

Information Disclosure and Authorization & Questionnaires

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INSTRUCTIONS

- If the Client requires the assistance of a translator or interpreter, please have the Interpreter Services Declaration completed by both the Client and the interpreter.
- Completion of the corresponding Canadian Residency or U.S. Persons questionnaire is required for Clients who have residential connections to or citizenship in Canada or the U.S.
- Completion of questionnaires is required only when applicable.
- If you opt into the Non-Medical Underwriting program, please proceed with the attached Health History Questionnaire which can be found on page **14**. Otherwise, complete the Confidential Medical Questionnaire which is located on page **20**.
- **REMINDER:** Please provide a copy of the Confidential Medical Questionnaire to the medical facility that the Client will be attending.
- All of the materials included in this booklet are available in our Broker Portal, at www.sunlife.com/international.

Information Disclosure and Authorization

Please PRINT clearly.

SECTION I. INFORMATION DISCLOSURE

A. Personal Information

Please PRINT name exactly as you wish it to appear in future documents.

1. Mr. Mrs. Ms. Mdm. Other Title

<input type="text"/> Family Name/Last Name	<input type="text"/> Given Name/First Name	<input type="text"/> Suffix
Are you/have you been known under any Former Name, Maiden Name, Western Name or Alias? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," please provide the other names below		
<input type="text"/> Date of Birth (dd/mm/yyyy)		<input type="text"/> Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

2. City of Birth Country of Birth

3. a. Country(ies) of Citizenship

b. Permanent Resident Address

4. a. City State/Province Country Postal Code

Email address Country Code and Phone Number

- b. How long have you lived at the present address? _____ (years)
- c. If less than 10 years, did you live in a different country? Yes No
If "Yes," please name the previous country of residence:

- d. Do you own additional residential properties (vacation home, second home, time share, etc.)? Yes No
If "Yes," please give full address of each and amount of time spent there each year:

Property Purpose	Full Address	Amount of Time Spent There Each Year

SECTION I. INFORMATION DISCLOSURE (continued)

5. Do you hold a current passport, visa, or have permanent resident status in any country other than listed above? Yes No

Country	Passport, Visa or Permanent Resident Status	Amount of Time Spent There Each Year

6. Have you or any close relative ever held a senior position in a government, political party, military, tribunal, or government owned corporation? Yes No

If "Yes," please provide title/rank, details of duties, time period position was held, and nature of relationship with the PEP: Refer to Field Underwriting Guide for further information.

Title/Rank	Details of Duties	Time Period Position Was Held (mm/yyyy to mm/yyyy)	Nature of Relationship to the PEP

7. Do you participate in hazardous avocations such as scuba diving, hang gliding, mountain climbing, automobile racing or other hazardous activity? Yes No

8. Do you participate in aviation activities other than as a passenger on scheduled commercial airlines? Yes No

If you answered "Yes" to questions 7 and/or 8, please complete the appropriate questionnaire(s).

9. Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vapour products, marijuana, nicotine patches, nicotine gum, hookah, e-cigarettes or shisha)? Yes No
If "Yes," please provide details:

Product(s)	Amount(s)	Frequency of Use	Date(s) last used (mm/yyyy)

SECTION I. INFORMATION DISCLOSURE (continued)

- 10. a.** In the past 10 years, have you been convicted of reckless driving, driving while intoxicated, or had a driving license suspended or revoked? Yes No
- b.** Have you ever been convicted due to an automobile accident? Yes No
- 11.** Do you have any pending charges, or have you ever been charged with or convicted of any criminal offense, or are you currently on probation, parole or statutory release? Yes No

If you answered "Yes" to any of the questions 10a through 11, please provide details and dates:

SECTION I. INFORMATION DISCLOSURE (continued)

12. Have you travelled over the past 12 months? Yes No
If "Yes," please provide details:

Past 12 months

City/Cities	
Country	
Length of Visit	Frequency of Visits

City/Cities	
Country	
Length of Visit	Frequency of Visits

City/Cities	
Country	
Length of Visit	Frequency of Visits

13. Do you plan to travel in the next 12 months? Yes No
If "Yes," please provide details:

Next 12 months

City/Cities	
Country	
Length of Visit	Frequency of Visits

City/Cities	
Country	
Length of Visit	Frequency of Visits

City/Cities	
Country	
Length of Visit	Frequency of Visits

SECTION I. INFORMATION DISCLOSURE (continued)

14. Do you plan to live outside your current country of residence within the next two years? Yes No
 If "Yes," please complete questions 14a - d.

a. Name the city and country in which you plan to reside:

City	Country
------	---------

b. Reason for your change in residence:

c. How long will you be at this new residence? _____

d. Do you plan to return to your current country of residence? Yes No
Complete the appropriate questionnaire if applicable.

B. Life Insurance In Force

1. Do you have Life Insurance In Force? Yes No
 If "Yes," please complete question 2.

2.

Name of Insurance Company	Amount of Coverage In Force	Year of Issue

3. Do you plan to:

- Replace Yes No
- Change Yes No
- Use values from any existing insurance coverage as a source of premium payment for coverage being applied for Yes No

If "Yes," please provide details:

SECTION I. INFORMATION DISCLOSURE (continued)

C. Insurance History

Have you ever had any applications for life, disability, critical illness, health or long term care insurance declined, rated, postponed, cancelled or modified in any way? Yes No
 If "Yes," indicate when, which company and why:

Year of Application	Insurance Company	Product Applied For	Decision and Reason

D. Life Insurance Currently Applied For

1. Do you have any applications for life insurance currently pending or contemplated? Yes No
 If "Yes," please provide details:

Name of Insurance Company	Amount of Coverage	Date of Application

2. Ultimate Total Line

What is the ultimate total amount to be placed in all companies (including existing in force life insurance coverage)?

SECTION II. CONFIDENTIAL FINANCIAL STATEMENT

A.1. Business/Employer Information

Name of Business/Employer		Nature of Business (manufacturing, hospitality etc.)	
Business Street Address			
City	State/Province	Country	Postal Code
Business Website Address			
Job Titles and Duties			

A.2. Income Statement (in U.S. dollars)

- Joint, shared with _____ (indicate relationship). Portion earned by Client _____%.
- Individual

Earned Annual Income	US\$	Unearned Annual Income	US\$
Salary		Investments (Bonds, Dividends, Interest, etc.)	
Bonus		Real Estate (Profit from sales of properties, Rental income, etc.)	
Others		Business (Directorship, LLP, Partnership, Sole-proprietorship, etc.)	
Others		Others (Gift, Inheritance, etc.)	
Total Annual Income (Earned + Unearned)			

A.3. Assets/Liabilities

- Joint, shared with _____ (indicate relationship). Portion earned by Client _____%.
- Individual

Assets	US\$	Liabilities	US\$
Cash and Savings		Personal Loans	
Stocks and Bonds		Margin Account	
Value of Business Interest (please provide details in A4)		Loan Guarantees	

SECTION II. CONFIDENTIAL FINANCIAL STATEMENT (continued)

A.4.

