Application for Life and Critical Care Insurance

Comprehensive Application Form (Includes Short Form Application)

Additional questionnaires may be found on CUMIS LifePages.

AGENTS CHOICE — please indicate:

- ☐ **Comprehensive Application:** Complete all pages

  or

- ☐ **Short Form Application:** A TeleInterview will be conducted when this option is selected.
  i. Only complete pages 2 through 11 **and** 18 through 23
  ii Do not order any age or amount requirements

CUMIS®

Agent Checklist

Use this checklist BEFORE you submit the application:

- ☐ Have all fields been completed clearly and completely – for both Life Insureds?
- ☐ Has the application been signed and dated by all adult Life Insureds?
- ☐ Has the application been signed by an Owner who is not a Life Insured?
- ☐ Has an application for a child under 16 been signed by a consenting parent or guardian – even if that person has already signed in another capacity?
- ☐ For replacements only – have you confirmed that the replacement is in the Life Insured's best interest by assessing the Life Insured's needs?
- ☐ Have you prepared the applicants for a TeleInterview (if applicable)?
- ☐ Have you prepared the applicants for Insurance Medical requirements?
- ☐ Has the Assignment of Certificate as Collateral been completed, if applicable?
- ☐ Have you explained any unusual circumstances and offered additional information?

Have you attached to the application:

- ☐ Supplementary questionnaires (if required)?
- ☐ Payment for the first month's premium?
- ☐ Void cheque with legible banking codes (if requesting PAC)?
- ☐ Replacement form/Disclosure Statement (if applicable)?
- ☐ A signed Illustration for all Universal Life plans?
- ☐ MVR Authorization?

Have you detached and given to the Applicant:

- ☐ Medical Information Bureau Pre-Notice?
- ☐ Temporary Insurance Receipt (if applicable)?

Underwriting requirements ordered by Agent or MGA (for Comprehensive Application only):

Life Insured #1

- ☐ Paramedical
- ☐ Blood
- ☐ Urine
- ☐ ECG
- ☐ Stress ECG
- ☐ Medical Exam
- ☐ PSA
- ☐ Other: _____

Life Insured #2

- ☐ Paramedical
- ☐ Blood
- ☐ Urine
- ☐ ECG
- ☐ Stress ECG
- ☐ Medical Exam
- ☐ PSA
- ☐ Other: _____

Underwriting requirements ordered from:

- ☐ Hooper Holmes / Portamedic
- ☐ Medisys
- ☐ Quality Underwriting Services
- ☐ Watermark Insurance Services
- ☐ Other (specify): _____

Agent's Report

Agent's Information

This information is required in order to process this application and to pay your commission. Missing information causes delays. Please print clearly throughout the application. All questions must be answered for this application to be processed.

AGENT NAME	AGENT CODE
CREDIT UNION OR ORGANIZATION AFFILIATION	**CONTRACT NUMBER**

☐ This is the first piece of business I am submitting under CUMIS Life Insurance Company
(Please attach a signed copy of your CLHIA form, along with a copy of your license and E&O insurance).

	YES	NO
1. Are any clients or Owners of this application an employee of the The CUMIS Group Limited?	☐	☐
2. CUMIS Life highly recommends that an appropriate Needs Analysis be completed for all situations. Has this been completed?	☐	☐
3. Do you want to back date to save age? (applicable to life coverage only) If "YES", back premiums will be required and has your client has been advised accordingly?	☐	☐
4. CUMIS Life recommends that the client's Risk Profile Category be identified for Universal Life only. (i.e. Conservative, Moderate, Aggressive)		
5. Were you licensed in the province where this application was written on the date signed? If "NO", CUMIS Life cannot accept this application.	☐	☐
6. Are you splitting this case with any other agent(s)? If "YES", provide the following details:	☐	☐

AGENT'S NAME	AGENT NO.	AGENT'S PERCENTAGE

	YES	NO
7. Are you submitting any other related applications at this time with CUMIS Life? If "YES", provide:	☐	☐

NAME	POLICY NO.

8. Who initiated this application?
☐ Proposed Life Insured ☐ Client Referral ☐ Proposed Owner ☐ Credit Union Referral ☐ Cold Call

	YES	NO
9. Did you meet face to face with the proposed Life Insured(s)/proposed Owner(s)?	☐	☐
10. If this is an application on a child, did you see the child on the date of application?	☐	☐

11. How long have you known the proposed Life Insured(s)? IN YEARS/MONTHS: YRS MTHS

a) For the child application, how long have you known the child? IN YEARS/MONTHS: YRS MTHS

	YES	NO
12. Is this application on the life of your spouse, child or any other person residing in your residence?	☐	☐
13. Is/are the proposed Life Insured(s) and proposed Owner(s) fluent in the language of this application? If "NO", describe (in agent comments section) the steps that were taken to ensure that the person(s) identified understood the questions and authorizations in this application and details regarding the insurance coverage applied for.		
Proposed Life Insured #1:	☐	☐
Proposed Life Insured #2:	☐	☐
Proposed Owner:	☐	☐

Agent Comments:

Please elaborate on any questions above AND provide us with any other information that may be useful in reviewing this application:

I confirm that I have:

a) taken the necessary steps to determine if the Owner is acting on behalf of a third party.

b) seen the original government issued picture identification or have taken steps to have government identification signed by a guarantor of the proposed Life Insured(s) and proposed Owner(s).

c) Conducted an appropriate needs analysis/considered the suitability of the product applied for in relation to those needs and have discussed this with each Owner. I further confirm that I have disclosed to each Owner all existing and potential conflicts of interest that I may have in this transaction, including how I am compensated when the policy or change is placed or renewed.

AGENT SIGNATURE	DATE SIGNED	*day*	*month*	*year*

Application for Life and Critical Care Insurance

The information disclosed on an application for joint lives, including personal and medical information, will be disclosed to all applicants. If either applicant does not wish disclosure of this information, two separate applications should be completed. If an applicant is a child under the age of 16, the parent or legal guardian must complete this application on their behalf.

Please print clearly.

SECTION 1 Proposed Life Insured(s) and Owner Details

1. Life Insured #1

SALUTATION
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other:

FIRST NAME

MIDDLE NAME

LAST NAME

MAIDEN NAME *(if applicable)*

GENDER ☐ MALE ☐ FEMALE

SMOKING STATUS ☐ SMOKER ☐ NON-SMOKER*

Life Insured #2

SALUTATION
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other:

FIRST NAME

MIDDLE NAME

LAST NAME

MAIDEN NAME *(if applicable)*

GENDER ☐ MALE ☐ FEMALE

SMOKING STATUS ☐ SMOKER ☐ NON-SMOKER*

*** Non-Smoker Definition:** No use of tobacco, nicotine products, nicotine patch, nicorettes, cannabis (marijuana) or any other substance within the past 12 months preceeding the date of this application.

