

Supplemental Information to Verify Insurability

Please **PRINT** clearly.

Family Name/Last Name	Given Name/First Name
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Since the earlier of the date(s) on which you signed the Information Disclosure and Authorization, the Confidential Medical Questionnaire and/or the Health History Questionnaire:

1. **a.** Have you been examined or treated by, or consulted a physician or other practitioner? Yes No
- b.** Have you had an electrocardiogram, x-ray or other diagnostic test? Yes No
- c.** Have you used marijuana, cocaine, or any other drugs except as prescribed by a physician? Yes No
- d.** Have you been treated or counseled for alcoholism or drug abuse? Yes No
- e.** Have you been diagnosed or treated by a qualified physician for Acquired Immune Deficiency Syndrome (AIDS),
 AIDS Related Complex (ARC) or any other disorders of the immune system? Yes No
2. Are you aware of any symptom or complaint, regarding your health, for which you have not yet consulted a physician
 or received treatment? Yes No
3. 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

For all "Yes" answers to questions 1 through 3, please provide full details. Details should include dates, date of onset of symptoms, diagnoses, duration, and name and address of attending physician and medical facility.

4. 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)

5. Has your work or financial status changed? Yes No

If "Yes," please explain:

6. Has your participation in aviation activity (other than as a passenger on scheduled commercial airlines) changed? Yes No

If "Yes," please complete and submit the appropriate questionnaire.

If "Yes," describe:

7. Has your participation in any avocation (hazardous sporting activities) changed? Yes No

If "Yes," please complete and submit the appropriate questionnaire.

If "Yes," describe:

8. Has any application for, or reinstatement of, life or health insurance been refused or been accepted under special terms? Yes No

If "Yes," state company name and reason:

9. Has your life insurance in-force coverage changed since you completed the Information Disclosure and Authorization form? Yes No

If "Yes," please explain:

10. Do you have any applications pending for life insurance coverage with other carriers? Yes No

If "Yes," please provide details including total amount applied for:

REPRESENTATION AND SIGNATURE

I understand and agree that no insurance coverage will be in effect until the Company has accepted the information provided on this form, advises in writing that the coverage will be issued, and has received and accepted the full amount of premium due.

If there is a change in insurability between the time of this supplemental information and the Company's approval, the insurance applied for will not be effective.

I declare that the above answers are full and true to the best of my knowledge and belief. I understand that if I misrepresent any of my answers or statements, the 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.

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)