Assets	US\$	Liabilities	US\$
Real Estate (please provide details below)		Mortgages	
Others		Others	
Total Assets		Total Liabilities	
Net Worth (Total Assets – Total Liabilities)			

Real Estate: City and Country	Purpose	
1	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Rental	\$
2	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Rental	
3	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Rental	
4	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Rental	

Net Business Interests: Company Name	City and Country	Percentage Owned	Website	
1				\$
2				
3				
Other (please specify)				

A.5. In the last 5 years, have you declared or been petitioned into personal or corporate bankruptcy? Yes No
 If "Yes," please provide dates and details:

A.6. Is the purpose of insurance related to business? Yes No
 If "Yes," please complete the Business Financial Statement on Page 9.

B. Financial References

Name of Bank/Financial Institution	Country	Name of Contact

SECTION III. BUSINESS FINANCIAL STATEMENT

A. If the purpose of insurance is related to business, please complete this questionnaire.

Name of Business		
Permanent Business Address		
Current Mailing Address, If Different		
City	State/Province	Country
Business Website Address		

Purpose of Insurance

Key person Credit coverage Deferred compensation Buy/Sell Other _____

Type of Business

Sole proprietorship Corporation General Partnership Limited Partnership Limited liability company Other _____

Nature of the Business

General Data

Client's Position in the Company	Salary \$ (U.S.)
Length of Service	Bonus \$ (U.S.)
Client's Ownership Share of the Business	

1. Are other key employees to be insured? Yes No
2. Have you ever declared bankruptcy? Yes No

If "Yes" to question 1 or 2, please give further details:

--

Balance Sheet (in U.S. dollars)

Attach a copy of current audited financial statement.

Assets	\$	
Net Worth	\$	
Gross Income	\$	

Liabilities	\$	
Market Value	\$	
Net Income	\$	

SECTION III. BUSINESS FINANCIAL STATEMENT (continued)

I authorize

Name of Contact at Financial Institution
--

of

Financial Institution

to discuss and/or release information regarding the assets held in my account by the above mentioned financial institution.

SECTION IV. MEDICAL INFORMATION

For Non-Medical underwriting submissions, please complete the Health History Questionnaire.

A. Medical Advisor/Clinic/Hospital Information

Refer to Confidential Medical Questionnaire

Do you have a personal care physician? Yes No

If "Yes," provide details below:

Name of personal physician, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

If information is to be released by a person or facility located in the U.S., the Authorization for Release and Disclosure of Health Related Information form must be attached.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility to release any and all information contained in my records to any life insurance company. The life insurance company may disclose this information to (1) insurers, (2) reinsurers, or (3) any financial representative, broker, or agent to determine my insurability for life insurance.

SECTION V. CONSENT AND AUTHORIZATION

This is PART I of the Consent and Authorization and requires signatures as set out.

Attention Authorized Representative: Did you act as a translator or did you require a third party translator to question the Client? Yes No
If "Yes," complete and attach an Interpreter Services Declaration form.

The undersigned hereby acknowledges and agrees that personal information about the proposed insured obtained by the Company, including via this questionnaire, may be relied upon by the Company and used by:

Authorized Representative Name (Please PRINT clearly.)	
Authorized Representative Signature	Date (dd/mm/yyyy)
X	

as my representative and agent, as the basis for making application for life insurance coverage on my life. This questionnaire does not constitute an offer of life insurance coverage, nor is it intended to be a solicitation on behalf of any life insurance company. My answers to the questions on this form and any ancillary forms will be used to assess my insurability, and I represent and warrant that my answers are complete, correct and true to the best of my knowledge and belief. I have given all information which is relevant and which could influence a company's underwriting decision (if unsure whether a particular fact is relevant, it should be disclosed here in writing), and I understand and agree that the failure to provide all relevant information in complete detail may result in benefits being contested by any company which provides me with life insurance coverage, including that the policy may be cancelled or terminated. In addition to my answers to this questionnaire, information about me from other sources may be considered. This information may include personal information, such as results of a physical examination, information from my health care providers, from third parties, existing databases, and additional questionnaires which I may be asked to complete and sign.

Also, by this form, I hereby authorize and appoint the above named Authorized Representative, as my attorney in fact, and as my representative and agent to submit this questionnaire (or a copy) and to complete such other ancillary forms as may be required in connection with placing insurance coverage for up to, but not exceeding \$ _____ (U.S. dollars) in face benefits, or \$ _____ (U.S. dollars) of initial premium. I understand and agree that any life insurance coverage requested based on the information contained herein will not become effective until and unless (a) the Policy issued during the lifetime of the Insured (b) the annual premium is received in good order by the life insurance company, and (c) the statements made in this Information Disclosure and Authorization, the Confidential Medical Questionnaire, the Health History Questionnaire and any ancillary forms/questionnaires remain complete and true as of the date the policy is delivered. No premium or other consideration has been paid with this questionnaire, and no premium will be payable until and unless such coverage has been placed, as communicated in writing, to the financial representative or owner, by the life insurance company providing such coverage.

I understand and agree that:

1. All information that the Company collects about me (including personal information), which includes the information provided via this questionnaire and all ancillary forms (and together with the information I provide at the time of my medical examination) will, and may be used by the Company in connection with, and to form the basis of, and will also become part of, any life insurance issued as a result thereof.
2. The Company has fundamentally relied upon all such information to issue such life insurance policy.
3. No Financial Representative, broker, agent or medical examiner has the authority to make or modify any life insurance policy, to decide whether I am an acceptable risk or to waive any rights or requirements of any insurance company.
4. In accepting any policy that may be issued, I authorize the Authorized Representative to accept any corrections and amendments made by the life insurance company. No change in plan, amount, benefits, age at issue or classification can be made without the Authorized Representative's written consent.
5. The Authorized Representative is acting on my behalf and not as the soliciting agent for any life insurance company, and no solicitation for life insurance has been made in my country of residence in connection herewith.
6. Any life insurance company, bank or trust company may rely on the information contained herein as if this questionnaire was prepared directly for use by any of them. A copy shall be deemed to be the same as the original questionnaire by any such company.
7. I understand that any illustration which may be presented to me is intended only to demonstrate how life insurance may perform. Cash values, life insurance benefits and net annual outlays may be greater or less than those shown in the illustration, depending on future interest rates, future cost of insurance charges and the timing and amount of future premium payments and policy loans. I acknowledge that any illustration presented to me does not form any part of any certificate/policy of life insurance coverage which may be issued on my life.
8. The limited power of attorney granted to the Authorized Representative in connection with the life insurance coverage described herein shall terminate automatically without any rights or duties surviving such termination upon acceptance by the Authorized Representative of any policy issued pursuant hereto and thereupon shall no longer be of any force and effect.
9. To the extent required or permitted by laws or regulations applicable to the life insurance company or its corporate parent(s), subsidiaries, or affiliates, the policy [certificate] and any person's interest therein may be reported to tax and regulatory authorities in Bermuda or other applicable jurisdictions.