Current Address (Life Insured #1)

ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE

EXTENSION | NUMBER OF YEARS/ MONTHS AT CURRENT ADDRESS YRS MTHS

DATE OF BIRTH *day month year*

PLACE OF BIRTH | PROVINCE | COUNTRY

SOCIAL INSURANCE NUMBER *(Mandatory for UL only)*

Current Address (Life Insured #2)

☐ Address is the same as Life Insured #1

ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE

EXTENSION | NUMBER OF YEARS/ MONTHS AT CURRENT ADDRESS YRS MTHS

DATE OF BIRTH *day month year*

PLACE OF BIRTH | PROVINCE | COUNTRY

SOCIAL INSURANCE NUMBER *(Mandatory for UL only)*

Citizenship (Life Insured #1)

Are you either a Canadian citizen or permanent resident?

☐ YES ☐ NO

Length of time you have resided in Canada? YEARS / MONTHS: YRS MTHS

If "NO", please indicate:

PREVIOUS COUNTRY OF RESIDENCE

CURRENT IMMIGRATION STATUS IN CANADA

Citizenship (Life Insured #2)

Are you either a Canadian citizen or permanent resident?

☐ YES ☐ NO

Length of time you have resided in Canada? YEARS / MONTHS: YRS MTHS

If "NO", please indicate:

PREVIOUS COUNTRY OF RESIDENCE

CURRENT IMMIGRATION STATUS IN CANADA

Government Issued Valid Picture Identification

Please record one piece of valid identification. If verification cannot be completed face to face by the agent, please attach a photocopy of the picture identification signed by a guarantor.

Identification (Life Insured #1)

TYPE OF IDENTIFICATION

ID NUMBER

EXPIRY DATE *day month year* | PLACE OF ISSUE

Identification (Life Insured #2)

TYPE OF IDENTIFICATION

ID NUMBER

EXPIRY DATE *day month year* | PLACE OF ISSUE

2. Employment Details (Life Insured #1)

EMPLOYER'S NAME		
TYPE OF BUSINESS		
ADDRESS		
CITY	PROVINCE	POSTAL CODE
OCCUPATION	DUTIES	
LENGTH OF TIME (YEARS / MONTHS) YRS MTHS	ANNUAL INCOME	
NET WORTH	OTHER INCOME AND SOURCES	

Employment Details (Life Insured #2)

EMPLOYER'S NAME		
TYPE OF BUSINESS		
ADDRESS		
CITY	PROVINCE	POSTAL CODE
OCCUPATION	DUTIES	
LENGTH OF TIME (YEARS / MONTHS) YRS MTHS	ANNUAL INCOME	
NET WORTH	OTHER INCOME AND SOURCES	

3. Calling Information for TeleInterview (Life Insured #1)

Call at: ☐ Home ☐ Business

RESIDENCE TELEPHONE			
BUSINESS TELEPHONE			
	EXTENSION		
PREFERRED CALL DAY	APPROXIMATE CALL TIME	☐ AM ☐ PM	
PERSON TO CONTACT FOR CHILD APPLICATION *(if applicable)*			
RELATIONSHIP TO CHILD *(if applicable)*			

Calling Information for TeleInterview (Life Insured #2)

☐ Same as Life Insured #1 OR; Call at: ☐ Home ☐ Business

RESIDENCE TELEPHONE			
BUSINESS TELEPHONE			
	EXTENSION		
PREFERRED CALL DAY	APPROXIMATE CALL TIME	☐ AM ☐ PM	
PERSON TO CONTACT FOR CHILD APPLICATION *(if applicable)*			
RELATIONSHIP TO CHILD *(if applicable)*			

4. Owner (Complete only if different from proposed Life Insured(s) or in case of a Third Party Application)

Each Owner must be a resident of Canada, as defined for Canadian Income Tax purposes. If this application is owned by a business/non-individual, please complete the Business Profile Worksheet. The person designated as Owner for business insurance should be documented in the Business Profile Worksheet (Authorized Signing Officer).

Owner #1

NAME *first*	*middle*	*last*		
SOCIAL INSURANCE NUMBER *(Mandatory for UL only)*				
GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	*day*	*month*	*year*
RELATIONSHIP TO LIFE INSURED(S)				

Owner #2

NAME *first*	*middle*	*last*		
SOCIAL INSURANCE NUMBER *(Mandatory for UL only)*				
GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	*day*	*month*	*year*
RELATIONSHIP TO LIFE INSURED(S)				

Government Issued Valid Picture Identification

Please record one piece of valid identification. If verification cannot be completed face to face by the agent, please attach a photocopy of the picture identification signed by a guarantor.

Identification (Owner #1)

TYPE OF IDENTIFICATION				
ID NUMBER				
EXPIRY DATE	*day*	*month*	*year*	PLACE OF ISSUE

Identification (Owner #2)

TYPE OF IDENTIFICATION				
ID NUMBER				
EXPIRY DATE	*day*	*month*	*year*	PLACE OF ISSUE

Future notices are to be sent to the following address:

☐ Life Insured #1 ☐ Life Insured #2 ☐ Owner

ADDRESS	CITY	PROVINCE	POSTAL CODE

5. Contingent Owner

If all policy owners predecease the proposed Life Insured(s), all ownership rights under this policy go to the contingent Owner, if appointed below. In the absence of a contingent Owner, ownership passes to the estate of the last surviving policy owner.

(Not applicable if Owner is the only applicant, a Corporation, or a Trustee)

NAME *first* *middle* *last*	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH *day* *month* *year*
SOCIAL INSURANCE NUMBER *(Mandatory for UL only)*		RELATIONSHIP TO LIFE INSURED(S)

6. Beneficiary Designation

All beneficiaries are revocable unless otherwise stated below. An irrevocable beneficiary cannot be changed without the written consent of the designated irrevocable beneficiary. The beneficiary for Critical Care Insurance and the Child Rider is the Policy Owner.

Life Insured #1

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

Life Insured #2

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

Ensure the total percentage for all Life Insureds combined beneficiaries equals 100%.
If there are more than two beneficiaries for a Life Insured, attach a separate sheet of paper, signed, dated, and witnessed.

7. Contingent Beneficiary Designation

If all beneficiaries predecease the applicant(s), the insurance proceeds are payable to the Contingent Beneficiary, if designated, otherwise insurance proceeds are payable to the Estate of the Owner.

Life Insured #1

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

Life Insured #2

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

☐ Irrevocable	DATE OF BIRTH *day* *month* *year*
NAME *first* *middle* *last*	
RELATIONSHIP TO LIFE INSURED	% SHARE

Ensure the total percentage for all Life Insureds combined contingent beneficiaries equals 100%.
If there are more than two beneficiaries for a Life Insured, attach a separate sheet of paper, signed, dated, and witnessed.

