Application for Insurance

securian CANADA

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Policy numbers 59956 and 17856

Canadian Dental Hygienists Association

In this application *you* and *your* refer to the person applying for insurance. *We* and *the Company* refer to Canadian Premier Life Insurance Company ("Securian Canada").

Clear

1. General information

Information about you

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		
Residence address (street number and name)			Apartment or suite
City		Province	Postal code
Telephone (home)	Telephone (office)	Fax	Email address

Information about your spouse (if applying for coverage)

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
☐ Non-smoker ☐ Smoker	*Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		

Information about your dependent(s) (if applying for coverage)

Dependent must be under age 21 (age 25 if a full time student at an accredited institution of learning) or to any age if mentally or physically handicapped.

First name	Middle initial	Last name	☐ Male ☐ Female
Date of birth (dd-mm-yyyy)			

First name	Middle initial	Last name	☐ Male ☐ Female
Date of birth (dd-mm-yyyy)			

First name	Middle initial	Last name	☐ Male ☐ Female
Date of birth (dd-mm-yyyy)			

2. Coverage applied for - Option 1 - Member Bundled Plan (complete sections 3, 9, 10 and 11)

For additional coverage, please complete sections 4 to 11.

Term Life insurance $30,000

Accidental Death and Dismemberment $30,000

☐ Single ☐ Family (includes Couple and Member + 1 dependent child)

Long Term Disability $750/month with a 120-day elimination period*

Extended Health Care insurance ☐ Single ☐ Couple (or Member +1 dependent child) ☐ Family

Beneficiary's first name	Beneficiary's last name
Relationship to plan member	Beneficiary designation** ☐ Revocable ☐ Irrevocable

* This coverage contains a pre-existing provision. Please refer to the product reference material for more information.

** You must check *revocable* or *irrevocable* for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

3. Simplified Medical Underwriting questionnaire (complete if applying for option 1)

1. Are you currently a CDHA member in good standing and working at least 18 hours a week? ☐ Yes ☐ No
2. In the last 5 years, have you been treated for, had symptoms of, or consulted a doctor or other healthcare professional for anxiety, depression, burnout, schizophrenia, psychosis or any other psychological disorder? ☐ Yes ☐ No
3. In the last 12 months, have you been treated for, had symptoms of, or consulted a doctor or other healthcare professional for any disease, disorder or injury (including sprains and strains) of the bones, joints, tendons, muscles or limbs including knees, hips, shoulders, back or neck that lasted more than one week or recurred more than once in the same location? ☐ Yes ☐ No

   If *yes*, indicate affected joint(s):

4. In the last 12 months, have you applied for insurance where the insurance company did not approve the application or issued the insurance with some changes? ☐ Yes ☐ No
5. Have you ever submitted a Critical Illness or Long-Term Disability claim? ☐ Yes ☐ No

4. Coverage applied for - Option 2 - Standalone Products (complete sections 4 to 11)

Minimum - $30,000 Maximum - $500,000 in units of $10,000

Term Life insurance

Amount of insurance **applied for at this time** $	Beneficiary's first name	Beneficiary's last name
Relationship to proposed insured	Beneficiary designation* ☐ Revocable ☐ Irrevocable	

* You must check *revocable* or *irrevocable* for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

Minimum - $30,000 Maximum - $500,000 in units of $10,000

Member must be covered for Spouse to be eligible.

Spousal Life insurance**

Amount of insurance **applied for at this time** $

Amount cannot exceed member coverage.

Dependent(s) Life insurance**

$10,000 for each dependent child ☐ Yes

Member must be covered for Dependent to be eligible.

** The member is automatically the beneficiary for the spousal and dependent child life coverage.

4. Coverage applied for - Option 2 (continued)

Minimum - $30,000 Maximum - $500,000 if Term Life insurance was elected or $200,000 without Term Life insurance in units of $10,000.