This authorization and/or copies of it will be used for purposes of assessing all eligibility for life insurance coverage and for the administration of said life insurance coverage that may be issued by the company on the life of the Client.

continued on next page

SECTION V. CONSENT AND AUTHORIZATION (continued)

This is PART II of the Consent and Authorization and requires signatures as set out.

I hereby represent to any life insurance company which is provided this Information Disclosure and Authorization (“IDA”) booklet that the information I have provided in this IDA booklet including my answers to the above questions contained in this IDA booklet are complete, correct, and true to the best of my knowledge and belief. I agree that my answers, as listed in this IDA booklet, together with all ancillary forms (and information provided by any medical examination) will be fundamentally relied upon by such life insurance company and, as such, shall form the basis for life insurance coverage and that all such documents shall be incorporated as part of any Policy or Certificate issued which provides life insurance coverage on my life. I confirm I am not acting on behalf of or at the direction of an undisclosed third party or identification information as prescribed by the insurance company is submitted herewith.

Without limiting any other provision of this Consent and Authorization, by signing below, the undersigned agrees, consents to and acknowledges that the Company will collect, use and may disclose personal information to others for the following purposes:

(a) in any connection with any life insurance coverage the undersigned may apply for or secure; (b) undertaking any evaluations, analytics, assessments and determinations related to actuarial, pricing and policy terms and conditions that may be required; (c) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as “your policy”), (d) to underwrite an application for your policy, (e) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (f) to administer coverage, benefits, and other features provided by your policy, (g) to obtain reinsurance, or (h) for any other legally permissible purpose related to your policy provided by the Company; and, as set out and described in the Privacy Notice concerning the Company’s use of the undersigned’s personal information by, which the undersigned hereby confirms and represents to the described herein the undersigned has accessed, reviewed and understands. You may obtain a copy of the Company’s Privacy Notice by visiting the Company’s website or by requesting a copy from your Financial Representative.

I further authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility to release any and all information contained in my records to any life insurance company.

The undersigned agrees that the life insurance company may disclose your personal information, including medical information, to any third parties who may reasonably require such information in any connection with the insurance policy and coverage, including to: (1) reinsurers, (2) affiliates, (3) third party service providers, (4) professional advisers, and (5) any financial representative, broker or agent, to carry out the described with administration of your policy, and otherwise as permitted by applicable law and as set out in the Company’s Privacy Notice. You may also obtain a copy of the Company’s Privacy Notice from your Financial Representative.

With respect to financial records, I authorize the following financial institution to discuss and/or release to the life insurance company for the purposes detailed herein any information regarding the assets held in my account at the financial institution:

Name of Contact at Financial Institution
--

of

Financial Institution

Identification

Please attach an authenticated copy of your passport or government-issued identity document. **The identification number, your photograph and your signature must be legible.**

Government ID Number	Country of Issue
Passport Number	Country of Issue
Date of Expiration (dd/mm/yyyy)	

NOTE: If the proposed insured is under age 18 then the signature of a parent or legal guardian is required in the space provided below.

Proposed Insured Name (Please PRINT clearly.)	
Signature of Proposed Insured X	Date (dd/mm/yyyy)
Signature of Parent/Legal Guardian (please circle which applies) X	Date (dd/mm/yyyy)

Interpreter Services Declaration

For use with Information Disclosure and Authorization, Confidential Medical Questionnaire/Health History Questionnaire

Please PRINT clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
Financial Representative's Family Name/Last Name	Financial Representative's Given Name/First Name	General Agent

CLIENT'S DECLARATION

I, _____, of the city of _____,

in the state/province of _____, country _____, declare that:

1. I am the person whose life is to be insured and I consent to a policy being placed on my life.
2. All statements made on the above indicated document are complete and true.
3. I have had the above indicated document fully explained to me in my native language by a translator.

I attest to understanding the questions as translated and to my answers, as recorded.

Location signed (city, state/province)	Location signed (country)
Signature of Client X	Date (dd/mm/yyyy)

INTERPRETER'S DECLARATION

I, _____, of the city of _____,

in the state/province of _____, country _____, declare that:

1. I faithfully and truly interpreted the above indicated document to:

_____ on _____ whose native language is _____.

2. I read over the contents of the above indicated document and explained the nature and contents to be completed by the Client.
3. The Client appeared to understand the questions as asked and his/her answers, as recorded. The Client has signed the above indicated document in my presence.

Location signed (city, state/province)	Location signed (country)
Signature of Interpreter X	Date (dd/mm/yyyy)

Health History Questionnaire

INSTRUCTIONS

Please follow these instructions closely. The information obtained is important for underwriting your insurance submission. Please review the Field Underwriting Guide with your Broker if you have any questions on completing this questionnaire. We sincerely appreciate your business.

- Please print clearly
- Print in black ink
- All recorded answers must be in English
- Answer every question
- Use the additional space to provide full details of your health history
- Any answer changes must be initialed by the Proposed Insured
- Please sign and date this form once completed

Did you require a third-party translator to complete these questions? Yes No
 If "Yes," complete and attach an Interpreter Services Declaration form.

PROPOSED INSURED INFORMATION

Family Name/Last Name	Given Name/First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy)
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Passport or government identity document:

Type of Identification	Passport Number or Government ID Number
Country of Issue	Date of Expiration (dd/mm/yyyy)

CURRENT HEALTH STATUS

Height _____m _____cm Weight _____kg

Has your weight changed over the last 12 months? Loss/Gain (circle one): _____kg Reason: _____

PERSONAL HEALTH HISTORY

Please circle the specific condition for which any "Yes" answer is given.

- A. Have you ever been treated for or had any symptoms or indication of:
1. High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels? Yes No
 2. Anemia, hemophilia, or any other blood or bleeding disease or disorder? Yes No
 3. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder? Yes No

Provide details to "Yes" answers in Section Q on page 5.