8. Trustee Designation

CUMIS Life recommends that you complete this section if you have named a minor, under the age of 18, as a beneficiary. By completing this section, you agree that any benefit that becomes payable to a minor will be paid to the trustee, to hold in trust for the minor until he/she reaches legal age. Duration is 18 years of age or unless otherwise stated below.

Life Insured #1

NAME *first* *middle* *last*		
RELATIONSHIP	DATE OF BIRTH	*day* *month* *year*
DURATION AGE		

Life Insured #2

NAME *first* *middle* *last*		
RELATIONSHIP	DATE OF BIRTH	*day* *month* *year*
DURATION AGE		

SECTION 2 Product Information

Insurance Applied For:

Important: The Illustration Quote, which includes the "Agent's Report", is to be submitted with this application.

☐ as per signed illustration attached, dated _____

CUMIS Universal Life

Base Plan Type:

- ☐ Single Life
- ☐ Multi-Life
- ☐ Joint Last-to-Die

Cost of Insurance:

- ☐ Constant (Level Term)
- ☐ Constant with Premium Protection Option
- ☐ Yearly Renewable Term (for life)
- ☐ Yearly Renewable to Age 85/20 Year Term
- ☐ Constant to 1st Death
- ☐ Constant to 1st Death with Premium Protection Option

Death Benefit Options:

- ☐ Level
- ☐ Enhanced

Life Insured #1

Insurance Amount $ _____

☐ Life Insured is Juvenile

Increasing Insurance Options (Select One)

☐ Indexing Insurance Option (*circle one*)

2% 3% 4% 5% 6% 7% 8%

☐ Return of Premium Option

☐ Adjusted Cost Basis Option

Additional Renewable Term Riders

☐ 10-Year Rider ☐ 20-Year Rider $ _____

☐ Disability Premium Waiver

Additional Benefit Riders

☐ Accidental Death Benefit $ _____

☐ Guaranteed Insurability Option $ _____

☐ Business Guaranteed Insurability Option $ _____

☐ Total Disability Waiver of Charges

☐ Owner's Death Waiver of Charges[1]

☐ Owner's Death or Total Disability Waiver of Charges[1]

☐ Universal Life Child Rider[2]

[1] *Available for Juvenile Application only.*

[2] *For each child, complete the Child Riders section on page 9.*

Life Insured #2

Insurance Amount $ _____

☐ Life Insured is Juvenile

Increasing Insurance Options (Select One)

☐ Indexing Insurance Option (*circle one*)

2% 3% 4% 5% 6% 7% 8%

☐ Return of Premium Option

☐ Adjusted Cost Basis Option

Additional Renewable Term Riders

☐ 10-Year Rider ☐ 20-Year Rider $ _____

☐ Disability Premium Waiver

Additional Benefit Riders

☐ Accidental Death Benefit $ _____

☐ Guaranteed Insurability Option $ _____

☐ Business Guaranteed Insurability Option $ _____

☐ Total Disability Waiver of Charges

☐ Owner's Death Waiver of Charges[1]

☐ Owner's Death or Total Disability Waiver of Charges[1]

[1] *Available for Juvenile Application only.*

Investment Instructions ***(Important:** Deposits will be allocated to the Daily Interest Account unless specified otherwise in this section)*

Premium Protection Account (PPA) – *Select One*

- ☐ Allocate all premiums to the Premium Protection Account
- ☐ Deposit the Lifetime Lapse Prevention Premium amount to Premium Protection Account and transfer the excess to the Investment options below. (Note that the Automatic Sweep Option is not available on policies where the Premium Protection Option elected)
- ☐ Allocate all premiums directly to the Investment Options selected below

Investment Options – Indicate all Investment Options choices using the following guidelines:

- Deposits will be allocated to the Daily Interest Account unless otherwise specified in this section
- Select One Guaranteed Interest Account for Automatic Sweep Option. A $250 minimum amount is required to enter a Guaranteed Interest Account
- One-time deposits into any GIA account should be specified in Special Investment Instructions in the space provided
- Total Allocations (A + B + C + D) must equal 100%

Guaranteed Interest Accounts (GIA) – *Select One*	**Index Linked Accounts (ILA):**		**Portfolio Index Linked Accounts (ILA):**	
☐ 1 Year Term GIA	DEX 91 Day Canadian T-Bill ILA	%	CUMIS Very Conservative Portfolio ILA	%
☐ 2 Year Term GIA	DEX Short Term Bond ILA	%	CUMIS Conservative Portfolio ILA	%
☐ 3 Year Term GIA	DEX Universe Bond ILA	%	CUMIS Moderate Portfolio ILA	%
☐ 4 Year Term GIA	S&P/TSX 60 ILA	%	CUMIS Aggressive Portfolio ILA	%
☐ 5 Year Term GIA	S&P500 ILA	%	CUMIS Very Aggressive Portfolio ILA	%
☐ 10 Year Term GIA	MSCI EAFE ILA	%		
☐ 25 Year Term GIA	MSCI Emerging Markets ILA	%		
Subtotal (A): %	**Subtotal (B):**	0 %	**Subtotal (C):**	0 %

Daily Interest Account (D) %

Total Allocations (A + B + C + D) Must Equal 100% 0 %

Special Investment Instructions:

CUMIS TERM 100

Base Plan:

- ☐ Life Pay
- ☐ Paid Up in 20 Years

Base Plan Type:

- ☐ Single Life
- ☐ Multi-Life
- ☐ Joint First-to-Die
- ☐ Joint Last-to-Die
- ☐ Joint Last-to-Die – Paid Up Rider

Life Insured #1

Insurance Amount $

Additional Renewable Term Riders:

- ☐ 10-Year Rider
- ☐ 20-Year Rider $
- ☐ Disability Premium Waiver

Life Insured #2

Insurance Amount $

Additional Renewable Term Riders:

- ☐ 10-Year Rider
- ☐ 20-Year Rider $
- ☐ Disability Premium Waiver

CUMIS PREFERRED TERM

Base Plan:

- ☐ 10-Year Renewable Term
- ☐ 20-Year Renewable Term

Base Plan Type:

- ☐ Single Life
- ☐ Joint First-to-Die
- ☐ Multi-Life

Life Insured #1

Insurance Amount $

Additional Benefit Riders:

- ☐ Disability Premium Waiver
- ☐ Term Child Rider

Critical Care Riders:

- ☐ Term 10 Rider ☐ Term 75 Rider $
- ☐ Disability Premium Waiver
- ☐ Return of Premium on Expiry
- ☐ Critical Care Child Rider[1]

[1] *For each child, complete the Child Riders section below.*

Life Insured #2

Insurance Amount $

Additional Benefit Riders:

- ☐ Disability Premium Waiver

Critical Care Riders:

- ☐ Term 10 Rider ☐ Term 75 Rider $
- ☐ Disability Premium Waiver
- ☐ Return of Premium on Expiry

