BMO Insurance

NON FACE-TO-FACE APPLICATION for Life and Critical Illness Insurance

(by Telephone or Internet)

Underwritten by BMO Life Assurance Company
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Important Information and Instructions for the Advisor

Completing the Application

1. You must complete Sections 1 though 12 with your client if you are completing this application via telephone.
2. Your client must complete Sections 1 through 12 if they are completing this application via internet.
3. If the Eligibility Questions in Section 3 are answered "No", do not proceed with this application.
4. You must complete Section 13 - Advisor Report, before uploading the entire application to Watermark (pages 1 - 26). This is your electronic signature to allow us to proceed with the application.
5. Other than the fully completed application, **do not** upload any other forms, e.g., replacement forms, lifestyle questionnaires, to Watermark.
6. Section 14 through Section 21 will be completed and/or collected exclusively by an authorized paramedical professional from Watermark.

The Watermark paramedical professional will complete Sections 14 through 21 AND:

- Verify the client's identification
- Collect required signatures
- Collect a VOID cheque (if required)
- Detach and leave with the client Section 20 - Temporary Accidental Death Benefit Agreement
- Detach and leave with the client Section 21 – Privacy and Personal Information Authorization and MIB Inc. Notice
- Complete the paramedical exam
- Submit completed applications to BMO Insurance's New Business department.

Watermark provides the advisor with online status inquiry for each paramedical order.

7. Temporary Insurance is not available. *DO NOT COLLECT PREMIUM.* A Temporary Accidental Death Benefit is included at no cost.
8. Delivery Receipt is required. The Delivery Receipt is considered a settling requirement.

Replacement

1. Replacement business will be accepted only:
   a) If the existing policy to be replaced is term insurance; and
   b) You have personally discussed the advantages and disadvantages of replacement with the Proposed Insured(s).
2. If this insurance is intended to replace or change any existing insurance with this or any other Company, you must complete and submit to us proper replacement documentation in accordance to the rules established in the jurisdiction where the applicant resides.

Coverage Options and Eligible Plans

1. For Term 10, 15, 20, 25 or 30, Single Life and Joint First-to-die coverage option are available.
2. For Term 100, Single Life, Joint First-to-die and Joint Last-to-die coverage option are available.
3. **No third party policy ownership or third party payor - the owner(s) must be Proposed Insured 1 or Proposed Insured 2 or both. Exception: Sole Proprietor. An eligible sole proprietor must be Proposed Insured 1 or Proposed Insured 2 AND own 100% of the business.**

Plan Name	Eligible Age	Available Face Amount	Additional Benefits or Riders
Term 10	18 to 75	$100,000 to $5,000,000	• Waiver of Premium Benefit • Critial Illness (Living Benefit 10/20) Rider† • Accidental Death Benefit (ADB)* • Children's Term Rider**
Term 15	18 to 70		
Term 20	18 to 65		
Term 25	18 to 60		
Term 30	18 to 55		
Term 100	18 to 80	$50,000 to $5,000,000	• Waiver of Premium Benefit • Term 10, Term 15, Term 20, Term 25 or Term 30 Rider • Accidental Death Benefit (ADB)* • Critical Illness (Living Benefit 10, 20, 75 or 100) Rider† • Joint Last-to-Die Conversion Rider • Children's Term Rider**
Living Benefit 10	18 to 65	$25,000 to $2,000,000	• Return of Premium on Death • Waiver of Premium Benefit • Accidental Death Benefit (ADB)*
Living Benefit 20	18 to 55		
Living Benefit 75	18 to 65	$25,000 to $2,000,000	• Return of Premium on Death • Return of Premium on Surrender Benefit • Return of Premium on Expiry Benefit • Waiver of Premium Benefit • Accidental Death Benefit (ADB)*
Living Benefit 100	18 to 65		
15 Pay-Living Benefit 100	18 to 65		

*Maximum issue age = 60, Maximum coverage = The lesser of $500,000 and the Face Amount.
†Maximum issue age is 60, Maximum face amount $750,000
**Insured Issue Age: 18 - 60, Sum Insured $5,000 - $30,000 (increments of $5,000)

Section 1 – Coverage Option

NOTE: For every Single Life coverage you must complete and submit a separate application.

IMPORTANT ACTIVATION INFORMATION
In order to activate this fillable form, you must first complete in order
Section 1 – Coverage Option, followed by
Section 2 – General Acknowledgements, followed by
Section 3 –Eligibility Questions
If you answer any question incorrectly in Section 1, 2 or 3, you will need to RESET the form and start again.
Be sure to download the current version of Adobe Reader so that you can save the completed application form 431

X

Section 2 – General Acknowledgements

Must be read to or read by the Proposed Insured(s)

We use the information in this application to determine whether or not you are eligible for the coverage and to establish the premium rates for the coverage you are applying for. If you misrepresent any facts or the information you provide is not current, correct and complete, we can cancel any policy we have issued on the basis of the information you provided.

