SSQ insurance

## Individual insurance

# Policy application

For the following products:

- Permanent life
- Term life
- Critical illness
- Universal life

**Version: May 2021**

SSQ, Life Insurance Company Inc.
1225 Saint-Charles Street West, Suite 200
Longueuil, Quebec  J4K 0B9

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# Application – Individual Insurance

**SSQ, Life Insurance Company Inc.**, 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

RESET FORM

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| | T 843 531 411 |

## A – Basic information

- For more than 2 insureds, use additional applications as required.
- Enter the number of the primary application on each additional application and submit all applications together.
- **Please submit ALL the pages of this application, even if there is no information written on certain pages.**

☐ Preliminary application ☐ New application Language of correspondence: ☐ English ☐ French

Nature of application: ☐ Primary ☐ Additional to application **or** policy no.: _____

Internal cancellation and replacement **(complete)**: ☐ Yes ☐ No Cancelled policy no.: _____

Internal cancellation and replacement **(partial)**: ☐ Yes ☐ No Coverage cancelled: _____

**The cancellation will be processed when the new coverage or new contract will be issued.**

**Policy changes requiring evidence of insurability**

**If the policy is not already governed by the tax rules in effect as of January 1st 2017, certain changes that require evidence of insurability may cause a change to the tax rules applicable to the policy.**

**If there is more than one policyowner, EACH policyowner must sign Section L of this application.** For any addition of insured or addition of benefit on a policy, each insured and/or policyowner covered by Waiver of Premium on such policy must complete Sections I and J (use additional applications as required).

To request a policy change requiring evidence of insurability, complete the following sections of this application in accordance with the type of change requested:

☐ **Addition of insured** – Not available for any universal life insurance policy.
Complete Sections B1, B2, (B3, B4 and B6 if addition of whole life insurance or addition of policyowner), B5, B7, C, D5, E, F, G, H if child, I, J, K, L, N, O and the Authorization at the end of the application.

☐ **Addition of benefit or additional benefit** – The addition of term insurance benefits or critical illness insurance benefits on a universal life insurance policy is available only if the contract is individual. No addition available for a universal life insurance policy if the policy date is prior to January 1st 2017.
Complete Sections B1, B2 (B3, B4 and B6 if addition of whole life insurance or addition of policyowner), C, D5, E, F, H if child, I, J, K, L, N and the Authorization at the end of the application.

☐ **Revision of rating**
Complete Sections B1, B2, I, J, K, L, N and the Authorization at the end of the application.

☐ **Revision of exclusion / class (12 months after date of issue only)**
Complete Sections B1, B2, I, J, K, L, N and the Authorization at the end of the application.

☐ **Change to non-smoker rates – $25 fee for universal life insurance**
Complete Sections B1, B2, I, J, K, L, N and the Authorization at the end of the application.
(if change to non-smoker rate only, please complete the *Request for Non-smoker rates form*)

**Changes without evidence of insurability**

For any policy change request that does not require evidence of insurability, use the *Policy change without evidence of insurability* form.

**Change of beneficiary**

For any change of beneficiary request, use the *Change of beneficiary(ies)* form.

**Reinstatement**

For any reinstatement request, use the *Policy reinstatement* form.

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## B – General information

### B1 – Proposed insured(s)

Please write the first name and last name of the insured in capital letters.

- The first name and last name will appear on the insurance contract as indicated in this section.
- Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.
- When the address of the insured 2 is not indicated, we consider that it corresponds to that of the insured 1.

| Insured 1 | Insured 2 |
|---|---|
| ☐ Mr. ☐ Mrs. ☐ Ms. | ☐ Mr. ☐ Mrs. ☐ Ms. |
| First name | First name |
| Last name | Last name |
| Name at birth (if different) | Name at birth (if different) |
| Y Y Y Y M M D D<br>Date of birth | Y Y Y Y M M D D<br>Date of birth |
| Age* | Age* |
| ☐ Male ☐ Female<br>Sex | ☐ Male ☐ Female<br>Sex |
| Place of birth (country and city) | Place of birth (country and city) |
| If you were born **outside** of Canada, complete the information below: | If you were born **outside** of Canada, complete the information below: |
| Arrival date: Y Y Y Y M M D D | Arrival date: Y Y Y Y M M D D |
| Legal status in Canada: | Legal status in Canada: |
| ☐ Canadian citizen | ☐ Canadian citizen |
| ☐ Permanent resident (holds a permanent resident card) | ☐ Permanent resident (holds a permanent resident card) |
| ☐ Work permit (attach a copy of the work permit and a letter from Citizenship and Immigration Canada confirming the permanent residence request) | ☐ Work permit (attach a copy of the work permit and a letter from Citizenship and Immigration Canada confirming the permanent residence request) |
| ☐ Refugee | ☐ Refugee |
| ☐ Other (specify): | ☐ Other (specify): |
| (attach a letter from Citizenship and Immigration Canada confirming the permanent residence request) | (attach a letter from Citizenship and Immigration Canada confirming the permanent residence request) |

* Age at nearest birthday, that is six (6) months before or after the date the application is signed.

| Residential Address | Residential Address |
|---|---|
| Civic number and street name / Apt. | Civic number and street name / Apt. |
| City | City |
| Province / Postal code | Province / Postal code |
| Telephone (residential) | Telephone (residential) |
| E-mail address (internet) | E-mail address (internet) |

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## B2 – Employment details

| Insured 1 | Insured 2 |
|---|---|
| Profession/Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity) | Profession/Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity) |
| Tasks involved in occupation | Tasks involved in occupation |
| Nature of employer's business | Nature of employer's business |
| $ Gross annual income | $ Gross annual income |
| $ Net worth | $ Net worth |
| $ Other income | $ Other income |
| Specify source | Specify source |
| Employer's name | Employer's name |
| Civic number and street name | Civic number and street name |
| Suite number | Suite number |
| City | City |
| Province | Province |
| Postal code | Postal code |
| Telephone (office) | Telephone (office) |

## B3 – Policyowner(s)

- **When the policyowner(s) are not indicated, we consider that it corresponds to the insured(s) - Maximum 2 policyowners per policy.**
- **For whole life and universal life insurance, when the policyowner is a corporation or another type of entity, please complete the *Verification of the existence (identity) of corporations and other entities* form (FRA1235A) available in the "Forms and Questionnaires — Anti-money laundering" section of the library in the illustration software.**

**The policyowner(s) is (are):** ☐ Insured1 ☐ Insured 2 ☐ A distinct policy will be issued for insured 1 and insured 2. Each insured will be the sole policyowner of their policy. ☐ Other (if a policyowner is not one of the insureds, please provide the information requested below)

When the address of the policyowner 2 is different thant policyowner 1, we consider that the mailing address corresponds to that of the policyowner 1.

| Policyowner 1 (if not an insured) | Policyowner 2 (if not an insured) |
|---|---|
| First and last names or full legal name of company or other entity | First and last names or full legal name of company or other entity |
| Relationship to insured | Relationship to insured |
| Business number (if applicable) | Business number (if applicable) |
| Address | Address |
| Telephone | Telephone |
| **Principal business or detailed occupation and field of activity** (if retired, indicate the last profession and field of activity) | **Principal business or detailed occupation and field of activity** (if retired, indicate the last profession and field of activity) |
| **Complete if Waiver of Premium is requested** | **Complete if Waiver of Premium is requested** |
| Y Y Y Y M M D D Date of birth | Y Y Y Y M M D D Date of birth |
| Place of birth | Place of birth |
| Age* | Age* |
| Sex ☐ M ☐ F | Sex ☐ M ☐ F |

* Age at nearest birthday, that is six (6) months before or after the application.

Upon the death of a policyowner, the rights and interests of such deceased policyowner in the policy shall be transferred to the contingent / successor policyowner designated in this section.

| | |
|---|---|
| First and last name of contingent / successor policyowner 1 | First and last name of contingent / successor policyowner 2 |
| Relationship to insured | Relationship to insured |
| Y Y Y Y M M D D Date of birth | Y Y Y Y M M D D Date of birth |

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## B4 – Declaration of Tax Residence of policyowner(s) (self-certification)

(applicable to whole life and universal life insurance products)

The insured(s) and the policyowner(s) must be tax residents of Canada in order for an insurance policy to be issued. The information provided on the Declaration of Tax Residence section must be correct and complete. The policyowner(s) must provide SSQ, Life Insurance Company Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to be incomplete or inaccurate (for example, changing a bank account for one in a financial institution in a country other than Canada or the United States, changing an address for an address in a country other than Canada or the United States, etc.).