PERSONAL HEALTH HISTORY (continued)

- 4. Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder? Yes No
 - 5. Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn's disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver? Yes No
 - 6. Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder? Yes No
 - 7. Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones? Yes No
 - 8. Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy? Yes No
 - 9. Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder? Yes No
 - 10. Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson's disease, tremor, Alzheimer's disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system? Yes No
 - 11. Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth? Yes No
 - B. Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus? Yes No
 - C. Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system? Yes No
 - D. Have you ever had a blood transfusion? Yes No
 - E. Other than for conditions already disclosed, in the last 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests? Yes No
 - F. Have you been hospitalized or had any surgery in the last 10 years? Yes No
 - G. Do you have any symptoms for which you have not yet consulted a physician or received treatment? Yes No
 - H. Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results? Yes No
 - I. Do you have a deformity or an amputation? Yes No
 - J. Are you taking any prescribed or non-prescribed medications? Yes No
 - K. Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vapour products, marijuana, nicotine patches, nicotine gum, hookah, e-cigarettes or shisha)? Yes No
- If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

PERSONAL HEALTH HISTORY (continued)

L. In the last 10 years have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics? Yes No
 If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

M. Do you currently drink alcohol? Yes No

If "Yes," which of the following best describes the average frequency of your alcohol consumption?

Daily Weekly Monthly Less than once per month

On those days when you drink alcohol, how many drinks do you typically have? _____

N. Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counseling or medical advice due to your use of drugs or alcohol? Yes No

If "Yes," indicate the type of counseling or treatments, and dates started and ended (include any participation in organizations/support groups) in Section Q on page 5.

O. Family History

1. Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder? Yes No

If "Yes," complete the following chart:

Your relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

2. Please provide current age or age at death and cause of death of remaining family members not recorded above:

Family Member	Current Age	or Age at Death and Cause of Death
Mother		
Father		
Brothers		
Sisters		

PERSONAL HEALTH HISTORY (continued)

P. Medical Advisor/Clinic/Hospital Information

Do you have a personal care physician? Yes No
 If "Yes," provide details below:

Name of personal physician, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

If you have no personal physician or health care advisor, please provide details of why you last consulted any medical clinic, health care advisor or hospital. This includes details of any health screening exams.

Name of medical doctor, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

SIGNATURE

I declare and represent to the life insurance company that my answers provided in this Health History Questionnaire are complete, correct, and true to the best of my knowledge and belief. I understand and acknowledge that my answers, as recorded in this Health History Questionnaire, together with all ancillary forms and information as may be required by the insurance company, will form the basis for life insurance coverage and that all such documents may be incorporated as part of any policy or certificate issued which provides life insurance coverage on my life. I understand that if I misrepresent any of my answers or statements or fail to provide all relevant information in complete detail, that may result in benefits being contested by any company which provides me with life insurance coverage and the policy may be voided.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Broker.

NOTE: If the proposed insured is under age 18 then the signature of a parent or legal guardian is required in the space provided below.

Signature of Proposed Insured X	Date (dd/mm/yyyy)
Signature of Parent/Legal Guardian (please circle which applies) X	Date (dd/mm/yyyy)

Confidential Medical Questionnaire

Please PRINT clearly.

MEDICAL QUESTIONNAIRE – INSTRUCTIONS

Please follow these instructions closely. The information obtained is important for the person being examined.

- All recorded answers must be in English.
- If any party to this examination has a personal or professional relationship to the Client, please do not proceed.
- Part 1 and Part 2 may be completed by the Examining Physician, Physician's Assistant or Nurse; Part 3 must be completed by the Nurse or Examining Physician (i.e., Cardiologist, Internist, or General Practitioner). Part 4 must be completed by the Examining Physician (i.e., Cardiologist, Internist, or General Practitioner). Part 4 is NOT completed for Paramedical exams.
- Review the person's original identity document(s) and record the information on Part 1 of this form. Attach a certified copy of the identity document(s) with this questionnaire.
- Review the person's medical history, list condition(s), and record the information on Part 2 of this form. Please ask the medical history questions as they are written and record the answers as given in full detail.
- Perform the physical examination to determine the person's current health status and record the information on Part 3 and Part 4 of this form. Please pay particular attention to any vital signs or other results of the examination that relate to the person's medical history. Laboratory tests to complete the examination are not listed on this form but will be provided separately.
- If the Client requires the assistance of a translator or interpreter, please have the Interpreter Services Declaration completed by both the Client and the interpreter.

PART 1. PROPOSED INSURED INFORMATION (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy)
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Passport or government identity document of person examined:

Type of Identification	Passport Number or Government ID Number
Country of Issue	Date of Expiration (dd/mm/yyyy)

Please attach a **legible** certified copy of the identity document of person being examined.

Are you satisfied as to the identity of the person being examined? Yes No

IF YOU ARE NOT SATISFIED AS TO THE PERSON'S IDENTITY, OR HE OR SHE IS UNABLE TO PROVIDE SATISFACTORY IDENTIFICATION, PLEASE DO NOT PROCEED WITH EXAMINATION OR TESTING.

Family Name/Last Name of Examiner	Given Name/First Name of Examiner
Examiner Address	
Examiner Signature X	Date (dd/mm/yyyy)

PART 2. PERSONAL HEALTH HISTORY (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	Date of Birth (dd/mm/yyyy)
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Please circle the specific condition for which any "Yes" answer is given.

- A. Have you ever been treated for or had any symptoms or indication of:**
- High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels? Yes No
 - Anemia, hemophilia, or any other blood or bleeding disease or disorder? Yes No
 - Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder? Yes No
 - Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder? Yes No
 - Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn's disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver? Yes No
 - Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder? Yes No
 - Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones? Yes No

Provide details to "Yes" answers in Section Q on page 6.

PART 2. PERSONAL HEALTH HISTORY (continued)

- 8. Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy? Yes No
- 9. Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder? Yes No
- 10. Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson's disease, tremor, Alzheimer's disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system? Yes No
- 11. Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth?..... Yes No
- B. Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus? Yes No
- C. Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?..... Yes No
- D. Have you ever had a blood transfusion?..... Yes No
- E. Other than for conditions already disclosed, in the last 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests?..... Yes No
- F. Have you been hospitalized or had any surgery in the last 10 years? Yes No
- G. Do you have any symptoms for which you have not yet consulted a physician or received treatment? Yes No
- H. Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results? Yes No
- I. Do you have a deformity or an amputation?..... Yes No
- J. Are you taking any prescribed or non-prescribed medications? Yes No
- K. Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vapour products, marijuana, nicotine patches, nicotine gum, hookah, e-cigarettes or shisha)? Yes No
 If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

- L. In the last 10 years have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics?..... Yes No
 If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

PART 2. PERSONAL HEALTH HISTORY (continued)

M. Do you currently drink alcohol? Yes No

If "Yes," which of the following best describes the average frequency of your alcohol consumption?