CUMIS CRITICAL CARE

Base Plan:

- ☐ Critical Care Term 10
- ☐ Critical Care Term 75

Base Plan Type:

- ☐ Single Life
- ☐ Multi-Life

Life Insured #1

Insurance Amount $

Additional Benefit Riders: $

- ☐ Accidental Death Benefits
- ☐ Disability Premium Waiver
- ☐ Return of Premium on Expiry
- ☐ Increasing Benefit Rider (Term 10 only)
- ☐ Critical Care Child Rider[1]

[1] *For each child, complete the Child Riders section below.*

Life Insured #2

Insurance Amount $

Additional Benefit Riders: $

- ☐ Accidental Death Benefits
- ☐ Disability Premium Waiver
- ☐ Return of Premium on Expiry
- ☐ Increasing Benefit Rider (Term 10 only)

CUMIS CHILD RIDERS (For Universal Life and Critical Care Insurance complete the appropriate children's application)

CHILD'S NAME (*first, middle, last*)	TERM/UL CHILD RIDER	CRITICAL CARE CHILD RIDER	DATE OF BIRTH			GENDER
	$	$	*day*	*month*	*year*	☐ MALE ☐ FEMALE
	$	$	*day*	*month*	*year*	☐ MALE ☐ FEMALE
	$	$	*day*	*month*	*year*	☐ MALE ☐ FEMALE

SECTION 3 Information Regarding Life Insured(s) and Owner

Insurance History Information

	Life Insured #1 YES	Life Insured #1 NO	Life Insured #2 YES	Life Insured #2 NO
1. Do you have any life, health, critical illness, disability or long-term care insurance in force with CUMIS Life?	☐	☐	☐	☐
2. Do you have any other life, health, critical illness, disability or long-term care insurance in force with any other company?	☐	☐	☐	☐
3. Do you have any other life, health, critical illness, disability or long term-care insurance pending with CUMIS Life, or any other company?	☐	☐	☐	☐
4. Have you ever had an application for life, health, critical illness, disability or long-term care insurance declined, postponed, modified, or rated?	☐	☐	☐	☐

If "YES", to any of the above questions, provide the following details:

LIFE INSURED #	INSURANCE TYPE	COMPANY NAME	BUSINESS / PERSONAL		COVERAGE AMOUNT	DECISION DATE (mm/yyyy)	DECISION TYPE *(Pending, Issued, Modified, Rated, Postponed, Declined)*
			☐	☐			
			☐	☐			
			☐	☐			

5. Will this insurance replace or substantially change any other individual life, health, critical illness, disability or long-term care insurance policy or rider currently in force? If "YES", complete the appropriate "Disclosure Statement", and submit the required copy to CUMIS Life. If this is a change to an in force CUMIS Life Policy, the appropriate Policy Change Forms should be completed and mailed to CUMIS Life.	☐	☐	☐	☐

If the proposed applicant is a child under the age of 16 (for Universal Life base or any rider coverage), please answer the additional questions:

6. Does the child have any siblings? ☐ YES ☐ NO

   a) If "YES", are the siblings insured? ☐ YES ☐ NO
   If "NO", give reason. If "YES", provide coverage amounts for each child:

7. Is there any life insurance on the parents, either in force or applied for, with CUMIS Life or any other company? ☐ YES ☐ NO Details, if any:

Application for Temporary Insurance Agreement (TIA) (Refer to Temporary Insurance Receipt for **all** terms and conditions)

Applicant must be older than 15 days and under the age of 65. The maximum amount of insurance on the Life Insured under this and any other Temporary Insurance Agreement with CUMIS Life is limited to the lesser of:

a) The amount of Insurance applied for under the application; or
b) $500,000 for Life Insurance and $250,000 for Critical Care Insurance.

In this section, "you" and "your" refer to the proposed insured(s).

If any of the following questions are answered "YES", or left blank, no one is authorized to accept money or issue the Temporary Insurance Receipt. *(Complete only if offering temporary insurance).*

	Life Insured #1 YES	Life Insured #1 NO	Life Insured #2 YES	Life Insured #2 NO
1. Do you have, or have you ever consulted a doctor for, been treated for, or had any indication of heart or blood vessel disease, suspected heart attack, chest pain, abnormal ECG, diabetes, cancer or tumors (benign or malignant), transient ischemic attack or stroke, chronic kidney disease, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, loss of speech, coma, Alzheimer's or Parkinson's disease, amyotrophic lateral sclerosis (ALS), AIDS or HIV infection?	☐	☐	☐	☐
2. Have you been unable to perform regular activities for more than 7 consecutive days within the last 6 months because of sickness or injury?	☐	☐	☐	☐
3. Have you ever had an application for life, health, critical illness, disability or long-term care insurance declined, postponed, modified or rated in any way?	☐	☐	☐	☐
4. Within the past 12 months, have you been admitted, or advised to be admitted, to a hospital or other medical facility, other than for pregnancy or child birth?	☐	☐	☐	☐
5. Do you have any symptoms for which you have not yet sought medical advice or consultation; or have you been advised to have any tests, investigations, treatment or surgery not yet completed?	☐	☐	☐	☐

If every person to be insured answered "NO" to all questions in the above TIA, and if the conditions described on the Temporary Insurance Receipt have been met, your temporary insurance coverage will be effective immediately.

Financial Information

Life Insured #1

1. Assets $

2. Liabilities $

3. Is the proposed Insured gainfully employed? ☐ YES ☐ NO
   If "NO", what is the total family income? $

4. Does the proposed insured plan to change occupation? ☐ YES ☐ NO

5. Purpose of insurance (check one):
   ☐ Personal ☐ Buy Sell
   ☐ Key Person ☐ Other:

6. Source of Premium:
   ☐ Corporate ☐ Inheritance
   ☐ Savings ☐ Loan

7. Source of Deposit:

8. Have you ever been declared bankrupt, made voluntary assignment in bankruptcy, or are you currently an undischarged bankrupt? ☐ YES ☐ NO
   If "YES", provide details, including date of discharge, below:

9. Is the Owner making this application on behalf of a 3rd party? ☐ YES ☐ NO

10. If this application is for Business Insurance, please provide:
    a) Name of Business:
    b) Type of Business:
    ☐ Corporation ☐ Partnership ☐ Proprietorship
    c) Nature of Business:
    d) Fair Market Value: $
    e) Net Profit After Taxes: $
    f) Percentage of Ownership in Business: %
    g) Details of business insurance on other parties in the business:

Life Insured #2

1. Assets $

2. Liabilities $

3. Is the proposed Insured gainfully employed? ☐ YES ☐ NO
   If "NO", what is the total family income? $

4. Does the proposed insured plan to change occupation? ☐ YES ☐ NO

5. Purpose of insurance (check one):
   ☐ Personal ☐ Buy Sell
   ☐ Key Person ☐ Other:

6. Source of Premium:
   ☐ Corporate ☐ Inheritance
   ☐ Savings ☐ Loan

7. Source of Deposit:

8. Have you ever been declared bankrupt, made voluntary assignment in bankruptcy, or are you currently an undischarged bankrupt? ☐ YES ☐ NO
   If "YES", provide details, including date of discharge, below:

9. Is the Owner making this application on behalf of a 3rd party? ☐ YES ☐ NO

10. If this application is for Business Insurance, please provide:
    a) Name of Business:
    b) Type of Business:
    ☐ Corporation ☐ Partnership ☐ Proprietorship
    c) Nature of Business:
    d) Fair Market Value: $
    e) Net Profit After Taxes: $
    f) Percentage of Ownership in Business: %
    g) Details of business insurance on other parties in the business:

11. If this application is to be assigned, please attach a copy of the "Assignment of Certificate as Collateral" with this application and indicate the name and address for the assignee below.