**The policyowner is a corporation or other type of entity**

The Declaration of Tax Residence must be completed on the form V*erification of the existence (identity) of corporations and other entities* (FRA1235A).

| Policyowner 1 (individual) | Policyowner 2 (individual) |
|---|---|
| **Check (✓) all options that apply to you:** | **Check (✓) all options that apply to you:** |
| ☐ I am a tax resident of Canada | ☐ I am a tax resident of Canada |
| ☐ I am a tax resident in a jurisdiction other than Canada or the United States → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is mandatory.** | ☐ I am a tax resident in a jurisdiction other than Canada or the United States → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is mandatory.** |

## B5 – Identity verification

The financial security advisor / representative must:

- complete this section for any insurance application;
- verify the identity of each insured at all times;
- verify the identity of each policyowner, if not an insured (applicable to whole life insurance and universal life insurance- required by *the Proceeds of Crime (Money Laundering) and Terrorist Financing Act)*;
- review the applicable document indicated below for that person (must be a government issued photo identification document). In Quebec, you are not allowed to request the client's Health Card, but you can accept it only if the client offers it to you. In the provinces of Ontario, Manitoba, Nova Scotia and Prince Edward Island, the use of a Health Card for identification purposes is prohibited;
- indicate, for each person, which of the required documents has been reviewed, its number, its expiration date and jurisdiction. The identifying document must be an unexpired original. If the document is "Other photo identification document admissible by Law", please specify the type of document verified.

| Insured 1 | Insured 2 |
|---|---|
| **Name of the insured (as appearing on the document)** | **Name of the insured (as appearing on the document)** |
| ☐ Driver's licence ☐ Passport ☐ Citizenship card with photo | ☐ Driver's licence ☐ Passport ☐ Citizenship card with photo |
| ☐ Other photo identification document admissible by Law (specify): | ☐ Other photo identification document admissible by Law (specify): |
| Document number | Jurisdiction |
| Document number | Jurisdiction |
| Y Y Y Y M M D D<br>Document expiration date | SIN* |
| Y Y Y Y M M D D<br>Document expiration date | SIN* |

* When the insured and the policyowner are the same person, the Social Insurance Number (SIN) is required for tax purposes (applicable for whole life and universal life insurance products);

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**Complete *the Identity verification for each policyowner, if not an insured (applicable to whole life insurance and universal life insurance).***

## B5 – Identity verification (continued)

| Policyowner 1 | Policyowner 2 |
|---|---|
| **Name of the policyowner (as appearing on the document)** | **Name of the policyowner (as appearing on the document)** |
| Is the policyowner a canadian citizen or a permanent resident (holds a permanent resident card)? | Is the policyowner a canadian citizen or a permanent resident (holds a permanent resident card)? |
| ☐ Yes ☐ No | ☐ Yes ☐ No |
| **The policyowner must be a canadian resident.** | **The policyowner must be a canadian resident.** |
| ☐ Driver's licence ☐ Passport ☐ Citizenship card with photo | ☐ Driver's licence ☐ Passport ☐ Citizenship card with photo |
| ☐ Other photo identification document admissible by Law (specify): | ☐ Other photo identification document admissible by Law (specify): |
| Document number / Jurisdiction | Document number / Jurisdiction |
| Document expiration date (Y Y Y Y M M D D) / SIN* | Document expiration date (Y Y Y Y M M D D) / SIN* |

* Social Insurance Number (SIN) required for tax purposes (applicable for whole life and universal life insurance products); not required when the policyowner is a corporation or another type of entity.

## B6 – Third party determination (applicable for whole life and universal life insurance products)

In accordance with the ***Proceeds of Crime (Money Laundering) and Terrorist Financing Act*** and its regulations, the financial security advisor / representative must make reasonable efforts to determine, with regard to the present application, if the policyowner(s) is (are) acting on behalf of a third party (individual, company or other type of entity).

When you must determine whether a "third party" is involved, it is not about who "owns" the money, but rather about who gives instructions to deal with the money. If the individual in front of you is acting on someone else's instructions, that someone else is the third party. For the purposes of third party determination, employees acting on behalf of their employers are considered to be acting on behalf of a third party.

When the premium payer is a different person or entity than the policyowner(s), the payer is considered a third party and the section below must be completed.

**Is (are) the policyowner(s) acting on behalf of a third party (individual, company or other type of entity) or is there a third party to this contract?**

☐ Yes → complete the "Third party identification" section below.
☐ No
☐ It is impossible to determine whether the policyowner(s) is (are) acting on behalf of a third party, but I have reasonable grounds to believe that he/she (they) is (are) → complete the "Third party identification" section below.

**Is the person or entity paying the premiums/amounts in the insurance contract different from the policyowner(s)?**

☐ Yes → complete the "Third party identification" section below.
☐ No

**Third party identification (if applicable)**

Name of the third party / Date of birth (if third party is an individual) (Y Y Y Y M M D D)

Full permanent address of the third party

Principal business or detailed occupation and field of activity (if retired, indicate the last profession) / Relationship between the third party and the policyowner(s)

**If the third party is a corporation or other type of entity:** Business number / Place of issuance of its certificate of constitution

If you cannot obtain the above-mentioned information on the third party, please provide the reasons in the space below:

If you cannot determine if the policyowner is acting on behalf of a third party, but have reasonable grounds to suspect that he is, please provide the reasons in the space below:

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## B7 – Beneficiary(ies) – life insurance, critical illness rider and critical illness insurance

- Indicate both the first name and the last name of the person who will receive the sums insured when they become payable under the chosen benefits. If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) or their estate(s), as the case may be.
- If more than one beneficiary is designated, indicate the percentage allocated for each beneficiary. The total allocation must be 100%. If the allocated percentages are not indicated, the sums insured will be divided evenly among the surviving eligible beneficiaries.
- Beneficiary designations are revocable, unless stated otherwise. In Quebec however, the designation of a legally married or civil union spouse of the policyowner is irrevocable unless stated to be revocable.
- If the beneficiary predeceases the proposed insured, the sums insured are payable to the contingent beneficiary upon the death of the proposed insured.

**Beneficiary(ies) for life insurance**

| Insured 1 | Insured 2 |
|---|---|
| _____ _____ % | _____ _____ % |
| **First and last names of beneficiary 1** | **First and last names of beneficiary 1** |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse | ☐ Common-law spouse |
| ☐ Married/Civil union spouse | ☐ Married/Civil union spouse |
| ☐ Other (specify): _____ | ☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **First and last names of beneficiary 2** | **First and last names of beneficiary 2** |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse | ☐ Common-law spouse |
| ☐ Married/Civil union spouse | ☐ Married/Civil union spouse |
| ☐ Other (specify): _____ | ☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **First and last names of beneficiary 3** | **First and last names of beneficiary 3** |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse | ☐ Common-law spouse |
| ☐ Married/Civil union spouse | ☐ Married/Civil union spouse |
| ☐ Other (specify): _____ | ☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **First and last names of beneficiary 4** | **First and last names of beneficiary 4** |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse | ☐ Common-law spouse |
| ☐ Married/Civil union spouse | ☐ Married/Civil union spouse |
| ☐ Other (specify): _____ | ☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |

## B7 – Beneficiary(ies) – life insurance, critical illness rider and critical illness insurance (continued)

### Contingent beneficiary(ies) for life insurance

| Insured 1 | Insured 2 |
|---|---|
| _____ _____ % | _____ _____ % |
| **Contingent beneficiary 1** (In case of death of the beneficiary 1 designated above; the percentage must be equivalent) | **Contingent beneficiary 1** (In case of death of the beneficiary 1 designated above; the percentage must be equivalent) |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ | ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **Contingent beneficiary 2** (In case of death of the beneficiary 2 designated above; the percentage must be equivalent) | **Contingent beneficiary 2** (In case of death of the beneficiary 2 designated above; the percentage must be equivalent) |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ | ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **Contingent beneficiary 3** (In case of death of the beneficiary 3 designated above; the percentage must be equivalent) | **Contingent beneficiary 3** (In case of death of the beneficiary 3 designated above; the percentage must be equivalent) |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ | ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |
| _____ _____ % | _____ _____ % |
| **Contingent beneficiary 4** (In case of death of the beneficiary 4 designated above; the percentage must be equivalent) | **Contingent beneficiary 4** (In case of death of the beneficiary 4 designated above; the percentage must be equivalent) |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ | ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |

### Beneficiary(ies) for Critical Illness Rider

- If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) for the Critical Illness Rider.

| Insured 1 | Insured 2 |
|---|---|
| _____ | _____ |
| **First and last names of beneficiary** | **First and last names of beneficiary** |
| Relationship to insured (in Quebec, relationship to policyowner) | Relationship to insured (in Quebec, relationship to policyowner) |
| ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ | ☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____ |
| Designation: ☐ Revocable ☐ Irrevocable | Designation: ☐ Revocable ☐ Irrevocable |

## B7 – Beneficiary(ies) – life insurance, critical illness rider and critical illness insurance (continued)

**Beneficiary(ies) for Critical Illness Insurance**

- If there is no beneficiary designation, the sums insured will be payable to the policyowner(s) or their estate(s), as the case may be.

| Insured 1 | Insured 2 |
|---|---|
| **First and last names of beneficiary(ies) for Critical Illness benefit**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable | **First and last names of beneficiary(ies) for Critical Illness benefit**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable |
| **First and last names of beneficiary(ies) for Return of Premium on Death benefit (critical illness)**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable | **First and last names of beneficiary(ies) for Return of Premium on Death benefit (critical illness)**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable |
| **First and last names of beneficiary(ies) for Return of Premium on Surrender benefits (critical illness)**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable | **First and last names of beneficiary(ies) for Return of Premium on Surrender benefits (critical illness)**<br>Relationship to insured (in Quebec, relationship to policyowner)<br>☐ Common-law spouse<br>☐ Married/Civil union spouse<br>☐ Other (specify): _____<br>Designation: ☐ Revocable ☐ Irrevocable |

When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes. Not applicable in Quebec. If a trust is constituted, please complete the information below.