Daily Weekly Monthly Less than once per month

On those days when you drink alcohol, how many drinks do you typically have? _____

N. Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counseling or medical advice due to your use of drugs or alcohol? Yes No

If "Yes," indicate the type of counseling or treatments, and dates started and ended (include any participation in organizations/support groups) in Section Q on page 6.

O. Family History

1. Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder? Yes No

If "Yes," complete the following chart:

Your relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

2. Please provide current age or age at death and cause of death of remaining family members not recorded above:

Family Member	Current Age	or Age at Death and Cause of Death
Mother		
Father		
Brothers		
Sisters		

PART 2. PERSONAL HEALTH HISTORY (continued)

P. Medical Advisor/Clinic/Hospital Information

Do you have a personal care physician? Yes No

If "Yes," provide details below:

Name of personal physician, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

If you have no personal physician or health care advisor, please provide details of why you last consulted any medical clinic, health care advisor or hospital. This includes details of any health screening exams.

Name of medical doctor, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)			Date last visited
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

PART 2. PERSONAL HEALTH HISTORY (continued)

Question number	Date (dd/mm/yyyy)	Details	Name and address of doctors, medical clinics, health care advisors and hospitals

I declare and represent to the life insurance company that my answers provided in this Medical Questionnaire are complete, correct, and true to the best of my knowledge and belief. I understand and acknowledge that my answers, as recorded in this Medical Questionnaire, together with all ancillary forms and information as may be required by the insurance company, will form the basis for life insurance coverage and that all such documents may be incorporated as part of any policy or certificate issued which provides life insurance coverage on my life. I understand that if I misrepresent any of my answers or statements or fail to provide all relevant information in complete detail, that may result in benefits being contested by any company which provides me with life insurance coverage and the policy may be voided.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as “your policy”), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company’s privacy statement. You may obtain a copy of the Company’s privacy statement from your Financial Representative.

NOTE: If the proposed insured is under age 18 then the signature of a parent or legal guardian is required in the space provided below.

Signature of Person Examined X	Date (dd/mm/yyyy)
Signature of Parent/Legal Guardian (please circle which applies) X	Date (dd/mm/yyyy)

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information to process and evaluate an application, transaction, request, or administer coverage in connection with, life insurance, annuity, investment account, or other product or service the Company may offer or issue to a client, or for any other legally permissible purpose. The undersigned hereby consents to the collection, use, and disclosure by the Company of his or her personal information contained in (or included with) this form for the foregoing purposes.

Physician or Physician’s Assistant/Nurse (Family Name/Last Name, Given Name/First Name) (Please PRINT clearly.)	Date of Examination (dd/mm/yyyy)
Physician Signature X	Date (dd/mm/yyyy)
Physician’s Assistant/Nurse Signature X	Date (dd/mm/yyyy)

PART 3. CURRENT VITALS. COMPLETE FOR PARAMEDICALS AND MEDICALS. MUST BE COMPLETED BY THE NURSE OR THE EXAMINING PHYSICIAN (i.e., Cardiologist, Internist, or General Practitioner)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	Date of Birth (dd/mm/yyyy)
--	--	----------------------------

- A.** Height m cm Weight kg BMI
- Did Proposed Insured's weight change over the past 12 months? Yes No
- If "Yes," please provide details: _____
- Loss of Gain of kilograms
- B.** Pulse per minute Regular Yes No
- If irregular, type of irregularity: _____
- If extra systoles, please state number per minute: _____
- C.** Blood pressure (seated) / 2nd /
- D.** Urinalysis (Complete only if age 18 or older. Please fill in blanks or attach results and forward with this form)
- Protein Sugar Blood
- Date of last menses

For Paramedicals only: Skip to Part 6.

PART 4. CURRENT HEALTH STATUS. COMPLETE FOR MEDICALS ONLY. MUST BE COMPLETED BY THE EXAMINING PHYSICIAN (i.e., Cardiologist, Internist, or General Practitioner)

- A.** Is there any abnormality:
- Of the oral cavity, eyes, ears, nose, throat, skin (including xanthelasma, xanthomata, arcus senilis)? Yes No
 - Of the lymph nodes or the thyroid gland? Yes No
 - Of chest, spine or extremities? Yes No
 - Of lungs on percussion and auscultation? Yes No
- Please circle each condition where there is a positive response and report the details of such conditions on page 9.
- B.** Are any murmurs present? Yes No
- If "Yes," complete the following:
- Describe below the location of transmission, if any, and your diagnostic impression:
- Location: apex base intercostal space right of sternum left of sternum
 Intensity: Gr I Gr II Gr III Gr IV Gr V Gr VI
 Timing: systolic diastolic
 Classification: organic physiologic
 - Complete if more than one murmur:
 Location: apex base intercostal space right of sternum left of sternum
 Intensity: Gr I Gr II Gr III Gr IV Gr V Gr VI
 Timing: systolic diastolic
 Classification: organic physiologic
- C.** Is there:
- Intra-abdominal abnormality? Yes No
 - Any surgical scars? Yes No
 - A hernia? If "Yes," describe: _____ Yes No
 - Abnormality of the central nervous system (muscular power, reflexes, etc)? Yes No
 - Oedema of the ankles? Yes No
 - Inequality or inadequacy of the pulsations of the femoral, dorsalis pedis or posterior tibial arteries? Yes No
- For "Yes" answers, please provide details on page 9.

PART 5. MATURE AGE QUESTIONNAIRE

**PLEASE
NOTE**

To be completed for all Clients age 71 and over. Must be completed by the examining physician in conjunction with the Confidential Medical Questionnaire.

Please introduce this part of the exam as an assessment of mobility, daily living activities and memory.

1. Please indicate physical activity level (check all applicable)

- No mobility or gait limitations
- Uses aids, if checked, specify type: _____ (ie: walking stick, cane, walker, wheelchair, or other)
- Fall history in last 5 years, if checked, please specify number _____ and details.

Please provide details:

2. Does the Proposed Insured have any evidence of cognitive disorder such as dementia, memory loss, confusion, behavioral change, lack of comprehension, etc.? Yes No

If "Yes," please provide details:

3. Does the Proposed Insured need assistance with any activities of daily living including feeding, bathing, dressing, toileting, grooming and mouth care, transferring bed/chair, climbing stairs?..... Yes No

If "Yes," please provide details:

4. Please record how long it takes the Proposed insured to complete the following task.

Get up from a seated position, walk 10 feet, return and sit again.

