representative capacity, the undersigned warrants that he or she has the authority to bind the entity on whose behalf this document is being executed.

Insured	Date	Additional Insured, if any	Date
Policy Owner, if other than Insured	Date	Policy Owner, if other than Insured	Date
Assignee or Irrevocable Beneficiary, if applicable	Date	Other SIgnature, if required	Date

REQUEST FOR CONVERSION OF TERM INSURANCE

NOTE: If converting to a greater face amount than that currently in force, or adding benefits or riders, please complete Part B of this Policy Change Application. To qualify for the Non-Smoker's Discount, please complete Part B, #6.

RE: Policy Number _____ On the Life of _____

I/We, the undersigned, hereby request that ❑ all, or ❑ $ _____ of the term insurance provided under ❑ the above numbered policy or ❑ the _____ provision of the above-numbered policy be converted into insurance under a new policy of life insurance on the life of the above-named person.

Any remaining term insurance under the Policy is to be:

❑ cancelled as of date of conversion ❑ continued under original policy

New Policy Hereby Applied For

New Plan:	Date of Policy:	
Face Amount: $	This date shall be equivalent to the most current monthly premium due date under the original policy(ies), or the date of conversion, which is only available for (a) special PAC/EFT withdrawal date or (b) backdating to save age.	

Smoker: ❑ Yes ❑ No

Premiums To Be Paid:

❑ Annually ❑ PAC/EFT

❑ Semi-Annually ❑ Add to existing PAC/EFT under Policy No. _____

❑ Quarterly ❑ New PAC/EFT Form attached

Universal Life Plans Only

Death Benefit: ❑ Option A (Increasing) ❑ Option B (Level)

Billed Amount (or minimum required, if greater): $_____

Automatic Payment Benefit? ❑ Yes ❑ No ❑ APB Annual Amount $_____

Additional Benefits/Riders: _____

NON-Universal Life Plans

Waiver of Premium? ❑ Yes ❑ No Automatic Premium Loan, if available? ❑ Yes ❑ No

Dividend Option: ❑ Paid-Up Additions ❑ Repay Policy Loan ❑ Accumulate at Interest

❑ Reduce Premium (not avail. with PAC/EFT) ❑ Other _____

❑ Cash ❑ Purchase One-Yr. Term (Balance of div. to be _____)

❑ ECO Face Amt: $ _____ (or maximum avail., if less) ❑ Waiver of Premium

❑ ABR-Ann. Prem: $_____ ❑ ABR-Sgl. Prem: $_____ ❑ Term Rider: $_____

❑ Accidental Death: $_____ ❑ Guaranteed Insurability - No. of Units: _____

❑ Other: _____

REMARKS: (Not Applicable in West Virginia

IT IS HEREBY AGREED THAT:

(a) This application and such other material as may be required herewith shall form the basis of the contract evidenced by the new policy; and

(b) Unless otherwise provided in the above-numbered policy, any additional benefits to be included in the new policy shall be subject to such evidence of insurability as the Company may require, in which event, the insurance under any such additional benefit will not take effect until the new policy has been approved at the Home Office and any required premium has been paid while the facts concerning the insurability of the Proposed Insured are the same as described in this application.

If the undersigned is signing in a representative capacity, the undersigned warrants that he or she has the authority to bind the entity on whose behalf this document is being executed.

Policy Owner Signature	Date	Insured Signature	Date
SSN or Tax I.D. Number of Policy Owner		Other Signature, if required	Date