CREDIT UNION/INSTITUTION NAME			
ADDRESS	CITY	PROVINCE	POSTAL CODE

Non Medical

NOTE: For child application, any reference to "you" in this section pertains to the child.

A. SMOKING STATUS

The history listed below is relied upon to establish the policy's premium rate and is material to the risk. Failure to make proper disclosure will entitle CUMIS Life to render this policy null and void.

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
1. Within the past 5 years, have you ever used any of the following substances: Cigarettes, cigarellos, cigars, colts, pipe, nicotine substitutes (patch, gum, etc.), chewing tobacco, or marijuana? If "YES", please provide all details below.	☐	☐	☐	☐

LIFE INSURED #	SUBSTANCE USED	FREQUENCY OF USE (e.g. daily, weekly, monthly)	AVERAGE AMOUNT USED EACH TIME	DATE LAST USED (mm/yyyy)

B. ALCOHOL AND DRUG USE

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
2. a) Have you ever used any drugs not prescribed by a physician, including but not limited to narcotics, cocaine, steroids, amphetamines, hallucinogens, hashish and/or marijuana? If "YES", please complete the Drug Usage Questionnaire.	☐	☐	☐	☐
b) Have you ever been advised to have or received advice, counselling or treatment for the use or abuse of drugs? If "YES", please complete the Drug Usage Questionnaire.	☐	☐	☐	☐
3. a) Do you currently consume alcoholic beverages?	☐	☐	☐	☐

Life Insured #1:

If "YES", number of drinks per:

DAY	WEEK	MONTH	YEAR

If "NO", date last used:

day	month	year

Life Insured #2:

If "YES", number of drinks per:

DAY	WEEK	MONTH	YEAR

If "NO", date last used:

day	month	year

b) Have you ever been advised to have or received advice, counselling or treatment for the use or abuse of alcohol? If "YES", please complete the Alcohol Usage Questionnaire.	☐	☐	☐	☐

C. MOTOR VEHICLE USE

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
4. a) In the past 5 years, have you been convicted of, or have you/are you currently charged with careless or dangerous driving or refused a breathalyzer test? If "YES", indicate the type(s) of charges or convictions in the box below.	☐	☐	☐	☐
b) Has your driver's license been suspended or revoked in the past 5 years? If "YES", please provide details, including date of last suspension in the box below.	☐	☐	☐	☐
c) Have you been convicted of, or charged with, any motor vehicle or traffic violations (such as speeding, illegal lane changes or dangerous driving) in the past 5 years? If "YES", indicate the types and dates of all charges and/or convictions in the box below.	☐	☐	☐	☐
d) Have you been convicted of, or charged with, operating a motor vehicle while impaired by alcohol or drugs? If "YES", indicate the types and dates of all charges and/or convictions in the box below.	☐	☐	☐	☐

LIFE INSURED #	TYPE OF CHARGE	DATE OF CHARGE (dd/mm/yyyy)	ADDITIONAL DETAILS

D. OTHER INFORMATION

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
5. During the past 2 years, have you:				
a) Flown as a pilot, student pilot or crew member?	☐	☐	☐	☐
b) Participated in any hazardous activities, including but not limited to: motor vehicle racing, snowmobile racing, mountain or rock climbing, hang gliding/parasailing, parachute jumping, bungee jumping or scuba diving?	☐	☐	☐	☐
If (a) or (b) answered "YES", complete appropriate questionnaire.				
c) If "NO" to (a) or (b), is any such activity planned in the future? If "YES", provide details regarding anticipated time frame and the activities planned in REMARKS section on page 14.	☐	☐	☐	☐
6. a) Have you traveled or worked outside of North America in the past 12 months and/or do you intend to travel or work outside of North America in the next 12 months? If "YES", please complete the Foreign Travel Questionnaire.	☐	☐	☐	☐
b) Do you plan to reside outside of Canada? If "YES", provide details including the location, reason and length of time you anticipate residing outside of Canada in REMARKS section on page 14.	☐	☐	☐	☐
7. Have you been convicted of a criminal offense (whether or not a pardon has been granted)? If "YES", provide dates and details in REMARKS section on page 14.	☐	☐	☐	☐
8. Do you have any charges pending with respect to any criminal offense? If "YES", provide details in REMARKS section on page 14.	☐	☐	☐	☐
9. Have you ever had any license to practice an occupation suspended, revoked, or placed under review; been found guilty of any professional misconduct or had disciplinary measures recommended with respect to your occupational license? If "YES", provide dates and details in REMARKS section on page 14.	☐	☐	☐	☐

REMARKS (Details of "YES" answers and additional notes)

LIFE INSURED #	QUESTION #	DETAILS

Medical

If applying for life insurance coverage on a child, any reference to "you" in this section pertains to the child.

10.a) **Life Insured #1**

HEIGHT	☐ cm ☐ ft/in	WEIGHT	☐ kg ☐ lb

Has your weight changed by more than 10 pounds (4.5 kg) in the past 12 months? ☐ YES ☐ NO

If "YES", which change has taken place? ☐ Loss ☐ Gain

Amount and reason for Loss/Gain:

Who is your regular physician? ☐ None ☐ Clinic

NAME				
ADDRESS				
CITY		PROVINCE		
TELEPHONE				
DATE OF LAST VISIT	*day*	*month*	*year*	
REASON FOR VISIT				
RESULTS/DIAGNOSIS				
TREATMENT/MEDICATION				

b) **Life Insured #2**

HEIGHT	☐ cm ☐ ft/in	WEIGHT	☐ kg ☐ lb

Has your weight changed by more than 10 pounds (4.5 kg) in the past 12 months? ☐ YES ☐ NO

If "YES", which change has taken place? ☐ Loss ☐ Gain

Amount and reason for Loss/Gain:

Who is your regular physician? ☐ None ☐ Clinic

NAME				
ADDRESS				
CITY		PROVINCE		
TELEPHONE				
DATE OF LAST VISIT	*day*	*month*	*year*	
REASON FOR VISIT				
RESULTS/DIAGNOSIS				
TREATMENT/MEDICATION				