Full name of the trustee

Relationship to insured

# C – Insurance products and benefits

## C1 – Permanent life insurance

- Specify coverage and face amount for each insured.

| Insured 1 | | Insured 2 | |
|---|---|---|---|
| | **Face amount** | | **Face amount** |
| **Whole Life 20**<br>☐ Individual/Multi-Life | $ | **Whole Life 20**<br>☐ Individual/Multi-Life | $ |
| **Whole Life 100**<br>☐ Individual/Multi-Life<br>☐ Joint, First to die<br>☐ Joint, Last to die | $ | **Whole Life 100**<br>☐ Individual/Multi-Life<br>☐ Joint, First to die<br>☐ Joint, Last to die | $ |
| **Term 100**<br>☐ Individual/Multi-Life<br>☐ Joint, First to die<br>☐ Joint, Last to die | $ | **Term 100**<br>☐ Individual/Multi-Life<br>☐ Joint, First to die<br>☐ Joint, Last to die | $ |

## C2 – Term life insurance

- Specify coverage and face amount for each insured.

| Insured 1 | | Insured 2 | |
|---|---|---|---|
| | **Face amount** | | **Face amount** |
| **Term Plus 10**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 10**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 15**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 15**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 20**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 20**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 25**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 25**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 30**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 30**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 35**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 35**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Term Plus 40**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ | **Term Plus 40**<br>☐ Individual/Multi-Life – level<br>☐ Individual/Multi-Life – decreasing<br>☐ Joint, First to die – level<br>☐ Joint, First to die – decreasing | $ |
| **Total face amount:** | $ _____ | **Total face amount:** | $ _____ |

## C2 – Term life insurance (continued)

**Disability Rider (Term life insurance only)**

- The monthly indemnity amount requested must be determined following a needs analysis and based on eligible loans and monthly payments. The benefit payable in the event of a total disability claim may differ from the amount requested, as mentioned in Section L (article 7).
- Certain occupations are not insurable. Please refer to the *List of non-insurable occupations* available in the library of the illustration software. Note that a spouse on parental leave must have a regular occupation insurable according to our criteria to be eligible for a maximum amount of $1,000.

| | Insured 1 | Insured 2 |
|---|---|---|
| 1. Eligibility | | |
| a) Are you a stay-at-home spouse? If YES, maximum amount of up to $1,000 and duration of 2 years. Note: eligible only if the spouse is covered under the present policy. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) Are you a spouse on parental leave? If YES, maximum amount of up to $1,000 and duration of 2 years. Note: eligible only if the spouse is covered under the present policy. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) Do you currently work at least 21 hours per week? If NO, not eligible for disability rider. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) Have you worked 8 months or more during the last 12 months at a rate of at least 21 hours per week? If NO, not eligible for disability rider. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Home-based work (or from the home(s) of your clients) What percentage of your time do you work from home (or from the home(s) of your clients)? | _____ % | _____ % |
| 3. Insurance need (based on needs analysis) | $ / month | $ / month |
| 4. Amount requested (min. $300, max. 1.5% of the life insurance amount requested without exceeding $3,500) | $ / month | $ / month |
| 5. Duration | ☐ 2 years ☐ 5 years ☐ Up to age 65 | ☐ 2 years ☐ 5 years ☐ Up to age 65 |
| 6. a) Are the loans for which the disability insurance amount is requested already covered by another disability insurance policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) Are they covered by a creditor's group disability insurance offered by a bank, credit union or other lender? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) If YES, will this insurance be replaced? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Critical Illness Rider**

* available only when the initial life insurance request is submitted or when adding a life insurance face amount for which evidence of insurability is required.

| | | |
|---|---|---|
| Critical Illness Rider – $20,000 | ☐ Yes ☐ No | ☐ Yes ☐ No |

## C3 – Critical illness insurance

**Critical illness insurance - adult**

- Complete Section B7.
- Critical illness insurance is only available in Individual/Multi-Life coverage.
- The Return of Premium (ROP) is available only when the initial critical illness insurance is submitted or when adding a critical illness insurance face amount for which evidence of insurability is required.

| Insured 1 | | | | Insured 2 | | | |
|---|---|---|---|---|---|---|---|
| **Critical illness insurance** | Basic | Enhanced | **Face amount** | **Critical illness insurance** | Basic | Enhanced | **Face amount** |
| T10 | ☐ | ☐ | $ | T10 | ☐ | ☐ | $ |
| T20 | ☐ | ☐ | $ | T20 | ☐ | ☐ | $ |
| T75 | ☐ | ☐ | $ | T75 | ☐ | ☐ | $ |
| T100 | ☐ | ☐ | $ | T100 | ☐ | ☐ | $ |
| T100 paid-up 20 years | ☐ | ☐ | $ | T100 paid-up 20 years | ☐ | ☐ | $ |

**Additional benefits**

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation**

*ROP at expiry is available for T10, T20 and T75.

**ROP on cancellation is available for T75, T100 and T100 paid-up 20 years.

**Additional benefits**

☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation**

*ROP at expiry is available for T10, T20 and T75.

**ROP on cancellation is available for T75, T100 and T100 paid-up 20 years.

## C3 – Critical illness insurance (continued)

**Critical illness insurance - Child**

- Complete Section B7.
- Critical illness insurance is only available in Individual/Multi-Life coverage.

| Insured 1 | | Insured 2 | |
|---|---|---|---|
| **Critical illness insurance** | **Face amount** | **Critical illness insurance** | **Face amount** |
| T75 | $ | T75 | $ |
| T100 | $ | T100 | $ |
| T100 paid-up 20 years | $ | T100 paid-up 20 years | $ |
| **Additional benefits** | | **Additional benefits** | |
| ☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation | | ☐ ROP on death ☐ ROP at expiry* ☐ ROP on cancellation | |
| *ROP at expiry is available for T75 only. | | *ROP at expiry is available for T75 only. | |

## C4 – Universal life insurance

| | |
|---|---|
| **Type of coverage** | ☐ Individual ☐ Joint, First to die ☐ Joint, Last to die |
| **Face Amount** | $ _____ |
| **Cost of insurance type** | ☐ Yearly Renewable Term (YRT)<br>☐ T100<br>☐ Other (specify): _____ |
| **Death benefit option** | ☐ Level death benefit (only available for the YRT cost of insurance type)<br>☐ Increasing death benefit<br>When the death benefit is increasing:<br>**For a Joint, Last to die policy, funds will be payable upon last death.** |
| **Waiver of Premium**<br>- For a Joint policy, when more than one insured subscribes to Waiver of Premium, each insured will be covered by the same type of Waiver of Premium and for the same Duration. | **Insured 1:** ☐ Yes ☐ No **Insured 2:** ☐ Yes ☐ No<br>**Duration:** ☐ 4 months ☐ 6 months<br>**Type:**<br>☐ Waiver of minimum premium: $ _____<br>☐ Waiver of billing premium (up to the maximum premium): $ _____<br>Waiver of Premium for the policyowner(s) – (if the policyowner is not one of the insureds)<br>Name(s) of the policyowner(s): _____<br>- Complete Sections B3, I and J if the Waiver of Premium is for the policyowner and the policyowner is not one of the insureds. |
| **Face amount adjustment** (tax exemption)<br>- If there is no option chosen, the "No Increase" option will be applied by default. | ☐ Option 1: No Increase – No face amount increase (transfer of the excess funds to the transitory deposit account);<br>☐ Option 2: Exempt Test Increase – Face amount increase (maximum 8%) and, if necessary, transfer of the excess funds to the transitory deposit account;<br>☐ Option 3: Increase and Decrease – Increase and decrease of the face amount (minimum equals initial face amount);<br>☐ Option 4: Maximizer (complete the "Information for the Maximizer option" section below).<br>The Maximizer option is only available for the YRT cost of insurance type. |

## C4 – Universal life insurance (continued)

### Maximizer option

- Do not forget to specify durations and face amount.
- In the absence of details regarding the durations and minimum face amount, the default values are as follows: The beginning of duration will correspond to *6 years from the issue date*, the end of the duration will correspond to *100 years less the insured's age at issue* and the minimum face amount will correspond to *face amount of the policy*.

### Optimization of exemption test

☐ Beginning of the duration: _____ years (minimum duration: 6 years from issue date)

☐ End of the duration: _____ years (maximum duration: 100 years minus the age of the insured at issue date)

☐ Minimum face amount: $ _____ (minimum $25,000, maximum face amount chosen)

### Investment options and percentage split

- Please indicate your investment choices and percentage split below.
- The total percentage split must equal 100% (minimum 10% per account).
- In case no investment account is chosen, premiums and deposits are credited in the daily interest account.
- For two accounts or more, if no split percentage is specified, premiums and deposits are equally divided between the accounts.