_____ seconds

Comments:

5. In the space below, ask the proposed insured to:

Draw a circle

Mark in all the numbers to indicate the hours of a clock

Mark hands of clock to show 10 minutes past 9 o'clock (9:10)

Signature of Interviewer

X

Date (dd/mm/yyyy)

PART 6. EXAMINER INFORMATION

Did you act as a translator or did you require a third party translator to question the person examined? Yes No
If “Yes,” complete and attach an Interpreter Services Declaration form.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information to process and evaluate an application, transaction, request, or administer coverage in connection with, life insurance, annuity, investment account, or other product or service the Company may offer or issue to a client, or for any other legally permissible purpose. The undersigned hereby consents to the collection, use, and disclosure by the Company of his or her personal information contained in (or included with) this form for the foregoing purposes.

Family Name/Last Name of Examiner	Given Name/First Name of Examiner
Please state your Internal Medicine and/or Cardiology Certification(s)	
Number(s)	Country(ies)
Other Certifications and Countries Obtained	
Current Specialty of Practice	
Examiner's Signature X	Date (dd/mm/yyyy)
Address of Examiner's place of practice	

Was the examination completed at the examiner's normal place of practice and in a medical examination room? Yes No

If “No,” please describe the setting:

Canadian Residency Questionnaire

Please PRINT clearly.

CLIENT

1.	a. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Other Title	
	b. Family Name/Last Name		Given Name/First Name	
	c. Date of Birth (dd/mm/yyyy)		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	e. City of Birth		f. Country of Birth	
	g. Permanent Resident Address			
	City		State/Province	
	Country		Postal Code	

2. Are you a Canadian Citizen? Yes No

3. Do you hold a Permanent Resident Card (formerly Maple Leaf Card)? Yes No
If "Yes," provide details:

Issue Date (dd/mm/yyyy)	Expiry Date (dd/mm/yyyy)
-------------------------	--------------------------

If you answered **"YES"** to Question 3 and the Permanent Resident Card has **NOT** expired, you will need to provide a determination letter from the Canadian Revenue Agency confirming that you are not a tax resident of Canada in order to be eligible to apply.

- The determination letter must have been issued during the term of your Permanent Resident status. Please submit a copy of the determination letter with this completed Questionnaire.
- If you do not have a determination letter or the date of the letter is not within the term of your Permanent Resident Status, you are not required to complete this Questionnaire.

4. Have you declared non-residency status with the Citizenship and Immigration-Canada agency? Yes No
If "Yes," attach a copy of the determination or confirmation issued by the CIC.

5. How many days per year do you spend in Canada? _____

6. Where do you habitually reside and for how many days out of the year?

	Days
--	------

7. Do you maintain a home in Canada? Yes No
If "Yes," is the home occupied? Yes No

If "Yes," how is the home occupied and by whom?

For how long?

CLIENT (continued)

- 8. When the home is not occupied, is it leased to a third party? Yes No
- 9. How long did you previously reside in Canada? _____ Or N/A
- 10. Where does your spouse (if applicable) reside? _____ Or N/A
- 11. Do you have children residing in Canada? Yes No

If "Yes," provide details:

- 12. Do you have any familial connections with Canada, e.g. other family members who reside in Canada? Yes No

If "Yes," do you visit them in Canada, and how often and for how long?

- 13. Do you have any vehicles registered in Canada? Yes No
- 14. Do you maintain a Canadian Driver's License? Yes No
- 15. Do you maintain a Canadian Health Care Card? Yes No
- 16. Do you have a Canadian Bank Account? Yes No

If "Yes," is it active and how much income is earned from it?

- 17. Do you have any Canadian-source income? Yes No

If "Yes," what kind of income and how much?

- 18. Do you carry on business in Canada, personally or through a corporation, or have any business dealings or connections with Canada? Yes No

If "Yes," please describe:

- 19. Do you file a Canadian income tax return? Yes No

- If "Yes,"
 - a. Is it a non-resident tax return on Canadian source income only? Yes No
 - Or
 - b. Is it a resident return reporting worldwide income? Yes No

- 20. Do you intend to return to Canada to reside? Yes No

If "Yes," when and for how long?

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Financial Representative.

Client Signature X	Date (dd/mm/yyyy)
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U.S. Persons (Living Abroad) Supplemental Questionnaire

Please **PRINT** clearly.

This form is being completed by (please check all roles that apply): Insured Trustee Grantor/Settlor ("You")

CLIENT

1.	a. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Other Title		
	b. Family Name/Last Name		Given Name/First Name		
			Suffix		
	c. Date of Birth (dd/mm/yyyy)			d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	e. City of Birth		f. Country of Birth		
	g. Permanent Resident Address				
	City		State/Province		Country
				Postal Code	

2. Are you a U.S. citizen? (If "No," skip to 4) Yes No

3. Are you a U.S. dual citizen? Yes No

If "Yes," please list all countries of dual citizenship:

4. What is your country(ies) of citizenship?

5. Do you hold a current and unexpired U.S. Green Card? Yes No

If "Yes," provide issue date of your Green Card, the expiration date, the document number, and a photographed copy.

6. Do you maintain a permanent residence in the U.S.? Yes No

If "No," what is the country that you maintain a permanent residence?

7. Do you intend to continue residing outside the U.S. in the future? Yes No

If "No," please explain:

8. Are you a tax resident of the U.S. in the current and two (2) preceding years under the Substantial Presence Test? Yes No
Refer to the [U.S. Persons Tax Guidelines](#).
9. Is any policy/certificate beneficiary a U.S. Person? Yes No
10. Are you or any policy/certificate beneficiary an Exempt Individual? Yes No
11. For a trust, is a court within the U.S. able to exercise primary supervision over the administration of the trust; and does one or more U.S. Persons have the authority to control all substantial decisions of the trust? Yes No

AUTHORIZED SIGNATURE (INSURED OR TRUSTEE)

By signing below, you, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as “your policy”), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company’s privacy statement. You may obtain a copy of the Company’s privacy statement from your Financial Representative.

Any individual signing below on behalf of an entity or a trust represents and warrants that he or she has full authority to do so and is fully authorized to provide personal information about any individual(s) identified above or attached to or included with this package of documents who are associated with the entity or the trust, including any Director, CEO, Partner, Payor, Controlling Person, Settlor, Underlying Beneficial Owner, or Beneficiary.

You understand that certain foreign jurisdictions may impose a tax based on the citizenship or residency of the insured or policy owner. This tax may be assessed against the policy owner, the insured, and/or the insurer, for example as a percentage of premium paid. By way of example, but not of limitation, section 4371(2) of the U.S. Internal Revenue Code imposes a 1% excise tax in respect of foreign life insurance covering the life of a U.S. risk. The Policy Owner, (or Participant in the case of the Certificate, and Trust Participant in the case of the Master Trust), agrees to report and remit any such applicable tax(es) to the relevant taxing authority in a timely manner, failing which the Policy Owner (or Participant or Trust Participant as applicable) agrees to fully indemnify and reimburse the Company from and against all such taxes.

