

**CHILDREN'S TERM RIDER / PAYOR WAIVER OF PREMIUM QUESTIONNAIRE**

Children's Term Rider\*       Payor Waiver of Premium (for Universal Life only)

\* Only children, stepchildren and legally adopted children of the Proposed Insured, who are between 15 days and up to and including 17 years old on the date of the rider application, are eligible for coverage under the Children's Term Rider.

**Proposed Life Insured** \_\_\_\_\_

Name(s) of Children or Policyowner proposed for coverage.

First and Last Name	Relationship to Proposed Insured	Date of Birth dd/mm/yyyy	Age Last Birthday	Height	Weight	Name and Address of Personal Physician	Date & Reason Last Seen
				<input type="checkbox"/> cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lbs		
				<input type="checkbox"/> cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lbs		
				<input type="checkbox"/> cm <input type="checkbox"/> ft/in	<input type="checkbox"/> kg <input type="checkbox"/> lbs		

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Has anyone proposed for coverage above within the past five years:   | Yes                      | No                       |
| (a) Consulted a physician for any reason; had an electrocardiogram or other diagnostic tests; been in a clinic, hospital or medical facility for observation or treatment?                | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Been advised to have any diagnostic test, hospitalization or surgery which was not done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has anyone proposed for coverage above ever had or had indication of:  |                          |                          |
| (a) Cancer, stroke, heart attack or heart disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Diabetes, glandular or thyroid disorder, enlarged lymph nodes, epilepsy, or any mental, nervous or neurological disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Chest pain, angina, high blood pressure, heart murmur or other circulatory or blood disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Kidney, urinary or reproductive disorder, or sexually transmitted disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Liver or gastro-intestinal disorder, hepatitis or hepatitis carrier state?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Asthma, emphysema, or other respiratory disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Loss of vision, amputation, deformity, arthritis or other musculo-skeletal disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has anyone proposed for coverage above ever had or been told they have:<br>Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is anyone proposed for coverage above presently taking any medication?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has anyone proposed for coverage above:  |                          |                          |
| (a) Ever had a request for life or disability insurance declined, postponed, rated, or restricted in any way?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Within the past two years flown or taken instruction as a pilot or engaged in any kind of racing, scuba or sky diving, hang gliding or other hazardous activities or intend to do so? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Within the past five years used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug and alcohol use?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Ever had their driver's licence restricted, revoked or had three or more moving violations within the past three years?<br>If yes, provide drivers licence # _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Intend to reside or travel outside of Canada for more than four consecutive weeks?  | <input type="checkbox"/> | <input type="checkbox"/> |

Give full details for all "Yes" answers to questions 1 to 5. Give dates, treatment, duration of illness and names and addresses of all attending physicians and medical facilities.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby agree that the foregoing questions and answers shall form part of the application for insurance made by me to BMO Life Assurance Company on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_ ; and they shall be of the same effect as if contained in the original application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ of \_\_\_\_\_ 20\_\_\_\_\_

Witness

Proposed Insured