

# ScotiaLife® Term 1 Insurance Application

**Group Policy Number: 50133**

PO Box 215, Stn Waterloo, Waterloo ON, N2J 3Z9

Simply **complete, sign and return** this Application Form. **NO NEED TO SEND MONEY NOW.** If approved for coverage, premiums will be conveniently processed using the payment information you provide. In this Application Form, *you* and *your* refer to the person applying for insurance except where the context indicates a contrary intention. ScotiaLife Term 1 Insurance is underwritten by Scotia Life Insurance Company ("Scotia Life") under a group insurance policy issued to The Bank of Nova Scotia.

1 Information about you	Information about your spouse (if applying)																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Last Name</td> <td style="width: 10%;"><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td style="width: 10%;">Former Name</td> <td style="width: 60%;"></td> </tr> <tr> <td>First Name</td> <td>Date of Birth DD   MM   YYYY</td> <td colspan="2">Birth Country</td> </tr> <tr> <td colspan="4">Residence address (street number and name, apartment or suite)</td> </tr> <tr> <td>City</td> <td>Province</td> <td>Country</td> <td>Postal Code</td> </tr> <tr> <td colspan="2">Telephone (Residence)</td> <td colspan="2">Telephone (Other)</td> </tr> <tr> <td colspan="2">E-mail Address**</td> <td>Occupation</td> <td><input type="checkbox"/> Non-Smoker* <input type="checkbox"/> Smoker</td> </tr> </table>	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Former Name		First Name	Date of Birth DD   MM   YYYY	Birth Country		Residence address (street number and name, apartment or suite)				City	Province	Country	Postal Code	Telephone (Residence)		Telephone (Other)		E-mail Address**		Occupation	<input type="checkbox"/> Non-Smoker* <input type="checkbox"/> Smoker	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Last Name</td> <td style="width: 10%;">Former Name</td> <td style="width: 70%;"></td> </tr> <tr> <td colspan="3">First Name</td> </tr> <tr> <td>Date of Birth DD   MM   YYYY</td> <td colspan="2">Birth Country</td> </tr> <tr> <td colspan="2">Telephone (Residence)</td> <td>Telephone (Other)</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Non-Smoker*   <input type="checkbox"/> Smoker</td> <td><input type="checkbox"/> Male   <input type="checkbox"/> Female</td> </tr> <tr> <td colspan="2">E-mail Address**</td> <td>Occupation</td> </tr> </table>	Last Name	Former Name		First Name			Date of Birth DD   MM   YYYY	Birth Country		Telephone (Residence)		Telephone (Other)	<input type="checkbox"/> Non-Smoker* <input type="checkbox"/> Smoker		<input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail Address**		Occupation
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\* Non-Smoker means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.

\*\* Your e-mail address may be used in the event we need to contact you in connection with this Application Form.

## 2 Amount of insurance coverage applied for (minimum \$50,000, sold in units of \$25,000 to a maximum of \$1 Million)

<b>FOR YOU</b>	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$500,000	<input type="checkbox"/> \$750,000	<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> Other \$ _____
<b>FOR YOUR SPOUSE</b>	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$500,000	<input type="checkbox"/> \$750,000	<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> Other \$ _____

Do you or your spouse have any existing life insurance coverage with Scotia Life or any other company?  YES  NO If "Yes", please complete the following:

Name of Applicant	Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
			\$	<input type="checkbox"/> YES <input type="checkbox"/> NO
			\$	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you intend to replace coverage, do not cancel your existing coverage until you receive and review your Certificate of Insurance.

## 3 Financial information (complete only if applying for more than \$250,000 of coverage)

<b>YOU</b> Annual Net Income: after expenses (if any) but before taxes \$ _____	<b>YOUR SPOUSE (if applying)</b> Annual Net Income: after expenses (if any) but before taxes \$ _____
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## 4 Beneficiary designation

If the beneficiary is under the age of 18, please name a Trustee to receive the monies in trust for the beneficiary.