In order to help you choose an appropriate investment strategy, it is necessary to assess your risk tolerance and the amount of return you hope to achieve, while taking into account your time horizon. Each investor's target asset allocation mix is determined according to their situation, needs and constraints. With these factors in mind, it is necessary that your financial security advisor / representative establishes your investor profile with you in order for him/her to advise you accordingly.

| **Managed accounts** | | **Interest accounts** | |
|---|---|---|---|
| Conservative Strategy | % | Daily interest account | % |
| Balanced Strategy | % | 1-year guaranteed interest account | % |
| Growth Strategy | % | 3-year guaranteed interest account | % |
| Aggressive Strategy | % | 5-year guaranteed interest account | % |
| 100% Equity Strategy (available as of June 21, 2021) | % | 10-year guaranteed interest account | % |
| CI Cambridge Canadian Asset Allocation | % | **Indexed accounts** | |
| CI Signature Global Income and Growth | % | Canadian Money Market (3-month Treasury Bill) | % |
| Guardian Conservative Monthly Income | % | Canadian Bonds (FTSE Canada Universe Bond) | % |
| Guardian Monthly Income | % | Canadian Equity (S&P/TSX) | % |
| PIMCO Bond | % | US Equity (S&P 500) | % |
| PIMCO Global Bond | % | US Equity, Technology (MSCI US IM Information Technology 25/50) | % |
| Triasima Canadian Equity | % | Small Cap US Equity (S&P SmallCap 600) | % |
| Guardian Canadian Dividend Equity | % | International Equity (MSCI EAFE) | % |
| Hillsdale US Equity | % | Global Equity (MSCI World Ex Canada) | % |
| Fiera Capital Global Equity | % | Emerging Market Equity (MSCI Emerging Markets) | % |
| TD Global Dividend Equity | % | **Other (specify)** | |
| C WorldWide International Equity | % | | % |
| Lazard Global Infrastructure | % | | % |
| Fisher Emerging Markets Equity | % | | % |
| CI Global Real Estate (available as of June 21, 2021) | % | | % |
| | | **TOTAL** | **100%** |

### Transitory deposit account

- The transitory deposit account will be credited in accordance with the yield of the daily interest account.

## C5 – Additional benefits

| | Insured 1 | Insured 2 |
|---|---|---|
| Critical Illness Rider – $20,000* | ☐ | ☐ |
| Accidental Death and Dismemberment (ADD)* | Face amount: $ | Face amount: $ |
| Benefit in case of fracture* | ☐ | ☐ |
| Waiver of Premium (WP) 4 months | ☐ | ☐ |
| Waiver of Premium (WP) 6 months | ☐ | ☐ |

Waiver of Premium for the policyowner(s) – (if the policyowner is not one of the insureds)

Name(s) of the policyowner(s): _____

- Sections B3, I and J must be completed by each policyowner who is not one of the insureds and is applying for Waiver of Premium.

* available only when the initial life insurance request is submitted or when adding a life insurance face amount for which evidence of insurability is required.

**Coverage for children**

| | |
|---|---|
| Child Rider (CR) – (life insurance products only)<br>For Child Rider (CR), complete Section H. | Face amount: $ |
| Children's Endorsement (CE) – (critical illness products only)<br>For Children's Endorsement (CE), complete Section H and the *Critical Illness Questionnaire – Child.* | Face amount: $ |

## D – Payment of premiums

In accordance with the ***Proceeds of Crime (Money Laundering) and Terrorist Financing Act*** and its regulations, the financial security advisor / representative and the policyowner(s) must complete the *Determination of politically exposed persons and heads of an international organization (FRA1234A)* form for any lump sum deposit of $100,000 and more.

### D1 – First premium payment

- The payment of the first premium by pre-authorized debit will be withdrawn from the bank account indicated in Section M and appearing on the specimen cheque attached to this application.
- If the premium payment frequency is annual, the amount payable by credit card is limited to 1/12th of the annual premium (or 1/12th of the MINIMUM annual premium for universal life insurance), subject to a maximum of $5,000.
- If the premium payment frequency is monthly, the amount payable by credit card is limited to the first monthly premium (or first MINIMUM monthly premium for universal life insurance), subject to a maximum of $5,000.

Amount of first premium payment (amount paid with this application): $ _____

**Only check one box.**

Pre-authorized debit (available only if the payment frequency chosen in Section D3 is monthly)

- ☐ **Withdrawal upon receipt of this application**
- ☐ **Withdrawal upon settling of the policy**

☐ Enclosed cheque (payable to SSQ, Life Insurance Company Inc.).
**Cashed upon receipt of this application**

☐ Credit card **(in accordance with current legislation and regulation, when this type of payment is selected, the application must be sent by mail)**
**Cashed upon receipt of this application**
(complete Section P)

☐ On delivery of policy
**Payable upon receipt of settling requirements**

### D2 – Payment of premiums

Total of annual premium, including the primary application, as well as all additional applications: $ _____

Chosen or initial modal premium: $ _____

Annual billing premium for universal life insurance only (including all additional benefits): $ _____

### D3 – Payment frequency

☐ Annual
☐ Monthly (pre-authorized debits)

- If left blank, the payment frequency will be monthly.
- For pre-authorized debits, attach a specimen cheque and complete Section M.

### D4 – Day of withdrawal

☐ Day of withdrawal at issue date
**OR**
☐ Specify the day: _____

- If left blank, the day of withdrawal will be the policy issue date.
- If the day of withdrawal specified is the 29th, 30th or 31st, the day of withdrawal will be the 28th.
- **Universal life only: If the day of withdrawal specified is after the policy issue date, the day of withdrawal will be automatically changed to coincide with the policy issue date.**

### D5 – Policy change

Total premium amount for this policy change request: $ _____

New billing premium for the policy following the change (universal life insurance only): $ _____

**Method of payment**

☐ Enclosed cheque for the amount of: $ _____ Date of cheque: Y Y Y Y M M D D

☐ Pre-authorized debit drawn from the same bank account associated with the policy number mentioned on page 3 of this application

☐ Pre-authorized debit drawn from a new bank account (complete Section M and attach a specimen cheque)

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## E – Insurance in force (Section E must be completed at all times)

- If this application replaces any insurance in force, the prior notice of replacement form(s) must be completed and submitted, in accordance with the applicable terms of the concerned provinces, with the application or at the latest in the five (5) following working days (three (3) working days outside Quebec). A notice of replacement form is not required for the replacement of critical illness insurance, except in Quebec.
- If the insurance being replaced is a creditor's group insurance offered by a bank, credit union or other lender, a notice of replacement form is not required.

1. Do you have existing individual insurance?
**Insured 1 :** ☐ NO ☐ YES → If yes, please provide the information below.
**Insured 2 :** ☐ NO ☐ YES → If yes, please provide the information below.

| Insured No. | Company name | Amount | Type (Life, Disability, Critical Illness) | Year | Will this application replace in force insurance? | | Purpose of insurance | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Yes | No | Personal | Business |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |

| | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 2. Do you have any other applications that are pending or that have been submitted to other companies in the last six (6) months?<br>If yes, indicate name of company, the total amount of insurance that will be put into force and the type of insurance (life, critical illness or disability).<br>_____ | ☐ | ☐ | ☐ | ☐ |
| 3. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, rated, modified or postponed?<br>If yes, indicate date and reasons.<br>_____ | ☐ | ☐ | ☐ | ☐ |

4. If insurance for children:
   a) indicate the total amount of life insurance in force on the parents of the child: $ _____
   b) Please specify if there are other children and if so, indicate the amount of insurance in force on each one of them: $ _____

## F – Purpose of insurance

### F1 – Personal insurance

☐ Income / Loan protection ☐ Estate conservation ☐ Charitable donations

### F2 – Business insurance

**1. Type of business**

☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Other (specify): _____

**2. Purpose of insurance**

☐ Buy / sell agreement ☐ Collateral loan (specify the amount: $ _____) ☐ Estate planning ☐ Key person protection ☐ Other (specify at no. 7)

**3. Financial information of the company covering the last two (2) years:**

| | | | |
|---|---|---|---|
| Year: | Y Y Y Y | Year: | Y Y Y Y |
| Assets: | $ _____ | Assets: | $ _____ |
| Liabilities: | $ _____ | Liabilities: | $ _____ |
| Net profit: | $ _____ | Net profit: | $ _____ |
| Shareholders' Equity : | $ _____ | Shareholders' Equity: | $ _____ |
| Market value: | $ _____ | Market value: | $ _____ |

## F2 – Business insurance (continued)

**4. Please complete the following table for each shareholder.**
Indicate the name, title, percentage of shares as well as the amount of insurance in force and pending for each shareholder in the organization.

| Name | Title | % of shares | Insurance in force (business) | Insurance pending (business) |
|---|---|---|---|---|
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

**5. How long has the business been in operation?** _____

**6. If the associates are not insured for the same amount, please explain the reasons below.**

**7. Remarks**

## G – Temporary insurance agreement questions

- When questions 1 to 6 are answered "No" and the first premium has been received and is cashable on the date when the proposed insured(s) sign(s) the application, you are automatically eligible for temporary insurance.
- The temporary insurance agreement is not available for critical illness products and additional benefits.
- If the temporary insurance agreement is not applicable, any payment cashed upon receipt of this application will be applied towards the coming into effect of the insurance contract.

| | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 1. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, rated, postponed or otherwise modified? | ☐ | ☐ | ☐ | ☐ |
| 2. Have you ever suffered from any cardiovascular condition such as heart murmur, chest pain, palpitations, heart attack, peripheral vascular disease, cancer, AIDS or any other abnormality of the immune system? | ☐ | ☐ | ☐ | ☐ |
| 3. In the last three (3) months, have you been admitted to a medical facility, learned that you will be or that you are to undergo a medical procedure or evaluation for any reason other than for dental care, pregnancy or caesarean section? | ☐ | ☐ | ☐ | ☐ |
| 4. Have you ever been treated or have you been advised to undergo treatment for alcohol or drug abuse? | ☐ | ☐ | ☐ | ☐ |
| 5. In the last three (3) years, have you been found guilty of impaired driving, hazardous driving or refusing to submit to a breathalyzer test and/or has your driver's licence been suspended for any of the above reasons? | ☐ | ☐ | ☐ | ☐ |
| 6. Have you reached the age of 66 on the nearest birthday when the application is signed or is one of the insureds younger than 15 days old? | ☐ | ☐ | ☐ | ☐ |

## H – Child Rider / Children's Endorsement

**Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.**

1. _____ Y Y Y Y M M D D ☐ M ☐ F
a) First and last names b) Date of birth c) Sex

_____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the recommended treatments, if applicable

_____ _____ $ _____ Y Y Y Y M M D D
k) Insurance in force (life / critical illness) l) Company name m) Face amount n) Issue date

2. _____ Y Y Y Y M M D D ☐ M ☐ F
a) First and last names b) Date of birth c) Sex

_____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the recommended treatments, if applicable

_____ _____ $ _____ Y Y Y Y M M D D
k) Insurance in force (life / critical illness) l) Company name m) Face amount n) Issue date

3. _____ Y Y Y Y M M D D ☐ M ☐ F
a) First and last names b) Date of birth c) Sex

_____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
d) Relationship to policyowner(s) e) Height f) Weight

_____ _____ Y Y Y Y M M D D
g) Name of attending physician and/or hospital h) Address i) Date of last consultation

_____
j) Indicate the reason, the results and the recommended treatments, if applicable

_____ _____ $ _____ Y Y Y Y M M D D
k) Insurance in force (life / critical illness) l) Company name m) Face amount n) Issue date

| | Yes | No |
|---|---|---|
| 4. Has any child to be insured: | | |
| a) ever suffered from any congenital malformation or hereditary disease? | ☐ | ☐ |
| b) ever suffered from any other illness or affliction? | ☐ | ☐ |
| c) ever had an application for life insurance declined, rated or postponed? | ☐ | ☐ |
| **If you answered "yes" to questions 4 a), 4 b) or 4 c), give child(ren)'s first name(s) and provide details:** | | |
| **5. Are all the children to be insured presently in good health and free of any illness or affliction?** | ☐ | ☐ |
| If "no", give child(ren)'s first name(s) and provide details: | | |

If Children's Endorsement is chosen, also complete the *Critical Illness Questionnaire – Child.*

## I – Personal history

**- IF THE PARAMEDICAL OR MEDICAL EXAM IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION I.**

| Provide the details of all "Yes" answers here and if you need more space, continue in Section K. | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 1. a) In the last two (2) years, have you participated in activities such as motor vehicle racing, scuba diving, parachuting, ultralight flying, hang gliding, moutaineering or mountain climbing, bungee jumping, out of bounds skiing (heliski, catski, etc) or any other hazardous sports? If yes specify activity. _____ | ☐ | ☐ | ☐ | ☐ |
| b) Do you intend to practice any of these activities in the next two (2) years? If yes specify activity. _____ | ☐ | ☐ | ☐ | ☐ |
| 2. a) In the last three (3) years, have you flown in an aircraft as a pilot, student pilot or crew member? If yes, specify. _____ | ☐ | ☐ | ☐ | ☐ |
| b) Do you intend to practice aviation as a pilot, student pilot or crew member? If yes, specify. _____ | ☐ | ☐ | ☐ | ☐ |
| 3. a) In the last three (3) years, have you been convicted of two (2) or more driving offences and/or had your driver's licence suspended? If yes, provide dates and details. _____ | ☐ | ☐ | ☐ | ☐ |
| b) In the last ten (10) years, have you been charged with or convicted of impaired driving, hazardous driving or have you refused to take a breathalyzer test and/or had your licence suspended for any of these reasons? If yes, provide dates and relevant details. _____ | ☐ | ☐ | ☐ | ☐ |
| 4. a) Do you consume alcohol beverages? If yes, specify type and number of drinks consumed on a weekly basis (1 drink = 1 glass of wine (5 ounces) or 1 beer (12 ounces) or 1.5 ounces of spirits). _____ | ☐ | ☐ | ☐ | ☐ |
| b) Has your level of alcohol beverages been higher in the past? If yes, specify type, number of drinks consumed on a weekly basis and date of change in habits (1 drink = 1 glass of wine (5 ounces) or 1 beer (12 ounces) or 1.5 ounces of spirits). _____ | ☐ | ☐ | ☐ | ☐ |
| **If you answered "YES" to questions 4 a) or 4 b), please answer question 4 c) below.** | | | | |
| c) Have you ever received or been advised to undergo treatment for alcohol abuse, or received counselling for this problem? If yes, indicate date, treatment, result and complete the Alcohol Use questionnaire. _____ | ☐ | ☐ | ☐ | ☐ |
| 5. a) Do you use or have ever used drugs such as cannabis (marijuana, haschich, etc) LSD, cocaine, heroin, amphetamines (speed), anabolic steroids or other narcotics? | ☐ | ☐ | ☐ | ☐ |

**If yes, provide the information below and answer question 5 b) below:**

| Insured's name | Type | Quantity | Frequency of use | Dates of use |
|---|---|---|---|---|
| | | | | from to |
| | | | | from to |
| | | | | from to |

| | | | | |
|---|---|---|---|---|
| b) Have you ever received or been advised to undergo treatment for drug abuse, or received counselling for this problem? If yes, indicate date, treatment, result and complete the Drug Usage questionnaire. _____ | ☐ | ☐ | ☐ | ☐ |
| 6. Have you ever been charged with or convicted of a criminal offence? If yes, provide the date, the circumstances, the charge(s) and the sentence (probation start and end date if applicable). _____ | ☐ | ☐ | ☐ | ☐ |

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## I – Personal history (continued)

| Provide the details of all "Yes" answers here and if you need more space, continue in Section K. | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 7. a) In the last two (2) years, have you travelled or lived outside of Canada or the United States? If yes, indicate where, when and for how long. _____ | ☐ | ☐ | ☐ | ☐ |
| b) In the next two (2) years, do you intend to travel or live outside of Canada or the United States? If yes, indicate where, when and for how long. _____ | ☐ | ☐ | ☐ | ☐ |
| 8. Have you declared bankruptcy in the last three (3) years? If Yes, please provide details below:<br>☐ Personal bankruptcy Amount: $ _____<br>☐ Professional/commercial bankruptcy Amount: $ _____<br>Date filed: Y Y Y Y M M D D Date of release: Y Y Y Y M M D D | ☐ | ☐ | ☐ | ☐ |

## J – Medical history

**- IF THE PARAMEDICAL OR MEDICAL EXAM IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION J.**

### Insured 1

1. a) Height _____ ☐ ft ☐ m
Weight _____ ☐ lbs ☐ kg

b) Weight loss in last 12 months? **Loss:** ☐ No ☐ Yes How much? _____
Reason(s) for weight change: _____

c) Name and address of family doctor or the clinic holding your medical file: _____

d) Date and reason of last consultation _____
Results _____

e) Describe the symptoms that motivated this consultation _____

f) Tests performed _____
Results _____

g) Future tests or follow-ups recommended _____

h) Treatment provided and/or medication prescribed _____

### Insured 2

1. a) Height _____ ☐ ft ☐ m
Weight _____ ☐ lbs ☐ kg

b) Weight loss in last 12 months? **Loss:** ☐ No ☐ Yes How much? _____
Reason(s) for weight change: _____

c) Name and address of family doctor or the clinic holding your medical file: _____

