BMO Insurance

RESET PRINT

BMO Life Assurance Company
60 Yonge Street, Toronto, ON M5E 1H5
1-877-742-5244 • 416-596-4143 Fax

Long Form Health Certificate and Policy Change Application

Check your request and complete all sections. Return the signed and fully completed form (all pages) to BMO Life Assurance Company, address as shown above. For any questions, please contact Customer Service at 1-800-387-4483.

STOP **You are required to complete a new application form (form # 126E) for the following changes**:

a) Increase sum insured on a Life Dimensions Universal Life policy.
b) Add a new Life insured to a Life Dimensions Universal Life policy (change coverage from single life to multi-life).
c) Add a Critical Illness rider.

TYPE OF REQUEST

☐ Reinstatement - Payment Submitted? ☐ Yes Amount $ _____ ☐ No

☐ Change to Non-Smoker
(For joint-last-to-die coverage, each life insured needs to complete this form)

☐ Review Rating
(For joint-last-to-die coverage, each life insured needs to complete this form)

☐ Preferred renewal rates/Re-entry

☐ Add riders/benefits, please specify details:
(If adding term riders on 2 different lives, each life insured needs to complete a Long Form Health Certificate. See underwriting guideline for requirements based on age and face amount)
NOTE: For addition of Children's Term rider, please complete this form on the parent or guardian and Children's Term Rider Questionnaire (Form # 341E) on the child.

Plan _____ Face Amount $ _____

☐ Other changes: please specify details _____

_____

_____

☐ For Universal Life policies, change planned premiums to:

New planned premium $ _____ ☐ monthly ☐ annually ☐ semi-annually

Section 1 - Personal Information

Policy Number	Insured	Date of Birth (dd/mm/yy) dd/mm/yyyy
Owner (if other than insured)		
Mailing Address		Postal Code
Occupation	Employer	Annual Income / Net Worth

Insurance in force and pending (This and other Companies)

Name of Company	Amount	Accidental Death	Policy Issue Date

Section 2 - Medical Information

	Yes	No
1. a) What is your exact height? _____ ☐ cm ☐ ft/in weight? _____ ☐ kg ☐ lbs		
b) Any weight change in the last year? If "yes", indicate weight change and reason.	☐	☐

_____

2. a) Date of last consultation with a doctor, reason, outcome details.

_____

b) Name of doctor, address and telephone number.

_____

	Yes	No
3. Have you ever been treated for, tested for, or had any known indication of any of the following:		
a) Cancer, tumor, polyp or other growth, blood disorder or any form of malignant disease?	☐	☐
b) Heart attack, chest pain, angina, abnormal blood pressure, elevated cholesterol, or any other heart or circulatory disease?	☐	☐
c) Diabetes, kidney, bladder, prostate or breast disorder?	☐	☐
d) Hepatitis or any disorder of the liver, pancreas, stomach, intestines or colon?	☐	☐
e) Chronic lung or any other respiratory disorders?	☐	☐
f) Stroke, TIA, seizure, dizziness, fainting, paralysis or other disorder of the nervous system?	☐	☐
g) AIDS or tested positive for the HIV virus?	☐	☐
h) Mental illness, anxiety, depression, alcohol or drug abuse?	☐	☐
4. Are you now under observation or taking treatment for any disorder? If “Yes”, please list all medications you are presently taking and any treatment you may be undergoing.	☐	☐
5. Have you been advised or do you currently have any pending investigations, specialists consultations, upcoming medical or surgical procedures within the next 12 months? If "yes", please provide details.	☐	☐
6. Is there any other illness, symptom or abnormality that you have not yet consulted a doctor for? If "yes" please provide details.	☐	☐
7. Has any application or reinstatement ever been declined, rated, postponed, or modified in any way?	☐	☐
8. Are you involved in the operation of any aircraft or engaged in any kind of hazardous activities?	☐	☐
9. Have you ever been charged with a criminal offence, claimed bankruptcy, had your driver’s license restricted, revoked or had three or more moving violations within the past 24 months?	☐	☐
10. Have you used any tobacco, nicotine substitutes or marijuana within the last 12 months?	☐	☐
11. Have you traveled outside North America in the past 12 months or have any plans to do so in the next 12 months?	☐	☐
12. Have you used any habit forming drugs, marijuana, hash, cocaine, LSD, hallucinogens, barbiturates, narcotics (other than as prescribed by your physician)? If "yes" please complete Drug Usage Questionnaire (form #144E).	☐	☐
FAMILY HISTORY		
13. Have your parents, brothers or sisters had cancer, high blood pressure, heart or kidney disease, polycystic kidney disease, diabetes, mental or nervous disorder (including Alzheimer's Disease), stroke, multiple sclerosis, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Parkinson's Disease, or any other hereditary disorders?	☐	☐

MEDICAL HISTORY - Provide details below of FAMILY HISTORY for all parents, brothers and sisters.