<b>YOU</b>	Beneficiary (name in full)	Relationship to you	Name of Trustee for any Minor Beneficiary
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In Québec, the designation of spouse as beneficiary on this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

<b>YOUR SPOUSE*</b>	Beneficiary (name in full)	Relationship to you	Name of Trustee for any Minor Beneficiary
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In Québec, the designation of spouse as beneficiary on this application is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

\* You are automatically the beneficiary on any of your Spouse's coverage, unless otherwise indicated above in writing.

## 5 How would you like to pay your monthly premium?

- A. Pre-Authorized Chequing  
Please attach a personal blank cheque marked VOID.
- B. Credit Card (choose one):  MasterCard  Visa

Name on Credit Card	Date of Expiry MM / YYYY
Card Number	

### Authorization and Agreement:

- You authorize either Scotia Life or the group policy administrator, Sun Life Assurance Company of Canada, to debit your chequing account or charge your credit card account (identified above) each month for the premium payable for any insurance coverage issued to you in connection with this application. You acknowledge that your financial institution may treat any withdrawal made pursuant to this authorization as though it was made by you personally.
- You warrant and guarantee that all persons whose signatures are required to sign on the identified chequing account or credit card account (as applicable) have signed below.
- You agree and authorize Scotia Life to automatically cancel this agreement and terminate coverage if Scotia Life or the group policy administrator, Sun Life Assurance Company of Canada, is unable to debit your chequing account or charge your credit card (as applicable).

Signature(s) of Cardholder or Accountholder(s) X	Date DD   MM   YYYY
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ScotiaLife Term 1 Insurance is administered by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

## 6 Underwriting questionnaire

This application is **not valid** unless the Underwriting questionnaire is properly completed and the application is signed by all applicants.

Your Physician (Name)	Telephone
Physician's Address	
Date and reason of last consultation	
Your Height ft.   in.   m   cm	Your Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Change in weight in the last 12 months <input type="checkbox"/> lbs. <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> No Change _____ <input type="checkbox"/> kg	
Reason for weight change	

Spouse's Physician (Name)	Telephone
Physician's Address	
Date and reason of last consultation	
Spouse's Height ft.   in.   m   cm	Spouse's Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Spouse's change in weight in the last 12 months <input type="checkbox"/> lbs. <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> No Change _____ <input type="checkbox"/> kg	
Spouse's reason for weight change	

	YOU	YOUR SPOUSE
1. Have you (or your spouse) had a life insurance application declined, rated or modified in any way?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Within the past 5 years, have you (or your spouse) had your driver's license suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), driver's license no. and licensing province.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Do you (or your spouse) intend to engage in, or in the last 2 years have you (or your spouse) engaged in any hazardous sport or activity (e.g. auto or motorcycle racing, scuba or sky diving, hang gliding or other similar hazardous sport or activity)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Do you (or your spouse) expect to change your country of residence or have extended period(s) of travel outside Canada or the USA within the next 12 months? If "Yes", please explain.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you (or your spouse) ever received advice or treatment for the use of alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you (or your spouse) ever used cocaine, narcotics, hallucinogens, heroin, amphetamines or barbiturates?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you (or your spouse) for any of the following health problems, consulted a health care professional, undergone a medical exam or follow-up, suffered or been diagnosed or are you currently being treated for:		
a) Chest pain, angina, heart attack, heart disease or abnormal electrocardiogram (ECG), high or low blood pressure, high cholesterol, stroke, transient ischemic attack (TIA) or circulatory or blood disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Lymph or thyroid gland disorder, tumors, cancer or moles, other growths or disorders of the skin?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Respiratory problems or any lung disease, kidney or urinary tract problems or disease, liver problems or disease including hepatitis (or hepatitis carrier state), intestinal, colon, stomach or digestive problems or disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Breast, prostate or genital problems or disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Seizures, multiple sclerosis or disorder of the brain or nervous system?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Depression, anxiety, or any other psychiatric problem(s)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Diabetes or high blood sugar?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Arthritis, disorder or disease of the muscles, joints, back, bones or paralysis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) Any other condition not listed above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you (or your spouse) ever had any positive test, treatment for or exposure to HIV virus or AIDS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Have you (or your spouse) ever had symptoms or complaints regarding your health for which you have not yet consulted a physician or been advised to have any test or surgery which has not yet been completed, or within the past 5 years have you ever had any abnormal test result(s)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