d) Date and reason of last consultation _____
Results _____

e) Describe the symptoms that motivated this consultation _____

f) Tests performed _____
Results _____

g) Future tests or follow-ups recommended _____

h) Treatment provided and/or medication prescribed _____

## J – Medical history (continued)

| For every "Yes" answer in question 2, name the disorder(s) or condition(s) and provide details in Section K. Please specify dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results, and name of any attending physicians and medical facilities consulted. | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 2. Have you ever been treated for, had symptoms or been diagnosed with any of the following disorders or conditions: | | | | |
| a) **Cardiovascular system:** chest pain, high blood pressure, elevated cholesterol, heart murmur, heart attack, stroke, angina, palpitations or heart rate disorder, abnormal ECG, pulmonary hypertension, peripheral vascular disease, blood clots, transient ischemic attack (TIA), cerebrovascular accident (CVA), or any other disorders of the heart or circulatory system or any other heart surgery? | ☐ | ☐ | ☐ | ☐ |
| b) **Respiratory system:** asthma, chronic bronchitis, emphysema, cystic fibrosis, sleep apnea, chronic obstructive pulmonary disease (COPD), tuberculosis, coughing up blood, shortness of breath, chronic and persistent cough or any other respiratory disorders? | ☐ | ☐ | ☐ | ☐ |
| c) **Digestive system:** ulcers, colitis, bleedings, polyps or any other disorder of the stomach, esophagus, pancreas, liver such as hepatitis (including hepatitis carrier) or cirrhosis or intestines such as chronic diarrhea, ulcerative colitis, Crohn's disease or intestinal hemorrhaging? | ☐ | ☐ | ☐ | ☐ |
| d) **Genitourinary system:** sugar, protein, blood or pus in urine, stones or other disorders of the kidneys such as renal failure, nephritis, disorder of the urinary tract, bladder, prostate or reproductive organs, sexually transmitted disease? | ☐ | ☐ | ☐ | ☐ |
| e) **Breast disorder:** mass, lump, cyst, other physical changes or abnormal biopsy or mammogram findings? | ☐ | ☐ | ☐ | ☐ |
| f) **Neurological system:** loss of consciousness or balance, dizziness, migraine, convulsions, epilepsy, numbness, optic neuritis, multiple sclerosis, Huntington's chorea, amyotrophic lateral sclerosis (ALS), cerebral palsy, weakness of extremities, loss of sensation, memory loss, Alzheimer's disease, Parkinson's disease, motor neuron disease, paralysis, degenerative disease or any other disorder affecting the brain or spinal cord? | ☐ | ☐ | ☐ | ☐ |
| g) **ENT system:** eyes, ears, nose, mouth or throat disorder? | ☐ | ☐ | ☐ | ☐ |
| h) **Endocrine and lymphatic system:** diabetes, elevated glycemia, thyroid disorder, pituitary gland disorder, enlarged glands, unexplained infection or any form of endocrine or glandular disorder, malignant disease or any lymphatic gland disorder? | ☐ | ☐ | ☐ | ☐ |
| i) **Immune system:** acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), HIV positive or any other disorder of the immune system, test indicating the presence of the AIDS virus or antibodies to the AIDS virus? | ☐ | ☐ | ☐ | ☐ |
| j) **Psychological disorder:** depression, anxiety, adjustment disorder, panic disorder, burn-out, bipolar disorder, chronic fatigue, insomnia, suicide attempts, suicidal thoughts, eating disorder, attention deficit with hyperactivity (ADHD), schizophrenia, intellectual deficiency, autism spectrum disorder or any other mental health disorder? | ☐ | ☐ | ☐ | ☐ |
| k) **Cancer or tumor:** cancer, leukemia, tumor, cyst, nodule, polyp, mole, mass or growth? | ☐ | ☐ | ☐ | ☐ |
| l) **Other disorders:** skin disorder, blood disorder such as anemia and coagulation disorder or any other disease or physical disorder not mentioned above? | ☐ | ☐ | ☐ | ☐ |
| m) **Musculoskeletal disorder:** back and neck pain or disorder, arthrosis, herniated disc, sprain, tendinitis, bursitis, chronic pain, fibromyalgia, muscular dystrophy, arthritis, amputation or any other disorder affecting bones, muscles, ligaments or joints such as shoulders, elbows, wrists, hands, hips, knees, ankles or feet? Provide details of the last five (5) years only. | ☐ | ☐ | ☐ | ☐ |
| 3. Are you taking any medication at the moment (other than those mentionned above)? If yes, indicate name, dosage and date at which the treatment began and reason for which it was prescribed. _____ | ☐ | ☐ | ☐ | ☐ |
| 4. Are you aware of any symptoms, signs or discomfort for which you have not yet consulted a physician or received treatment? _____ | ☐ | ☐ | ☐ | ☐ |
| 5. Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done, which have not yet been completed? | ☐ | ☐ | ☐ | ☐ |
| 6. In the last five (5) years, have you been a patient at a hospital, clinic or any other medical facility? If yes, indicate name, dates, reasons and results. _____ | ☐ | ☐ | ☐ | ☐ |
| 7. In the last five (5) years, have you undergone an x-ray, electrocardiogram (rest or stress) or lab tests, biopsy, magnetic resonance imaging or any other diagnostic test? If yes, indicate dates, reasons and results. _____ | ☐ | ☐ | ☐ | ☐ |

## J – Medical history (continued)

| Provide the details of all "Yes" answers here, and if you need more space, continue in Section K. | Insured 1 | | Insured 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 8. In the last five (5) years, have you been absent from work or had to stop your regular duties, received disability benefits or any other type of benefits as a result of an accident or illness? If yes, provide date, reason and duration. _____ | ☐ | ☐ | ☐ | ☐ |
| 9. Do you have a mental or physical disorder that limits your daily activities? | ☐ | ☐ | ☐ | ☐ |
| 10. In the last five (5) years, have you consulted a chiropractor, physiotherapist, psychologist, audiologist, occupational therapist, osteopath, podiatrist, acupuncturist or any other health care professional? If yes, provide the information below: | ☐ | ☐ | ☐ | ☐ |

| Insured's name | Health care professional | Reason/diagnosis | Date of first treatment | Date of last treatment | Number of treatment per year | Date of last symptoms |
|---|---|---|---|---|---|---|
| | | | | | | |
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| 11. Have any members of your family, including father, mother, brother or sister had any of the following illnesses: heart disease, transient ischemic attack (TIA), cerebrovascular accident (CVA), primary pulmonary hypertension, cancer (provide type), diabetes, kidney disease, mental or neurological illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, multiple sclerosis, Alzheimer's disease, muscular dystrophy, Parkinson's disease or any other hereditary disorder?<br>If yes, please provide the information below: | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|

| Insured's name | Relationship | Illness | Age at onset | Current age | Age at death | Cause of death |
|---|---|---|---|---|---|---|
| | | | | | | |
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| 12. In the last 5 years, have you used tobacco in any form, including cigarettes, cigarillos (small cigars), cigars, pipe, chewing tobacco or snuff, shisha, betel nuts, Nicorette chewing gum, electronic cigarette or any other tobacco-derivative or nicotine-containing product?<br>If YES, provide the information below. | Yes | No | Yes | No |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |

| Insured's name | Type | Daily quantity | Date of last use |
|---|---|---|---|
| | | | Y Y Y Y M M D D |
| | | | Y Y Y Y M M D D |
| | | | Y Y Y Y M M D D |
| | | | Y Y Y Y M M D D |
| | | | Y Y Y Y M M D D |

**13.For women only:**

| a) Are you presently pregnant? If yes, indicate the number of weeks you are pregnant, your weight before the pregnancy. _____ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| b) Do you have or ever had any pregnancy complications (caesarean section, preeclampsia, ectopic pregnancy, other)? If yes, provide details: _____ | ☐ | ☐ | ☐ | ☐ |

## K – Details and additional information

| Question No. | Insured's First Name | Details<br>(Specify the disorder(s) or condition(s) and provide details, including dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results, and name of any attending physicians or hospitals.) |
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## L – Declarations, authorizations and signatures

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor / representative, during a personal meeting or a RECORDED telephone conversation with a paramedical company or another authorized person representing or acting for SSQ, Life Insurance Company Inc. The undersigned agree that the additional questionnaire shall be deemed to form part of this application and that the information it contains shall be used to draw up a contract with SSQ, Life Insurance Company Inc. The undersigned further agree to review such information upon receipt of the contract and to inform SSQ, Life Insurance Company Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that all information that they divulged during a RECORDED telephone interview to a paramedical company or another authorized person representing or acting for SSQ, Life Insurance Company Inc., including but not limited to, their medical history and state of health, is deemed to form part of this application and that this information shall be used to draw up a contract with SSQ, Life Insurance Company Inc. The undersigned agree that any recording, transcription or other notation of such information by SSQ, Life Insurance Company Inc. or on behalf of SSQ, Life Insurance Company Inc. shall be considered to be accurate, complete and binding as if given in writing to you.
3. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the requested contract), the contract shall be void with respect to such insured.
4. Agree that, if a temporary insurance agreement has been drawn up for life insurance, the amount payable under the aforesaid temporary insurance agreement and such other temporary insurance agreement as may be drawn up by SSQ, Life Insurance Company Inc. for each insured life shall be limited to the lesser of $500,000 or the total face amount requested in the insurance applications.
5. Agree that, if a conditional insurance policy is drawn up for critical illness insurance, the amount payable shall be the lesser of the face amount requested in this insurance application or $500,000 less all other face amounts under any critical illness insurance pending or in effect with SSQ, Life Insurance Company Inc.
6. Agree that this application, as well as the attached temporary insurance agreement relating to life insurance and the attached conditional insurance policy relating to critical illness insurance, if any, are subject to the laws of the province where the policyowner resides when the policy is issued, subject to applicable laws.
7. Agree that, under the Term Plus product, the benefit payable in the event of a total disability shall be based on the total amount of eligible monthly payments for all eligible loans in effect at the time of total disability, regardless of the monthly amount that is underwritten in the present application. The benefit payable shall not exceed the monthly amount that is underwritten in the present application, subject to the terms of the contract. Should there be no eligible monthly payment in effect at the time of total disability, the undersigned agree that the liability of SSQ, Life Insurance Company Inc. shall be limited to the refund of premiums received since the loan or loans were discharged, on the understanding that this refund shall not exceed a period of eighteen (18) months prior to the date the total disability benefit was requested.
8. Agree that they have received the advisor's explanations concerning the possibility of a tax rule change that certain changes, which require evidence of insurability, may cause, if any. As such, the entire policy could be subject to the tax rules in effect as of January 1st 2017, if it is not already the case.
9. Authorize any health care professional, hospital or private or public health or social services facility, insurance company, reinsurer or other institution or person holding any files or information about them or their health to release such files or information to SSQ, Life Insurance Company Inc. or its reinsurers, and such information shall be treated as confidential and confined in the file mentioned in the "Notice regarding personal files and personal information" which they have read.
10. Authorize SSQ, Life Insurance Company Inc. and its reinsurers, for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes, to hold, collect from, exchange and use with any individuals or corporate bodies holding any personal information about them such personal information as is needed in accordance with the object of the file as aforesaid and only such information, which individuals and corporate bodies shall include any other insurance company, medical practitioner or medical facility, the MIB Inc., any investigative agency and any individual or corporate body likely to be holding any such personal information about them, to disclose to the aforesaid individuals and corporate bodies only such personal information as is necessary, and to request an investigative report about them. The undersigned also authorize SSQ, Life Insurance Company Inc., and its reinsurers, to make a brief report of their personal information to MIB Inc. This authorization shall be valid for the period required to achieve the purposes for which it was requested. The undersigned have read the "Notice to proposed insured(s) and policyowner(s)" regarding the MIB Inc. and regarding personal files and personal information and understand that the information shall be treated as confidential and confined in the insured's file as mentioned in the latter notice.
11. Authorize SSQ, Life Insurance Company Inc. and its reinsurers for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes to have access to and use any relevant information held by any credit rating agency. This authorization remains valid for the length of time needed to achieve such purposes.
12. Declare that the information provided on the Declaration of Tax Residence section is correct and complete and agree to provide SSQ, Life Insurance Company Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to be incomplete or inaccurate.
13. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the insurance application with SSQ, Life Insurance Company Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.
14. Declare having received the Notice to proposed insured(s) and policyowner(s) and agree to accept its terms.