Accidental Death and Dismemberment (AD&D) insurance

☐ Single ☐ Family (includes Couple and Member + 1 dependent child)

Amount of insurance **applied for at this time** $		Beneficiary designation* ☐ Revocable ☐ Irrevocable
Beneficiary's first name	Beneficiary's last name	Relationship to proposed insured

* You must check *revocable* or *irrevocable* for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian of the minor child.

Minimum - $30,000 Maximum - $300,000 in units of $10,000

Member must be covered for Spouse to be eligible.

Critical Illness (CI) insurance

Amount of insurance **applied for at this time**
$

Spousal Critical Illness (CI) insurance

Amount of insurance **applied for at this time**
$

Dependent Child Critical Illness (CI) insurance. Amount cannot exceed member coverage.

Member must be covered for Dependent to be eligible.

Amount of new insurance applied for **at this time**
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

Extended Health Care (EHC) insurance

☐ Single
☐ Couple (or Member +1 dependent child)
☐ Family

Each person applying for coverage must be covered under their provincial health plan (RAMQ in Quebec) or have equivalent coverage under a group plan. In Quebec, the prescription coverage available under this plan is limited to costs not covered by the RAMQ Prescription Drug Insurance Plan.

Minimum - $700 Maximum - $5,000 in units of $100

Long-Term Disability (LTD) insurance

Amount of insurance **applied for at this time** (per month) $	Elimination period **120**
Cost of living adjustment rider ☐ Yes	

5. Insurance information (complete if applying for Option 2)

Do you and/or your spouse have any Life, Critical Illness or Disability insurance in-force or pending with any insurer, either as an individual policy, as a group benefit, or as part of an employment contract/partnership agreement?

☐ Yes ☐ No If *yes*, please provide details below.

You

Type of coverage (Life, LTD, CI)	Amount of benefit	Insurance company	Date of issue (mm-yyyy)	Benefit period	Taxable	Indicate if any insurance will be discontinued if this coverage is issued
	$				☐ Yes ☐ No	☐ Yes ☐ No
	$				☐ Yes ☐ No	☐ Yes ☐ No

Your spouse

Type of coverage (Life, LTD, CI)	Amount of benefit	Insurance company	Date of issue (mm-yyyy)	Benefit period	Taxable	Indicate if any insurance will be discontinued if this coverage is issued
	$				☐ Yes ☐ No	☐ Yes ☐ No
	$				☐ Yes ☐ No	☐ Yes ☐ No

6. Occupational information (complete if applying for Option 2)

Date employment started at current employer (dd-mm-yyyy)	Number of years in current occupation	Number of hours worked per week	Number of weeks worked per year

Do you have any other occupation or contemplate changing your job duties and/or hours of work?
☐ Yes ☐ No If *yes*, please describe fully.

7. Financial information (complete if applying for Option 2)

Only required if applying for LTD insurance.

	Current year-to-date from _____ (mm-yyyy) **to** _____ (mm-yyyy)	**Last year 20** _____
Gross annual income before business expenses **(A)**	**$**	**$**
Less annual total of all your business expenses **(B)**	**$**	**$**
Net annual income before tax **(A) - (B)**	**$**	**$**
Is any portion of your income from a salaried position? ☐ Yes ☐ No	If *yes*, please provide salary and employer name **$**	
Do you have any unearned income? ☐ Yes ☐ No	If *yes*, indicate annual unearned income **$**	Sources of unearned income

Have you ever declared or are you contemplating bankruptcy?
☐ Yes ☐ No If *yes*, date of discharge: (mm-yyyy)

If you are applying for LTD insurance, financial documents are required to confirm your income.

Please attach the following financial documents to this application:

<u>Sole Proprietors and Partnerships:</u> most current Personal Income Tax Return (pages 1 to 4) and Statement of Professional Activities (T2032) or Statement of Business Income (T2124).

<u>Corporations:</u> most current T4, Personal Income Tax Return (pages 1 to 4) and Business Financial Statements of the Corporation.

<u>Employees:</u> most current T4, Personal Income Tax Return (pages 1 to 4).

8. Statement of insurability (complete if applying for Option 2)

Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Please do not tell us about genetic testing or genetic tests results.