## 6 Underwriting questionnaire (continued)

If you (or your spouse) answered "Yes" to any of the questions 1-9, please give details below. If additional space is required, use a separate page, signed and dated.

Ques. No.	Name of Applicant	Nature of Disorder	Date and Duration	Treatment & Current Status	Attending Physician or Hospital

Scotia Life reserves the right to request additional medical information in order to assess your application and also reserves the right to accept or decline applications. You may receive a telephone call to request additional information.

## 7 Family history

Have any of your (or your spouse's) immediate family members (parents or siblings) had cancer (specify type), heart disease, stroke, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, Huntington's Chorea or any other hereditary disease? If "Yes", please complete the chart (s) below.

**YOU**      **YOUR SPOUSE**  
 YES    NO    YES    NO

### Your family history

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

## 8 Declaration and authorization (please complete all)

**You declare** that all of the information you have provided in this Application Form or in any other statement or answer submitted in connection with this Application Form is true and complete. **You understand and agree** that any false statement, material misrepresentation or deliberate omission in this Application Form or in any other statement or answer submitted in connection with this Application Form may cause any insurance coverage issued as a result of this application to be null and void.

**You acknowledge** that you have read and fully understand the content of the MIB INC. Notification displayed below.

**You authorize** MIB INC, to give Scotia Life, or its reinsurer(s), any information it may have about you necessary for the risk assessment relating to this application or investigation of any claim. A photocopy or electronic version of this authorization is as valid as the original, and shall remain in effect for the duration of your insurance coverage. You further authorize Scotia Life or its reinsurer(s) to share information it may have about you in its file with other insurance companies to whom you may apply for life or health insurance, as may be contractually required by MIB INC.

**You understand and agree:** (i) that in order to administer any coverage issued to you, Scotia Life can release your personal information to third party administrators (some of which may be located outside of Canada and subject to local law); (ii) to be bound by the terms of the Scotiabank Group Privacy Agreement, a copy of which is available at [www.scotiabank.com/privacy](http://www.scotiabank.com/privacy) and which will also be sent to you with the Certificate of Insurance, if this application is approved. **You authorize** Scotia Life, and its agents, service providers and its plan administrator, Sun Life Assurance Company of Canada, to use and exchange information needed for underwriting, administration and adjudicating claims under the *ScotiaLife* Term 1 Insurance Group Policy with any person or organization who has relevant information about you including health professionals, institutions, MIB INC., investigative agencies, insurers, plan administrators and reinsurers.

Your Signature <b>X</b>	Signed at (City/Town)	Date DD   MM   YYYY	Your Spouse's Signature (if applying) <b>X</b>	Signed at (City/Town)	Date DD   MM   YYYY
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<sup>TM</sup> Trademark of The Bank of Nova Scotia, used under license.    <sup>®</sup> Registered trademark of The Bank of Nova Scotia, used under license.

### Notification - please read carefully

Information regarding your insurability will be treated as confidential. Scotia Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to MIB, INC. a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, the Bureau, upon request, will furnish the member company or its reinsurer(s) with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at:  
MIB, INC.

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

Telephone: (416) 597-0590, or visit [www.MIB.com](http://www.MIB.com)

If you question the accuracy of the information in MIB's file, you may also contact MIB and seek a correction.

Scotia Life Insurance Company or its reinsurer(s) may also release information in its file to other insurance companies to whom you may apply for life or health insurance.

### Please mail completed form to:

ScotiaLife Financial  
PO Box 215, Stn Waterloo  
Waterloo ON N2J 3Z9