_____ This _____ day of _____ of year _____

Signed at (city and province) Date

**X** _____

Signature of insured 1

**X** _____

Signature of insured 2

**X** _____

Signature of the father, mother or legal guardian of the minor child (children's insurance)

**X** _____

Signature of policyowner 1 – only necessary if not an insured

**X** _____

Signature of policyowner 2 – only necessary if not an insured

### If the policyowner is a company or other type of entity:

_____

Name and Title of Authorized Signatory

**X** _____

Signature

_____

Name and Title of Authorized Signatory

**X** _____

Signature

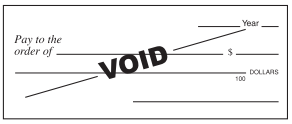
**T 843 531 411**
Application number

## M – Pre-authorized debit agreement

1. I hereby authorize SSQ, Life Insurance Company Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify SSQ, Life Insurance Company Inc. before the renewal date of the contract of insurance.
3. I understand that a financing charge may be applicable and spread over the instalments.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), SSQ, Life Insurance Company Inc., is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform SSQ, Life Insurance Company Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month on the day selected in the insurance application or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. **I agree and understand that SSQ, Life Insurance Company Inc. will not notify me before each withdrawal.**
9. In the event that I instruct SSQ, Life Insurance Company Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing SSQ, Life Insurance Company Inc. with thirty (30) days' notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
11. I understand that SSQ, Life Insurance Company Inc. reserves the right to terminate this Agreement upon fifteen (15) days' notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with SSQ, Life Insurance Company Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by SSQ, Life Insurance Company Inc.
13. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

**SSQ, Life Insurance Company Inc.**
Premium Accounting
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a specimen cheque, on which you have written "VOID", for the account to be debited.




**Important notice:** In the absence of completing the information below and providing a specimen cheque, SSQ, Life Insurance Company Inc. will withdraw the pre-authorized debits from the bank account of the cheque provided with this application.

Name of financial institution

Address, city, province and postal code of the branch

Branch | Financial institution number | Account number

## Authorization

**Is the account joint?** ☐ **Yes** ☐ **No**

**For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.**

Name of account holder or authorized person (in capital letters) | **X** Signature | Y Y Y Y M M D D Date

Name of account holder or authorized person (in capital letters) | **X** Signature | Y Y Y Y M M D D Date

## N – Financial security advisor's / representative's report

1. Source

☐ From insured ☐ Referred ☐ Associate ☐ Life customer ☐ P&C customer ☐ Other (specify): _____

2. Relationship with insured

☐ Personal friend ☐ Relative (specify): _____ ☐ Other (specify): _____

How long have you known each insured? Insured 1: Y Y Y Y M M D D Insured 2: Y Y Y Y M M D D

3. Do you have doubts about the insurability of one of the insureds?

☐ Yes ☐ No If yes, please specify: _____

4. Are you personally aware of the habits of the insured(s)?

☐ Yes ☐ No If yes, please give details: _____

5. Which language(s) has (have) been used to complete the application? _____

6. Has (have) the individual(s) told you he/she (they) understood the language used to complete the application?

☐ Yes ☐ No

7. If a language other than English has been used, please name the person who explained the application to the individual(s) to be insured. The person cannot be the beneficiary or a family member of the person(s) to be insured.

_____

### N1 – Underwriting requirements

| Evidence of insurability ordered from | Ordered requirements |
|---|---|
| ☐ Dynacare Insurance Solutions ☐ Other<br>☐ ExamOne<br><br>Y Y Y Y M M D D<br>Date of request of evidence of insurability<br><br>_____<br>Order number | ☐ Paramedical ☐ Resting EKG<br>☐ Medical exam ☐ Stress EKG<br>☐ HIV urine analysis ☐ Vital signs<br>☐ Blood profile ☐ Prostate Specific Antigen (for men)<br><br>**The Inspection Report (IR), the Motor Vehicle Report (MVR) and the Attending Physician's Statement (APS) are ordered by SSQ, Life Insurance Company Inc. when required.**<br><br>* In Alberta, the client must order the MVR himself/herself. |

### N2 – Financial security advisor / representative certification

I confirm that I have provided an *Advisor Disclosure Statement* to the policyowner(s) disclosing the following:

- the name of the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and critical illness insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflict of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this application has been signed.

I hereby declare that all information in this application is true and complete to the best of my knowledge.

If I am not the service advisor for this policy, I declare that I have informed the policyowner(s) of that fact and of the identity of his/her (their) service advisor as it appears in Section N3.

**Identity verification of the policyowner(s)** (whole life insurance and universal life insurance)

In accordance with the **Proceeds of Crime (Money Laundering) and Terrorist Financing Act** and its regulations, I have ascertained the identity of the persons who signed this application as policyowner(s) by examining all original documents supplied and by meeting with the policyowner(s) to complete this application.

**Party determination** (whole life insurance and universal life insurance)

In accordance with the **Proceeds of Crime (Money Laundering) and Terrorist Financing Act** and its regulations, I have made reasonable efforts to determine if the policyowner(s) is (are) acting on behalf of a third party.

_____ _____

Name of financial security advisor / representative (in capital letters) Code of financial security advisor / representative

**X** _____ Y Y Y Y M M D D

Signature of financial security advisor / representative Date

**T 843 531 411**
Application number

## N3 – Information about financial security advisor / representative

**The following information is necessary for the application to be processed and for commissions to be paid.**

**Name of service advisor** (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

**Name of other advisor sharing commission** (if applicable) (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

**Name of other advisor sharing commission** (if applicable) (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

☐ **I do not have an advisor's code with SSQ, Life Insurance Company Inc. This is my first application.**

## Comments and details from financial security advisor / representative

T 843 531 411
Application number

## O – Notices and agreements

### O1 – Conditional insurance policy – critical illness insurance

**Instructions for the financial security advisor / representative**

If ALL proposed insureds are 30 days old or more and less than 66 years old on the nearest birthday when the application is signed, please detach this conditional insurance policy and give it to the policyowner.

Regardless of whether any premium has been collected with the application, no guarantee is provided with regard to this conditional insurance policy unless all the conditions set out below and on the reverse are met.

**Conditional insurance policy – critical illness insurance**

SSQ, Life Insurance Company Inc. provides free temporary CONDITIONAL critical illness insurance in accordance with the conditions set out below and on the reverse. This conditional insurance policy, subject to the usual terms of the policy applied for, will take effect:

- on the date on which sufficient evidence of insurability for all individuals to be insured is received ("effective date"); and
- if all individuals to be insured represented a regular risk at the effective date, in accordance with the rules and common practice applied by SSQ, Life Insurance Company Inc. as far as risk selection is concerned; and
- if a payment for the amount of the first monthly premium or more was both received and cashable on the date the insurance application has been signed by all proposed insureds and by the financial security advisor / representative, or before this date; and
- if the aforementioned payment was made to SSQ, Life Insurance Company Inc. and was honoured by the financial institution the first time it has been presented.

The conditional insurance policy will terminate at the effective date of the requested contract.

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### O2 – Receipt – temporary insurance agreement – life insurance

Received from _____ $ _____ the sum of

**Instructions for the financial security advisor / representative**

If ALL proposed insureds are 15 days old or more and less than 66 years old on the nearest birthday when the application is signed, please detach this temporary insurance agreement and give it to the policyowner.