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
11. If you are a female applicant, are you pregnant? If "YES", what is your anticipated due date?:	☐	☐	☐	☐

DUE DATE OF LIFE INSURED #1	day	month	year	DUE DATE OF LIFE INSURED #2	day	month	year

12. Have any of your immediate family members (Father, Mother, Brother, Sister) ever had: heart disease, stroke, high blood pressure, elevated cholesterol, diabetes, cancer, hereditary kidney disease (including polycystic kidney disease), FAP (familial adenomatous polyposis), congenital polyposis or Gardiner's disease, mental illness, Alzheimer's disease, Huntington's disease, multiple sclerosis, Parkinson's disease, motor neuron disease including ALS (amyotrophic lateral sclerosis) or any other hereditary disease? If "YES", please provide all details below:	☐	☐	☐	☐

Life Insured #1

FAMILY MEMBER	NAME OF CONDITION (if cancer, specify type)	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH (if applicable)	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
SISTER					

Life Insured #2

FAMILY MEMBER	NAME OF CONDITION (if cancer, specify type)	AGE AT ONSET	AGE IF LIVING	AGE AT DEATH (if applicable)	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
SISTER					

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
13. Are you now under observation, or receiving advice or treatment from any physician or health care provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy etc.) or taking medication for any ailment or condition? If "YES", provide details including dates, medications, treatment etc. in REMARKS section on page 17.	☐	☐	☐	☐
14. Do you have any mental or physical impairment or disease, or any symptoms or complaints for which you have not yet consulted a physician or received treatment for? If "YES", provide details including dates, medications, treatment etc. in REMARKS section on page 17.	☐	☐	☐	☐
15. Have you ever had a positive test result for HIV, been diagnosed with Aquired Immune Deficiency Syndrome, been advised to have HIV testing, had an unknown result from an HIV test, or had any other disorder of the immune system? If "YES", provide details including dates, medications, treatment etc. in REMARKS section on page 17.	☐	☐	☐	☐
16. Are you contemplating any surgical operation or, have you been advised to have; or are you planning to have any tests or investigations that have not yet been completed or; do you have any symptoms of any type for which you have not yet sought advice or investigation? If "YES", provide details including dates, medications, treatment etc. in REMARKS section on page 17.	☐	☐	☐	☐

	Life Insured #1		Life Insured #2	
	YES	NO	YES	NO
17. Have you ever had, been told you have, or received treatment, investigations, testing or advice for:				
a) anxiety, depression, suicide attempts or any other mental or nervous disorder?	☐	☐	☐	☐
b) multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neuron disease, epilepsy or seizures, loss of consciousness, or any disease or disorder of the brain or nervous system?	☐	☐	☐	☐
c) asthma, bronchitis, emphysema, tuberculosis, COPD, shortness of breath or any other disease or disorder of the lungs or respiratory system?	☐	☐	☐	☐
d) chest pain, high blood pressure, palpitations, heart murmur, rheumatic fever, heart attack, stroke, transient ischemic attack (TIA) or other disorder of the heart, blood, blood vessels, circulatory system, elevated cholesterol or peripheral vascular disease?	☐	☐	☐	☐
e) hepatitis (including A, B, C, type unknown), hepatitis carrier, jaundice or other disease or disorder of the liver?	☐	☐	☐	☐
f) intestinal bleeding, colitis, crohn's disease; disorder of the pancreas, gallbladder, esophogus, stomach, intestines (including colon, bowel and rectum) or other disorder of the digestive system?	☐	☐	☐	☐
g) protein, pus or blood in the urine, kidney stone or other disease or disorder of the kidney or bladder?	☐	☐	☐	☐
h) cancer, tumour (benign or malignant), abnormal growth, cyst, unusual skin lesion, or other skin disease or disorder?	☐	☐	☐	☐
i) disorder of the breast, prostate or reproductive organs, sexually transmitted disease, abnormal PSA or PAP result?	☐	☐	☐	☐
j) arthritis, fibromyalgia, chronic fatigue syndrome, lupus, paralysis or any other disease or disorder of the muscles, bones, joints, nerves or spine?	☐	☐	☐	☐
k) leukemia, anemia, hemophilia or any other disease or disorder of the blood?	☐	☐	☐	☐
l) diabetes, sugar in the urine or elevated sugar in the blood?	☐	☐	☐	☐
m) thyroid, pituitary, adrenal or other glandular disease or disorder?	☐	☐	☐	☐
n) disorder of the mouth, throat, eyes, ears, or impairment of vision or hearing?	☐	☐	☐	☐
18. Other than the details disclosed above, have you within the past 5 years:				
a) consulted, received advice or treatment from, or been prescribed medication from any other medical advisor or alternative health care provider?	☐	☐	☐	☐
b) had any abnormal diagnostic test or laboratory results?	☐	☐	☐	☐
c) been advised of any diagnostic tests, hospitalization or surgery which has not yet been completed?	☐	☐	☐	☐
d) been aware of any symptoms, impairment or disease for which a medical advisor or alternative health care provider has not been consulted and/or for which you have not yet received treatment, investigation or advice?	☐	☐	☐	☐
e) had a check-up, consultation, treatment or advice from any medical advisor or alternative health care provider not previously disclosed on this application?	☐	☐	☐	☐

If any questions are answered "YES", provide details including diagnosis/test results, treatment/medications, frequency/duration, and the name of the hospital/clinic and medical advisor or alternative health care provider in the REMARKS section on page 17.

REMARKS (Details of "YES" answers and additional notes from previous pages)

LIFE INSURED #	QUESTION #	**DETAILS** (including date, diagnosis/results, treatment/medications, frequency/duration, physician/health care provider(s) name)

SECTION 4 Premium Payment Information

Premium Payment Information

Premium Quoted $ _____ for UL Planned Premium $ _____ Additional Deposit at issue $ _____

1. Initial Premium of $ _____ to be paid by:
   - ☐ Cheque submitted with application
   - ☐ Payment upon delivery (*Not an option for UL*)
   - ☐ By withdrawal from bank account (*Term and Critical Illness only*)

2. a) Future Premiums to be paid by:
   - ☐ Annual Direct Bill
   - ☐ Semi Annual Direct Bill
   - ☐ Monthly Pre-Authorized Chequing
   - ☐ Add to existing PAC agreement from policy number: (*2 months premium required for this option*) _____

   b) Preferred date of Withdrawal
   - ☐ Specific withdrawal date (1st to 28th of the month only) _____

   OR
   - ☐ Withdrawal based on issue date

   Please note: There is a possibility, that in some circumstances, two premium payments may be withdrawn from the account upon issue.