You understand that the Company makes no representations about the tax treatment of the policy or any benefits paid thereunder. Without limiting the foregoing, I/we understand that the policy will not comply with the U.S. tax definition of life insurance. It is strongly recommended that prospective Owners/Participants/Trust Participants consult their own tax and professional advisers before submitting an Application.

Print Family Name/Last Name	Print Given Name/First Name	<input type="checkbox"/> Insured <input type="checkbox"/> Trustee
Signature X		Date (dd/mm/yyyy)

Aerial Activities Questionnaire

Please PRINT clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
--------------------------------	--------------------------------	----------------------------

1. Type of activity:

- Ultra-Light Flying
 Hang Gliding
 Sky Diving/Parachuting
 Ballooning
 Para-Kiting
 Other (specify) _____

2. Are you a member of an organized club for this type of activity? Yes No

3. Give details of your training and certification:

4. a. How long have you been participating in this activity? _____

b. Number of times participating: Last 2 Years? _____ This Year? _____ Next Year? _____

c. Have you ever had an accident while participating in an aerial activity? Yes No

If "Yes," provide details:

5. a. Type of participation:

- As an Amateur
 As an Instructor
 Other (give details in the box below)
 In Exhibitions
 In Attempts for Altitude or Distance Records or Any Other Record Attempts
 For Remuneration or Profit
 Using Experimental Equipment (give details in the box below)

b. Give details to clarify above participation:

Declaration: I declare that the answers and statements to all of the questions are complete, correct, and true and shall form part of my application for insurance on my life. I understand that if I do not completely, correctly, and truthfully answer all of the questions or I misrepresent my answers or statements the life insurance company may void the policy.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Financial Representative.

Location signed (city)	Location signed (province)
Client Signature X	Date (dd/mm/yyyy)

Aviation Questionnaire

Please **PRINT** clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
--------------------------------	--------------------------------	----------------------------

1. What type(s) of aircraft(s) do you fly?

2. Please provide details of any Licenses or Certifications attained:

License/Certification Type	Country of Issue	Date of Issue	Date of Last Renewal	Date of Expiration
Student Visual				
Instrument Commercial				
Instructor Airline Transport				

3. Do you intend to change the scope of your present license? Yes No

If "Yes," provide details:

4. Are you a member of a flying club or association? Yes No

If "Yes," provide details:

5. How often do you fly and how many flying hours have you logged? (A copy of your logbook would be helpful.)

	Total	Last 12 months	Next 12 months (estimated)
Number of flights			
Number of hours			

6. Normal aviation patterns of where you fly to and from:

7. In the last 12 months, have you deviated from your normal aviation pattern or do you intend to in the next 12 months? Yes No

If "Yes," provide details:

8. Do you fly, or do you intend to fly for reasons other than for pleasure, e.g. for agricultural or commercial purposes etc.? Yes No

If "Yes," provide details:

9. Do you participate, or do you intend to participate in any stunt flying, aerobatics, competitions, exhibitions or test flying? Yes No

If "Yes," provide details:

10. Have you ever been involved in a flying accident or had your license restricted or suspended for any reason? Yes No

If "Yes," provide details:

11. Please provide any additional information that you feel is important:

Declaration: I declare that the answers and statements to all of the questions are complete, correct, and true and shall form part of my application for insurance on my life. I understand that if I do not completely, correctly, and truthfully answer all of the questions or I misrepresent my answers or statements the life insurance company may void the policy.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes:

(a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Financial Representative.

Location signed (city)	Location signed (province)
Client Signature X	Date (dd/mm/yyyy)

Motor Racing Questionnaire

Please PRINT clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
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1. AUTOMOBILE RACING

Types(s) of racing engaged in: (Check all boxes that apply)

Auto Crash

- T-bone, Rollover, Dive Bomber, etc.
- Demolition Derby

Midget/Sprint Car

- 1/4, 1/2
- 3/4 Full (Outlaw)

Drag Racer

- Top Fuel Dragster, Funny Car, Prostock (PRO)
- Other or Amateur

Rally

- Professional
- Other or Amateur

Jet Car

- Exhibition
- Record Attempts

Sports Cars

- Can-Am
- Formula Car

Kart

- Enduro, Sprint
- Experimental, Others
- Grand Touring (including Trans-Am and IROC)
- Record Attempts
- IMSA GT
- Indy Light Car
- Vintage or Other Sports Car Racing
- Off-Road (Baja 500, Mexican 1000, etc.)
- Stock Car (Specify type)

Record Attempts

- Sedan Racing (BMW, Audi, etc.)
- Time Trials

Specify make(s), model(s) and engine size(s) of vehicle(s):

Other: _____

2. MOTORCYCLE RACING

Types(s) of racing engaged in: (Check all boxes that apply)

- Road Racing (Grandprix or Productions)

Engine Size: _____ cc

Make and Model: _____

- Motorcross

Engine Size: _____ cc

Make and Model: _____

- Drag Racer

- Modified

- Stunt Riding, Acrobats, Daredevils, Time Trials or Speed Record Attempts

- Street or Stock

- Speedways (Ovals)

Engine Size: _____ cc

Make and Model: _____

- Top Fuel

Other: _____

3. POWERBOAT RACING

Types(s) of racing engaged in: (Check all boxes that apply)

Stock Offshore Racing Other: _____

4. COMPLETE IN ALL CASES

Where do you race?	What type(s) of surface(s) do you race on?	What type(s) of course(s) do you race on?	What is your maximum speed?

How often do you race? Last 12 months: _____ Next 12 months: _____

Name of sanctioning body: _____

Why do you race? Pleasure Income Both

Do you have any professional training? Yes No

If "Yes," provide details:

Declaration: I declare that the answers and statements to all of the questions are complete, correct, and true and shall form part of my application for insurance on my life. I understand that if I do not completely, correctly, and truthfully answer all of the questions or I misrepresent my answers or statements the life insurance company may void the policy.