8.1 Background information

Information about you

Height ft in / m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		
Name of physician, date and reason for last consultation with physician (if none, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them.		

8. Statement of insurability (complete if applying for Option 2) (continued)

Please complete if applying for Spousal coverage.

Information about your spouse

Height	Weight	Change in weight in the last 12 months
ft in / m cm	☐ lbs ☐ kg	☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		
Name of physician, date and reason for last consultation with physician (if none, please state *none*)		
Diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them.		

8.2 Family history

Please do not tell us about genetic testing or genetic tests results.

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had cancer (specify type), heart disease, stroke, diabetes, polycystic or other kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), Muscular Dystrophy, familial polyposis of the bowel, Huntington's Chorea or any other hereditary disease?

You	Your spouse
☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the chart(s) below.

Your family history

	Which condition	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Your spouse's family history

	Which condition	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

8.3 Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

You	Your spouse	Your dependent children
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			
			$			
			$			
			$			

8. Statement of insurability (continued)

8.4 Medical information

Please do not tell us about genetic testing or genetic tests results.	You	Your spouse	Your dependent(s)
Have any of the persons to be insured ever:			
a) had chest pain, angina, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, peripheral vascular disease, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had a stroke, transient ischemic attack (TIA or 'mini stroke'), phlebitis, paralysis, dizziness, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or neurological system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) had diabetes, impaired fasting glucose, sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or abnormal pap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) had disorder of the breast including lumps, cysts, abnormal mammogram findings or biopsy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) had tumours, cancer, polyps, moles or other growth; disorder of the skin or lymph glands; blood or immune disorder, leukemia or any other form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had sleep apnea or chronic lung or respiratory disorder; disease or disorder of the eyes (excluding near or far sightedness), ears, nose or throat or had loss of speech?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have any of the persons to be insured ever:			
h) had any disorder of the colon, rectum, intestines (including Crohn's or colitis), ulcer, gallbladder, stomach or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; amputation; fibromyalgia or rheumatic/ arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) had any psychiatric disorder; depression, suicide attempts or ideations; anxiety state or panic attacks; eating disorder; other emotional disorders; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) had a disorder of the liver, tested positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepatitis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) had any other illness, disease, disorder, condition or injury not listed above; had any health symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past five years, have any of the persons to be insured:			
m) consulted a physician, chiropractor, psychologist, physiotherapist, psychiatrist, or any other health care professional, or been admitted to a hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) had any symptoms or adverse findings, or were advised to have further examinations, diagnostic tests, hospitalization or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) submitted to ECGs, blood tests, x-rays, a biopsy or any other diagnostic tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) had any surgical operation, treatment, ailment, abnormality or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) received any treatment or are currently taking any medication, over-the-counter medications, including any herbal supplements or remedies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
r) been advised to have any further examinations, diagnostic tests, hospitalization or surgery which has not been completed, or had any symptoms or complaints regarding your health for which a physician has not yet been consulted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
In the next six months, did any of the persons to be insured:			
s) contemplate medical or surgical treatment, or a hospital stay?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 12 months:			
t) have you, your spouse or dependent child(ren) been unable to work for more than five consecutive days or made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. Statement of insurability (continued)

8.5 Additional information

You

a) Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes*, please record the number of glasses in each category.

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

Your spouse

Do you consume alcoholic beverages? ☐ Yes ☐ No

If *yes*, please record the number of glasses in each category.

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

Within the past 10 years, have any of the persons to be insured:	**You**	**Your spouse**	**Your dependent(s)**
b) consumed substantially more alcohol than outlined previously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) been charged with impaired driving or been arrested, due to the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had your driver's license suspended or revoked, or had three or more moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use and/or abuse of non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had Life, Critical Illness, or Disability insurance declined, postponed rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years, have any of the persons to be insured:			
h) piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities such as skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do any of the persons to be insured:			
i) expect to change country of residence or expect to travel outside Canada or the USA within the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For female applicants only			
j) Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please indicate expected due date.	(mm-yyyy)	(mm-yyyy)	(mm-yyyy)
k) Have you had any previous complications of pregnancy such as miscarriage, preeclampsia, caesarean section, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. Statement of insurability (continued)

Please provide details below for any *yes* answers under sections 8.4 and 8.5. Include the results of all physical examinations and check-ups.