PRE-AUTHORIZED CHEQUING (PAC) INFORMATION

☐ From the attached Void Cheque ☐ as follows:

NAME OF FINANCIAL INSTITUTION		
TRANSIT NUMBER *(5 digits)*	**BANK NUMBER** *(3 digits)*	**ACCOUNT NUMBER** *(include zeros and spaces)*
ACCOUNT TYPE	**DEPOSITERS NAME(S) OR COMPANY NAME**	

a) All cheques must be in Canadian Funds drawn on a Canadian financial institution and be payable to CUMIS Life Insurance Company.

b) Has temporary insurance been applied for? ☐ YES ☐ NO
If "YES", please provide one full month of the annual premium to secure temporary insurance.

c) If the account being used is not the Life Insured(s)' or Owners' account, please provide the name of the account holder, relationship to the insured and signature of the account holder in the space provided below:

NAME	**RELATIONSHIP TO INSURED**				
SIGNATURE	**DATE**	*day*	*month*	*year*	

Receipt for Payment

AMOUNT RECEIVED
$

The first premium must be paid by cheque in Canadian funds drawn on a Canadian financial institution, and be made payable to CUMIS Life Insurance Company. This Receipt does not bind CUMIS Life Insurance Company to provide coverage under the Temporary Insurance Agreement unless all of the terms and conditions thereof are satisfied. This Receipt is to be given to the Owner when a valid payment is made. The amount received is payable to CUMIS Life Insurance Company for an application for insurance on the proposed insured person(s) named below.

NAME OF LIFE INSURED #1 *first* *middle* *last*		NAME OF LIFE INSURED #2 *first* *middle* *last*			
TOTAL INSURANCE COVERAGE APPLIED FOR	SIGNATURE OF AGENT	DATE	*day*	*month*	*year*

Temporary Insurance Receipt

This form is to be given to the Owner only if ALL Temporary Insurance Agreement requirements have been met. (otherwise, return to CUMIS Life Insurance Company along with the application)

1. If you are older than 15 days and under the age of 65 years on the date the application is signed; and
2. The first initial premium has been paid with the application and your bank honours the cheque when we first present it for payment; and
3. Your first premium is at least one full month of the annual premium for your basic policy and any additional benefits and riders; and
4. All of the individuals to be insured answered "NO" to all questions on the Temporary Insurance Agreement; and
5. You have received the Receipt for Payment, subject to conditions 1 through 4 outlined above having been satisfied.

Temporary Life Insurance Coverage

The maximum amount of insurance on the Life Insured under this and any other Temporary Insurance Agreement with CUMIS Life is limited to the lesser of:

a) The amount of Insurance applied for under the application; or
b) $500,000 for Life Insurance and $250,000 for Critical Care Insurance.

In applying for the maximum aggregate liability amount, amounts payable between this and other Temporary Insurance Agreements shall be pro-rated.

The Temporary Insurance coverage for a proposed Life Insured will be the same amount (subject to the maximum amount specified above) and of the same plan type (single, joint first-to-die or joint last-to-die) as applied for under this application with respect to that proposed Life Insured.

This agreement excludes coverage under a Term Child Rider, Universal Life Child Rider, Critical Care Child Rider.

Side A

Medical Information Bureau

Medical Information Bureau (MIB) – Pre-Notice to Applicants

Information regarding your insurability will be treated as confidential. CUMIS Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, 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 at 1-866-692-6901 (TTY 1-866-346-3642). 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:

330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7.

CUMIS Life Insurance Company, 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.

CUMIS®

Insurance Limitations

No Benefits will be paid under this Temporary Insurance Agreement if:

1. Any applicant(s) [or any Owner if different from the applicant(s)] has, in the application, for the coverage being applied for, or in the Temporary Insurance Agreement, failed to disclose or misrepresented facts within his/her knowledge which are material to the risk; or
2. The claim occurs as a result of suicide or self-inflicted injuries while sane or insane, or results directly or indirectly from a drug or alcohol related condition; or
3. The claim occurs as a result of committing or attempting to commit a criminal offense; or
4. Where the applicant(s) [or any Owner if different from the applicant(s)] is applying for Critical Care coverage only, if that person is diagnosed with cancer or with any other covered condition as would be defined in the policy applied for and death occurs from the covered condition within 30 days of the diagnosis; or
5. The application is for any of the following:
   – insurance through a "conversion" provision of an existing policy.
   – insurance through an election of a survivor's benefit.

Condition for Termination

Coverage under this Temporary Insurance Agreement will end on the earliest of:

1. The date the insurance applied for becomes effective; or
2. The date CUMIS Life notifies the Owner that the application for coverage has been declined, postponed or withdrawn/not proceeded with, or if we offer you a policy based on terms other than those outlined in your application and you do not accept the policy; or
3. The date the Owner requests the application to be closed/withdrawn; or
4. The 90th day following the date the application for insurance has been signed and dated; or
5. The date CUMIS Life refunds the amount paid with the application.

Limitation of Authority: No agent or broker is authorized to waive or modify any part of this Agreement.

AGENT'S NAME					**PROPOSED INSURED'S NAME (LIFE #1)**	*first*	*middle*	*last*
DATE	*day*	*month*	*year*	**SUM INSURED**	**PROPOSED INSURED'S NAME (LIFE #2)**	*first*	*middle*	*last*

Side B

CUMIS®

Agreement, Declaration and Authorization

Please read this entire section carefully. It explains how your personal information is used to issue and administer the insurance policy you have applied for.

At the end of this section we ask you to sign. Your signature means that you authorize and agree to the ways we collect, use, share and retain your personal information and that you agree to the terms described in this application.

By signing this application, I agree that:

1. I was present during the completion of the application for insurance (the "Application") to CUMIS Life Insurance Company ("CUMIS Life"). I have read and reviewed the entire contents of the application and declare that all statements made and answers given by me including, without limitation, my responses to questions, are true and complete and have been correctly recorded.
2. The application, whether for a new policy or for a change or conversion to an existing policy, consists of:
   a) CUMIS Life's paper application form; or, where applicable
   b) CUMIS Life's electronic application form, including my responses to health questions posed by a telephone interviewer representing CUMIS Life; and
   c) any supplementary applications, questionnaires or forms required by CUMIS Life; and
   d) the Agreement, Declaration and Authorization.
3. If a telephone interview is required by CUMIS Life to complete the application, I consent to the audio recording of the interview and acknowledge that I am entitled to receive a copy upon request. I understand that my responses to the telephone interview will be relied upon by CUMIS Life to assess my insurability and that I am bound by those responses. I further understand that my completed application resulting from the telephone interview will form part of my contract for insurance with CUMIS Life (the "Policy") and may be subsequently used by CUMIS Life to administer or adjudicate any claim under the Policy.
4. If I do not agree with the responses recorded by the telephone interviewer in the application and feel that the information has not been recorded accurately or is incomplete, I must contact CUMIS Life immediately at 1-800-263-9120 so that my eligibility for insurance can be fully assessed by CUMIS Life.
5. I must disclose in the application all information that I am aware of that is relevant to the coverage that I am applying for. If I conceal or misrepresent information or make a false declaration, the Policy may be cancelled by CUMIS Life and I may have no insurance when a claim is made. I further understand that no agent or representative of CUMIS Life is authorized to waive or modify any part of the application.
6. Insurance coverage will begin when the Policy is delivered to me, as long as I am in the same state of health as when I completed the application, and have paid my first premium to CUMIS Life. By accepting delivery, I will be confirming that my health has not changed and will be agreeing to the terms and conditions of the Policy.
7. If my health has changed between the time of my application and the delivery of the Policy, I must advise CUMIS Life immediately.
8. If the application is delivered by facsimile transmission, the facsimile copy received by CUMIS Life will be considered the original document for all purposes. A photocopy of this Agreement, Declaration and Authorization will be considered an original document for all purposes but, if required by CUMIS Life, I agree to provide additional signed copies.
9. I understand the language in which this application is written and recorded.
10. I have received a copy of the Medical Information Bureau Pre-Notice and this Agreement, Declaration and Authorization.
11. If the insurance applied for is on the life of a child under the age of 16, the parent or legal guardian of the child specifically consents, by their signature below, to the application.

I Authorize:

1. Each licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or such other organizations, institution or person that has any records of knowledge of me or my health, to disclose any such information to CUMIS Life or its reinsurers.
2. CUMIS Life and its representatives to collect, test and disclose the results of any medical tests that may have been required by CUMIS Life to underwrite the application. Such tests may include but may not be limited to, examinations, x-rays, electrocardiograms, blood, urine or saliva tests for cholesterol or other lipid, diabetes, liver and kidney disorders, immunological disorders including AIDS Virus (HIV), the presence of medications and other drugs and metabolites of nicotine. CUMIS Life may release the results of the tests and examinations to its reinsurers, my attending physicians, the Medical Information Bureau and, where required, to public health authorities. In the event of my death and upon request of CUMIS Life, the Owner or beneficiary of the Policy, or the representative or administrator of my estate, is expressly authorized to provide information to CUMIS Life to administer or adjudicate a claim under the Policy.
3. The Motor Vehicle Division in any province to provide CUMIS Life or its representatives copies of my driving record and any other driving-related information that is relevant to this application.
4. CUMIS Life to draw premiums (including any overdue premiums) from my financial institution to pay for the Policy.
5. CUMIS Life to use my social insurance number for tax reporting and administration of any benefits, policies or contracts under which I am insured.
6. My life insurance agent, if I intend to replace an existing insurance policy with the Policy I have applied for, is to provide the completed replacement disclosure form to CUMIS Life and to the insurer that issued the existing policy.

SIGNATURE OF LIFE INSURED #1	DATE	*day*	*month*	*year*
SIGNATURE OF LIFE INSURED #2	DATE	*day*	*month*	*year*

Your Privacy Matters to Us

I understand and agree that the personal information furnished on this insurance form and provided by me will be used by CUMIS Life Insurance Company ("CUMIS Life") to establish a file on me where information will be used by authorized personnel to issue, administer and service the coverage that I am applying for. I authorize the collection, use and disclosure of such personal information for this purpose. I understand that I am entitled to consult the personal information contained in my file, and where applicable, to have any inaccuracies in my file corrected.

I also understand and acknowledge that CUMIS Life has entered into service provider and data processing arrangements with companies located in Canada and the United States. I therefore understand and acknowledge that my personal information may be stored or processed in either country, and that under applicable law, governments, courts, law enforcement, or regulatory agencies may, by lawful order, obtain disclosure of my personal information.

I consent to the personal information provided in the application form (other than payment, health or lifestyle information) also being shared with my financial institution and affiliates, other CUMIS Life affiliates, or entities with whom my financial institution has made arrangements, to advise me of various products and services which may be of value to me ("Other" purposes). I understand that, if I wish, I may choose not to have my information shared or used for these Other purposes by contacting CUMIS Life in any of the manners set out below.

Questions about Your Privacy can be directed via email at privacy.officer@cumis.com or by calling CUMIS Life toll-free at 1-800-263-9120.

You can also visit us online at www.cumis.com or send a note to:

CUMIS Life Privacy Officer
P.O. Box 5065, 151 North Service Road
Burlington, ON, L7R 4C2

Signatures

Please review this application, including the authorizations and agreements on pages 21 and 22 and sign below.

By signing below you are confirming that:

- You have read the application and confirm that the statements in it are complete, current and accurate to the best of your knowledge and belief. You will immediately notify CUMIS LIfe of any errors or omissions.
- You have read and understood the policy illustration, including the fact that some values in the policy may not be guaranteed. You will contact CUMIS LIfe immediately if you have any concerns regarding your illustration.
- If you are eligible for temporary insurance, you have read and understood the information contained in the Temporary Insurance Receipt (see page 19).
- You agree to the terms described in this application.
- A copy of this authorization is as valid as the original document.

Your Agent's access to your personal information

- If our findings concerning blood pressure, cholesterol level or physical build affect your application, CUMIS LIfe may share this information with your agent.
- If the information you provide in this application or in any associated telephone interview or paramedical interview affects your application, CUMIS LIfe may tell your agent whether the relevant information relates to your family history or medical information.

You agree that CUMIS LIfe may share the information with your agent as described above and that your agent can use this information to discuss your insurance options with you. If you do not agree, select the applicable box below.

Life Insured #1 does not agree ☐

Life Insured #2 does not agree ☐

Note: If the policy owner is a corporation, we require the signature and title of the signing officer.

SIGNED AT (CITY/TOWN, PROVINCE)	DATE SIGNED	*day*	*month*	*year*

SIGNATURE OF LIFE INSURED #1	SIGNATURE OF WITNESS
SIGNATURE OF LIFE INSURED #2	**SIGNATURE OF WITNESS**

SIGNATURE OF OWNER (IF NOT LIFE INSURED #1 OR #2)	TITLE (IF OWNER IS A BUSINESS)	SIGNATURE OF WITNESS
SIGNATURE OF OWNER (IF NOT LIFE INSURED #1 OR #2)	**TITLE (IF OWNER IS A BUSINESS)**	**SIGNATURE OF WITNESS**

FOR CORPORATIONS: FULL LEGAL NAME (INCLUDING COMPANY, LIMITED, INC, ETC.)

If a person to be insured is under age 16, the mother, father or guardian (if they are not also a policy owner) must sign below to consent to this application for insurance (if juvenile application or any child rider(s)).

Relationship to the person to be insured: ☐ Mother ☐ Father ☐ Guardian

SIGNATURE	SIGNATURE OF WITNESS

151 North Service Road, Burlington, Ontario L7R 4C2 • 1-800-263-9120

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