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
REINSTATEMENT	1
RE-ENTRY	2
INCREASE SPECIFIED AMOUNT/CHANGE DEATH BENEFIT OPTION	3
REVIEW OF EXTRA RATING/UNDERWRITING CLASS CHANGE	4
DIVIDEND OPTION CHANGE TO PAID-UP ADDITIONS	5
SMOKING QUESTIONNAIRE	6
STATEMENT OF HEALTH/DETAILS	7, 8

NOTE:

You must complete all of Part B, a HIPAA and a Physician Information form for the following requests: Reinstatement, Re-entry, Increase Specified Amount or Change Death Benefit Option, Review of Extra Rating or Underwriting Class Change, Dividend Option Change to Paid-Up Additions, 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.
- 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.

2. RE-ENTRY

❑ Please exchange this policy on the re-entry date.

3. INCREASE SPECIFIED AMOUNT/CHANGE DEATH BENEFIT OPTION (For UNIVERSAL LIFE Plans Only)

Change to Option: ❑ Increasing ❑ Level ❑ New Specified Amount: $

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

4. REVIEW OF EXTRA RATING/UNDERWRITING CLASS CHANGE

❑ Please review the existing additional rating on this policy for possible reduction/removal.

❑ Please review the underwriting class (Preferred or Preferred Plus, if available)

❑ Please change to Non-Tobacco/Non-Smoker

5. DIVIDEND OPTION CHANGE TO PUA/OYT

❑ Please CHANGE the divident option to Paid-Up Additions

Existing dividend credits (if any) will be applied under the new option unless indicated below

❑ Please apply existing dividend credits to this option ❑ Withdraw

❑ Leave at credit under existing option ❑ Other:

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:

PART B (Continued from Previous Page)

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?	❑	❑

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

8. (Continued from Previous Page) 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

FEDERAL FAIR CREDIT REPORTING ACT NOTIFICATION

THE FEDERAL FAIR CREDIT REPORTING ACT REQUIRES THAT YOU BE GIVEN A COPY OF THIS NOTICE

This is to inform you that as part of Canada Life's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your: character; general reputation; personal characteristics; and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Canada Life Assurance Company or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in it's file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set form in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The Canada Life Assurance Company or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THE CANADA LIFE ASSURANCE COMPANY INFORMATION PRACTICES

This notice is provided to give you a brief description of our information practices. If you would like a more detailed description, please write to us at the address shown below.

One of our important objectives is to see that our insurance coverages are priced in a way that is fair to all policyholders. To do this, we need personal information about you and your family members proposed for coverage under your policy. You are the prime source of that information, but we may also obtain information from other sources such as physicians, hospitals, the Medical Information Bureau and consumer reporting agencies. You may request to be interviewed in connection with the preparation of a consumer report and you are entitled to obtain a copy of the report on request.

The information about you which we obtain and keep in our files will not be disclosed to others without your authorization except to the extent necessary to conduct our business. For example, some may be disclosed for research study purposes, but no report of such studies would include identification of individuals.

You have a right of access to information we maintain in our files about you (medical information is normally disclosed only to a physician of your choice) and to request correction of any information you believe to be incorrect. Should you wish further details about your right of access or our information practices, write to: Underwriting Department, The Canada Life Assurance Company, 8515 East Orchard Road, Greenwood Village, Colorado 80111, USA.