Please do not tell us about genetic testing or genetic tests results.

If you need more space, please complete on separate sheet of paper and sign and date it.

Question	Name of person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results

Back pain questionnaire (Please complete, if applicable.)

Location of back pain ☐ Upper back/neck ☐ Mid back ☐ Low back	Date problems began (dd-mm-yyyy)	What caused the pain or made it worse?
In the last 2 years, how frequent was the pain?	Was time lost from work? ☐ Yes ☐ No	Give dates and duration.
Treatment ☐ Medicine (give name(s)) ☐ Operation ☐ Chiropractic ☐ Other (specify):		Dates of treatment (dd-mm-yyyy)
Duration of treatment	Are you still under treatment? ☐ Yes ☐ No	How long have you been free of symptoms?
Is further treatment contemplated? ☐ Yes ☐ No If yes, please specify: ☐ Medicine ☐ Chiropractic ☐ Operation		

Mental/Nervous questionnaire (Please complete, if applicable.)

Type ☐ Anxiety ☐ Depression ☐ Stress ☐ Other (specify):	
Date problems began (dd-mm-yyyy)	Date of other occurrence(s) (dd-mm-yyyy)
Cause and duration of symptoms at each occurrence	Was time lost from work? Give dates and duration. ☐ Yes ☐ No
Treatment ☐ Medicine (give name(s)) ☐ Hospitalization ☐ Psychiatrist consulted ☐ Other (specify):	
Are you still under treatment? ☐ Yes ☐ No	How long have you been free of symptoms?
If you have ever had suicidal tendencies or attempted suicide, please elaborate.	

9. Premium payment method

• Please attach to this application form a personal blank cheque, marked VOID across the front.

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize Canadian Premier Life Insurance Company ("Securian Canada") to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Securian Canada notify you of any payments after the first payment whether the amount of the monthly premium is changed or not.** You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Securian Canada is unable to make a withdrawal from your account.

This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting *www.payments.ca*.

Securian Canada may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit *www.payments.ca*.

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5
Telephone number: 1-877-363-2773

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Your first name	Last name	
Signature of account holder **X**		Date signed (dd-mm-yyyy)
Payor(s) first name (if different than policyholder)	Last name	
Payor(s) signature **X**		Date signed (dd-mm-yyyy)
Joint account holder(s) first name	Last name	
Signature of joint account holder (if both signatures required) **X**		Date signed (dd-mm-yyyy)

10. Payor information

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payor(s) name (first and last) or full legal name of corporation/entity		
If applicable, date of birth (dd-mm-yyyy)	Relationship to you	
Address (street number and name)	City	
Province	Country	Postal code

11. Declaration and authorization

Please read and sign this section.

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I hereby certify that I have read the Medical Information Bureau (MIB) notice (see section 12), and having read the contents, I have, by the signature(s) below, authorized the MIB to give to Canadian Premier Life Insurance Company ("Securian Canada"), or its reinsurers, any information it may have.

I authorize Securian Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original, and shall remain in effect for the duration of my insurance coverage.

I have read and understand the details of the insurance which I am about to purchase.

Your signature **X**		Your spouse's signature **X**
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)

Please return your completed application to:

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

12. Medical Information Bureau notice

In the course of underwriting your application, Canadian Premier Life Insurance Company ("Securian Canada") may disclose information about you or your spouse to its reinsurers. Securian Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you and/or your spouse may apply for life or health insurance or to whom a claim for benefits may be submitted.

Securian Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you and/or your spouse also applies for insurance coverage or submit(s) a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to the MIB at: Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

or call: 416-597-0590

13. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *http://www.securiancanada.ca/privacy-statement.*