Family Member	Disease (if cancer, indicate type)	Age at onset	Age if living	Age at death	Cause of Death

	Yes	No
14. **ARE YOU NOW IN GOOD HEALTH?**	☐	☐

If you answered “YES” to any of questions 1 through 13, please provide details.

Section 3 - Representations, Acknowledgements, Authorizations and Signatures

1. I, the undersigned Applicant request BMO Life Assurance Company (BMO Insurance) to reinstate the above mentioned policy in accordance with its terms and conditions. I understand that reinstatement will take effect, if approved at Head Office, as of the date of this application or the date of settlement of premium arrears. I understand that the provisions of the reinstated policy with respect to incontestability and suicide will be deemed to apply from the effective date of reinstatement.
2. It is declared that the statements made in this application are complete and true and together with any supplement to the application shall be the basis of any reinstatement of or change to the above numbered policy. It is agreed that if any answers are untrue, the reinstatement or change shall be considered not to have taken effect. Any reinstatement or change is subject to the provisions of the policy. Any payment of arrears or premiums and interest on reinstatement, or any balance of premium on a change, or any restrictions or limitations shall apply from the date of approval of the reinstatement or change.

Authorization - *Do not detach*

(Valid in Alberta for a period of twelve (12) months and not more than twenty-four (24) months)

I, we hereby authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, any insurance company, insurance advisor or advisor, or its affiliate, the Medical Information Bureau, any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide to and exchange with BMO® Insurance or its reinsurers all such information and records. This same complete authorization is made concerning any member of my family proposed for coverage. Note: Parent or legal guardian signing on behalf of a minor must indicate relationship. (A photographic copy of this authorization shall be as valid as the original.)

Date (dd/mm/yyyy)	Witness	Proposed Insured
/ /	X	X
/ /	X	X
/ /	X	X

Date (dd/mm/yyyy) — Witness — Proposed Additional Life Insured

Date (dd/mm/yyyy) — Witness — Proposed Life Insured, Parent or Legal Guardian and relationship (if Proposed Life Insured is a minor)

Signatures

Signed at _____ this _____ day of _____ , 20 _____

X _____
Proposed Life Insured or Consenting Parent or Guardian (Child age 16 or older, age 18 or older in Quebec, must sign application)

X _____
If company owned, 2 Signatures and Titles or 1 Signature and Corporate seal

X _____
Additional Proposed Life Insured

X _____
Payor(s) (if other than the Proposed Life Insured(s) or if Owner Waiver elected)

X _____
Owner (If other than Proposed Life Insured(s)

X _____
Witness

Advisor Information

_____ Advisor Name (please print)

_____ Advisor Code

_____ % Percentage Split

_____
Print name of MGA and MGA code # here:

X _____
Advisor Signature

_____ Advisor Name (please print)

_____ Advisor Code

_____ % Percentage Split

_____
Print name of MGA and MGA code # here:

X _____
Advisor Signature

Please detach and give to Proposed Insured.

RECEIPT

BMO Insurance

60 Yonge Street
Toronto, Ontario, Canada M5E 1H5

NOTICE TO OWNER: If the application for reinstatement is not accepted this payment will be refunded.

Lapsed Policy No. _____ Date _____ , Year _____

Received From _____ the sum of

_____ dollars
100

It is agreed that no rights or benefits are created or acquired by the owner by reason of the payment acknowledged until application for reinstatement of the lapsed policy is approved by the Company and a certificate of reinstatement is issued by the Company during the continued good health and insurability of the Life Insured.

Medical Information Bureau-Notice

Information regarding your insurability will be treated as confidential. BMO Insurance or its Reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

BMO Insurance or its Reinsurer(s) may also release information to other life or health insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7, telephone (866) 692-6901. BMO Insurance or its reinsurer(s) may also release information in its files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

BMO Insurance privacy and confidentiality notice

BMO Insurance has requested personal information in respect of your Application for insurance. BMO Insurance will use this information and information in its existing files to assess risk, process your application, administer any policy, if issued and to investigate claims. BMO Insurance will also use and collect additional information from third parties to evaluate and investigate claims. BMO Insurance will keep your information in a file in its offices and will not disclose the information in that file except to those BMO Insurance employees, advisors, its affiliates, administrators or reinsurers who need access to assess risk and investigate claims. From time to time, BMO Insurance may wish to offer you upgrades to your coverage and additional products and services. You may ask us not to make these offers to you by writing to our Privacy Officer at the address below. You may also request, upon presentation of proper identification and proof of entitlement, to review and if appropriate, correct, your personal information in our possession by writing to:

Privacy Officer
BMO Life Assurance Company
60 Yonge Street, Toronto, Ontario,
Canada M5E 1H5