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Location signed (city)	Location signed (province)
Client Signature X	Date (dd/mm/yyyy)

Mountain Climbing Questionnaire

Please PRINT clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
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1. Indicate the class of climbing in which you participate:

- Class 1 Hiking/Trails Walking without using hands or special equipment.
- Class 2 Scrambling Climbing over rocks or boulders using hands and wearing proper shoes.
- Class 3 Easy Climbing Steeper than Class 2, using hand and footholds and sometimes ropes.
Number of easy climbs per year: _____
- Class 4 Moderate Climbing Climbers are roped together and only one climber moves at a time.
The stationary climber protects the others by bracing with the rope.
Number of moderate climbs per year: _____
- Class 5 Difficult Climbing Free climbing while using special equipment to protect the climber.
Class and number of difficult climbs per year: _____
5.0 to 5.7: _____ 5.8 to 5.11: _____ 5.12 up: _____
- Class 6 Artificial - Aid Climbing Using special equipment to climb otherwise inaccessible or impassable routes.
Number of aided climbs per year: _____

2. Do you ice climb? Yes No Number of ice climbs per year: _____
 Do you climb glaciers? Yes No Number of glacier climbs per year: _____
 Do you participate in canyoneering? Yes No Number of canyoneerings per year: _____
 Do you climb solo? Yes No Number of solo climbs per year: _____

3. How long have you been climbing? _____

4. Where do you climb? _____

5. What seasons do you climb? Spring Summer Fall Winter

6. Are you a member of a club? Yes No If "Yes," name of club: _____

7. Do you ever climb alone? Yes No

8. List the equipment you use: _____

9. Length of average climbs? Hours: _____ Day(s): _____

10. Do you, or do you intend to alpine climb? Yes No
 Altitudes: _____ Number of alpine climbs per year: _____

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Location signed (city)	Location signed (province)	
Client Signature X	Date (dd/mm/yyyy)	

Underwater Diving Questionnaire

Please PRINT clearly.

Client's Family Name/Last Name	Client's Given Name/First Name	Date of Birth (dd/mm/yyyy)
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1. Date you began diving (dd/mm/yyyy): _____
2. Are you a certified diver (PADI, NAUI, ACUC, YMCA, Other (specify): _____? Yes No
 If "No," do you always dive with an instructor? Yes No

Provide details:

3. Do you engage in any specialty diving? Yes No
 If "Yes," check all that apply below:
- Night Diving Cave Diving Ice Diving Search and Rescue Free Diving Potholes Diving
 Live Boat Drift Diving Record Attempts Rebreather Mixed Gases Live Aboard
 Wreck Diving: Limited Penetration within Light Zone or Full Penetration
 Other: _____

Provide the following details: type of specialty certification, number of times you have engaged in each of these activities, location(s) and date of last participation.

4. Where do you dive? (Check all that apply)
 Ocean Lake Quarry River Other: _____
5. Do you ever dive alone? Yes No

If "Yes," provide details:

6. Depth of dives:

Depth	Number of recreational dives		Number of commercial dives	
	Last 12 months	Next 12 months	Last 12 months	Next 12 months
Up to 120 feet (36 metres)				
121 to 150 feet (37 to 45 metres)				
151 feet (46 metres) and over				

7. Maximum depth of dives: _____ feet metres Date of last dive (dd/mm/yyyy): _____

Commercial divers must complete questions 8 and 9.

8. Indicate in the box below the type of underwater work you perform, equipment used, frequency and duration:

9. Do you work with or near explosives or high voltage?..... Yes No

If "Yes," provide details:

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Location signed (city)	Location signed (province)
Client Signature X	Date (dd/mm/yyyy)

Mature Age Questionnaire

INSTRUCTIONS TO PHYSICIAN

- Complete this questionnaire if the Proposed Insured is age 71 years and over
- If any party to this examination has a personal or professional relationship with the Proposed Insured, please do not proceed
- Please answer every question and complete this questionnaire in English
- Obtain and submit a certified true copy of the Proposed Insured's **identity document** presented during this examination. If you are not satisfied with the Proposed Insured's identity, or he or she is unable to provide satisfactory identification, please do not proceed with the examination
- A Physician (Cardiologist, Internist, or General Practitioner) must complete this questionnaire with the Proposed Insured
- If the Proposed Insured requires assistance from an interpreter, please have the Interpreter Services Declaration completed by both the Proposed Insured and the Interpreter

Please inform the Proposed Insured that this questionnaire is an assessment of their mobility, daily living activities and memory.

1	<p>Please tick all applicable boxes to indicate the Proposed Insured's physical activity level</p> <p><input type="checkbox"/> No mobility or gait limitations</p> <p><input type="checkbox"/> Uses Aids – please provide type (walking stick, cane, walker, wheelchair, other)</p> <p><input type="checkbox"/> Fall history in the past 5 years – please provide details (number of falls, dates, any injury)</p>
2	<p>Is there any evidence of cognitive disorder such as dementia, memory loss, confusion, behavioral change, lack of comprehension, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please provide details</p>
3	<p>Does the Proposed Insured need assistance with any activities of daily living including feeding, bathing, dressing, toileting, grooming and mouth care, transferring bed / chair, climbing stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please provide details</p>
4	<p>Please record the time it takes for the Proposed Insured to get up from a seated position, walk 3 meters, return and sit again</p> <p style="text-align: center;">seconds</p> <p>Please provide comments</p>
5	<p>In the space below, please ask the Proposed Insured to:</p> <ul style="list-style-type: none"> ▪ Draw a circle ▪ Mark in all the numbers to indicate the hours of a clock ▪ Mark hands on the clock to show 10 minutes past 9 o'clock (9:10)

CONSENT AND AUTHORISATION

I declare and represent to the life insurance company that my answers provided in this Medical Questionnaire are complete, correct, and true to the best of my knowledge and belief. I understand and acknowledge that my answers, as recorded in this Medical Questionnaire, together with all ancillary forms and information as may be required by the insurance company, will form the basis for life insurance coverage and that all such documents may be incorporated as part of any policy or certificate issued which provides life insurance coverage on my life. I understand that if I misrepresent any of my answers or statements or fail to provide all relevant information in complete detail, that may result in benefits being contested by any company which provides me with life insurance coverage and the policy may be voided.

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Signature of Proposed Insured	
Name of Proposed Insured	
ID / Passport Number of Proposed Insured	Date (dd/mm/yyyy)

EXAMINER INFORMATION AND SIGNATURE

Did you complete the questionnaire at your normal place of practice and in a medical examination room?
If "No," where was the questionnaire completed?

Yes No

Did you or a third party act as an interpreter for the Proposed Insured?
If "Yes," please provide an Interpreter Services Declaration form.

Yes No

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information to process and evaluate an application, transaction, request, or administer coverage in connection with, life insurance, annuity, investment account, or other product or service the Company may offer or issue to a client, or for any other legally permissible purpose. The undersigned hereby consents to the collection, use, and disclosure by the Company of his or her personal information contained in (or included with) this form for the foregoing purposes.

Physician's Signature

Date (dd/mm/yyyy)

Surname / Family Name / Last Name

Given Name / First Name

Current Specialty

Medical License Number

Practice Address