- The amount paid to the financial security advisor / representative must equal the first monthly premium or one-twelfth ($^1/_{12}$) of the annual modal premium and must be cashable on the date the insurance application is signed by the proposed insured(s).
- No insurance will be effective unless the payment is honoured the first time it is presented.
- No one may waive or change any of the terms of this temporary insurance agreement.
- **See Provisions and Conditions on reverse.**

_____
Signed at (city and province)

**X** _____ Y Y Y Y M M D D
Signature of financial security advisor / representative — Date

T 843 531 411
Application number

**This notice must always be given to the policyowner.**

### O3 – Notice to proposed insured(s) and policyowner(s)

**Notice regarding the MIB Inc.**

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including SSQ, Life Insurance Company Inc. (SSQ), work with an organization called the MIB, Inc. (MIB).

Information regarding your insurability will be treated as confidential. SSQ or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing **Canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

SSQ 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. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

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## Conditional insurance policy – Critical illness insurance (ctd.)

The face amount for a critical illness insurance for a proposed insured as defined by this conditional insurance policy will be limited to the lesser of:

- the face amount requested in this application on the proposed insured; or
- $500,000 less all other face amount for any critical illness insurance payable by SSQ, Life Insurance Company Inc. to the proposed insured.

If any proposed insured is diagnosed with cancer, no payment will be made according to this conditional insurance policy.

If any proposed insured dies 30 days following the diagnosis of a covered critical illness, no payment will be made according to this conditional insurance policy.

If any proposed insured is less than 30 days old or 66 years old or more, no payment will be made according to this conditional insurance policy.

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## Provisions and conditions – temporary insurance agreement – life insurance

**1. AMOUNT OF INSURANCE AND LIMITS**
In consideration for payment of the premium indicated in Section D, SSQ, Life Insurance Company Inc. agrees to provide a temporary insurance benefit, up to $500,000 on each of the insureds according to the Provisions and Conditions attached to this temporary insurance agreement. If the face amount as indicated in Section C is less than $500,000 the amount indicated in Section C will represent the face amount for the temporary insurance agreement. If the face amount as indicated in Section C is equal to or more than $500,000, the face amount for the temporary insurance agreement will be $500,000. In case of death of any insured while the temporary insurance agreement is in force, all the premiums paid in excess of the required premium of $500,000 coverage will be reimbursed. The maximum of $500,000 includes any other temporary insurance agreements issued by SSQ, Life Insurance Company Inc., as mentioned in Section L (article 4).

**2. EFFECTIVE DATE**
The temporary insurance agreement becomes effective when the temporary insurance agreement's receipt has been signed, provided the premiums required from all insureds have been paid and that the questions 1 to 6 of the temporary insurance agreement questionnaire in Section G of the application have been answered "No".

**3. END OF COVERAGE**
The temporary insurance agreement will end on the earliest of:

a) 90 days from the date of this application;
b) the date a counter offer has been presented to your financial security advisor / representative;
c) the date the policy applied for comes into force;
d) the date SSQ, Life Insurance Company Inc. notifies the policyowner(s) of the termination of the temporary insurance agreement;
e) the date SSQ, Life Insurance Company Inc. refuses this application.

SSQ, Life Insurance Company Inc. may terminate this temporary insurance agreement at any time provided the policyowner(s) is (are) notified. When the temporary insurance agreement ends in accordance with 3 a), b), c) or d) listed above, SSQ, Life Insurance Company Inc. shall retain the received premium in order to apply it towards the coming into effect of the insurance contract.

**4. EXCLUSIONS AND PARTICULARS**
a) Any additional benefits applied for under Section C5 of the application are excluded from the temporary insurance agreement.
b) The Total Disability Rider pertaining to the Tem Plus product is excluded from the temporary insurance agreement.
c) In case of suicide, fraud or misrepresentation, the temporary insurance agreement shall become void and the liability of SSQ, Life Insurance Company Inc. shall be limited to refunding the premium paid to the policyowner(s).
d) The financial security advisor / representative is not authorized to offer the temporary insurance agreement to an insured under the age of 15 days or age 66 or over.
e) The temporary insurance agreement does not apply to critical illness products.

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## Notice to proposed insured(s) and policyowner(s) (ctd.)

**Notice regarding the investigative consumer report**

For the insurance applications to be processed, all insurance companies, including SSQ, Life Insurance Company Inc., may ask for a personal investigative consumer report in order to obtain information through personal interviews with neighbours, friends, associates and other designated people. The investigative consumer report may concern your reputation, lifestyle and finances. A representative of a consumer reporting agency may visit you or call you.

**Notice regarding personal files and personal information**

The protection of your personal information is a priority for SSQ, Life Insurance Company Inc. («SSQ»). Your personal information is protected by high security standards, in accordance with the applicable laws and regulations regarding the protection of personal information.

**Consent for the collection, communicating, use and storage of your personal information**

SSQ collects, communicates, uses and holds your personal information for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes, and this, for the length of time needed to achieve such purposes.

SSQ, its affiliated companies and their distribution channels access, share with each other, use and hold your personal information for the same purposes as those mentioned above. Accordingly, their employees, agents and service providers may have access to your personal information, if they require such access to carry out their duties or if such access is required by a contract.

## Notice to proposed insured(s) and policyowner(s) (ctd.)

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**File purpose, storage location and access to your personal information**

SSQ collects, communicates, uses and stores your personal information for the purpose of managing your financial services, insurance, savings, annuities, credit and any other related services file.

Your personal information is held at SSQ's offices. It may be transferred and used securely outside of Canada. If so, it is governed by the laws applicable in that country.

If you would like to access your file or make a rectification to it, make your request in writing to the address below.

**SSQ, Life Insurance Company Inc.**
1225 Saint-Charles Street West, Suite 200
Longueuil, Québec J4K 0B9

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## P – Credit card payment (1st premium only)

- This method of payment is accepted only for new business.
- If the premium payment frequency is annual, the amount payable by credit card is limited to 1/12th of the annual premium (or 1/12th of the MINIMUM annual premium for universal life insurance), subject to a maximum of $5,000.
- If the premium payment frequency is monthly, the amount payable by credit card is limited to the first monthly premium (or first MINIMUM monthly premium for universal life insurance), subject to a maximum of $5,000.
- **In accordance with current legislation and regulation, when this type of payment is selected, the application must be sent by mail.**

Name of payer

Policy number

☐ Visa ☐ MasterCard

Credit card number

M M Y Y Y Y
Expiry date

**X** _____
Signature

$ _____
1st premium payment (cashed on reception of this application)
**This type of payment is available when the application is sent by mail**

| Policy number | Application number |
|---|---|
| | T 843 531 411 |

## Authorization

I hereby authorize any doctor, hospital, clinic, insurance company, credit rating agency, the MIB Inc. or any other institution or organization holding information about me, including specific information about my state of health, my family medical history, my lifestyle, my finances and my reputation, to communicate this information to SSQ, Life Insurance Company Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present application with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes.

In case of my death, the beneficiary, legal heir or executor of my estate is expressly authorized to communicate to the insurer, when required by it, any and all information or authorizations required for the settlement of the death claim and to obtain any justification requested. As well, SSQ, Life Insurance Company Inc. is permitted to obtain information about me or my state of health and I am willing to undergo any tests, X-rays, electrocardiograms, blood or urine tests which SSQ, Life Insurance Company Inc. may request in order to underwrite my insurance application. Furthermore, I authorize SSQ, Life Insurance Company Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the MIB Inc.

In addition, I authorize SSQ, Life Insurance Company Inc. to include all personal information contained in its existing or future files. A photocopy or an electronic copy of this authorization shall be valid as the original.

| Name of insured (in capital letters) | X Signature of insured | Y Y Y Y M M D D Date |
|---|---|---|
| **If a minor insured:** Name of the mother, father or legal guardian (in capital letters) | X Signature of the mother, father or legal guardian (indicate relationship to the insured) | Y Y Y Y M M D D Date |


| Policy number | Application number |
|---|---|
| | T 843 531 411 |

## Authorization

I hereby authorize any doctor, hospital, clinic, insurance company, credit rating agency, the MIB Inc. or any other institution or organization holding information about me, including specific information about my state of health, my family medical history, my lifestyle, my finances and my reputation, to communicate this information to SSQ, Life Insurance Company Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present application with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes.

In case of my death, the beneficiary, legal heir or executor of my estate is expressly authorized to communicate to the insurer, when required by it, any and all information or authorizations required for the settlement of the death claim and to obtain any justification requested. As well, SSQ, Life Insurance Company Inc. is permitted to obtain information about me or my state of health and I am willing to undergo any tests, X-rays, electrocardiograms, blood or urine tests which SSQ, Life Insurance Company Inc. may request in order to underwrite my insurance application. Furthermore, I authorize SSQ, Life Insurance Company Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the MIB Inc.

In addition, I authorize SSQ, Life Insurance Company Inc. to include all personal information contained in its existing or future files. A photocopy or an electronic copy of this authorization shall be valid as the original.

| Name of insured (in capital letters) | X Signature of insured | Y Y Y Y M M D D Date |
|---|---|---|
| **If a minor insured:** Name of the mother, father or legal guardian (in capital letters) | X Signature of the mother, father or legal guardian (indicate relationship to the insured) | Y Y Y Y M M D D Date |