We respect your privacy and are committed to keeping personal information about you confidential. Some of your personal information is required by BMO Insurance for insurance purposes, such as considering and processing your application, administering a policy if issued, or investigating a claim. Access to your personal information is limited to those BMO Insurance employees and sub-contractors such as the paramedical provider who have a business need for it.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
Do you agree to provide this information?	☐	☐	☐	☐

Section 3 – Eligibility Questions

1.	Do you understand the language (English or French) in which this Application for Insurance is written?	☐	☐	☐	☐
	If **No**, have the details of this Application been fully explained to you in your preferred language and are they completely understood?	☐	☐	☐	☐

If you answered "No" you are not eligible for this type of insurance coverage. Do not proceed with this application.

If **"Yes"** please describe the steps that were taken to ensure all questions and authorizations in this Application for insurance were understood. The insurance policy you applied for will only be issued in one of Canada's official languages (English or French, as requested). It is your responsibility to take measures to fully understand the terms and conditions of the policy contract.

Language for policy and future correspondence: ☐ English ☐ French

2.	Are you a resident of Canada for Canadian income tax purposes?	☐	☐	☐	☐

If you answered "No" you are not eligible for this type of insurance coverage. Do not proceed with this application.

Section 4 – Information About the Lives to be Insured

Section 4.1 - Proposed Insured 1

Legal Name (first, middle initial, last)				Maiden Name (if applicable)
Date of Birth (dd/mmm/yyyy)	Age	Place of Birth ☐ Canada ☐ United States	Province / State	☐ Other (indicate Country)
Sex at birth ☐ Male ☐ Female	I request that the policy be issued in English ☐ French ☐	Smoker Yes ☐ No ☐	Are you a resident of Canada for income tax purposes? ☐ Yes ☐ No	**If No, please do not proceed with this application.**
What is your residency status? ☐ Canadian Citizen ☐ Permanent Resident (give date of entry into Canada (dd/mmm/yyyy))			☐ Other (provide details)	
Address (Street, Apt., R.R.)			No. of Years this address	Home telephone number
City	Prov.	Postal Code		Preferred contact number
Occupation/Duties				Years with current Employer
Employer Name				Type of Business
Address (Street, Apt., R.R.)	City		Prov.	Postal Code

Section 4.2 - Proposed Insured 2

Legal Name (first, middle initial, last)				Maiden Name (if applicable)
Date of Birth (dd/mmm/yyyy)	Age	Place of Birth ☐ Canada ☐ United States	Province / State	☐ Other (indicate Country)
Sex at birth ☐ Male ☐ Female	I request that the policy be issued in English ☐ French ☐	Smoker Yes ☐ No ☐	Are you a resident of Canada for income tax purposes? ☐ Yes ☐ No	**If No, please do not proceed with this application.**
What is your residency status? ☐ Canadian Citizen ☐ Permanent Resident (give date of entry into Canada (dd/mmm/yyyy))			☐ Other (provide details)	
Address (Street, Apt., R.R.)			No. of Years this address	Home telephone number
City	Prov.	Postal Code		Preferred contact number
Occupation/Duties				Years with current Employer
Employer Name				Type of Business
Address (Street, Apt., R.R.)	City		Prov.	Postal Code

Section 4.3 - Proposed Owner - The proposed owner must be Proposed Insured 1 or Proposed insured 2 or both.

Who will own this policy?

☐ Proposed Insured 1 ☐ Proposed Insured 2 ☐ Jointly owned by Proposed Insured 1 and Proposed Insured 2

Is the Proposed Owner a sole proprietor? ☐ Yes ☐ No Do you want the policy owner to be the sole proprietor? ☐ Yes ☐ No

If Yes, please provide the full Business Name and Address.

Business Name			
Business Address (Street, Apt., R.R.)	City	Prov.	Postal Code

Section 5 - Plan Details - The type and amount of coverage being applied for.

Please select a Policy Date: ☐ Current Date or ☐ Date to save age for: ☐ Proposed Insured 1 ☐ Proposed Insured 2

Coverage Type: ☐ Single Life ☐ Joint-First-to-Die ☐ Joint-Last-to-Die

Plan Name: Face Amount $ Waiver of Premium

Rider 1 - Proposed Insured 1 (ADB) Face Amount $

Rider 2 - Proposed Insured 1 (ROPD) Face Amount $

Rider 3 - Proposed Insured 1 (Children's Term Rider) Face Amount $

Rider 4 - Proposed Insured 1 (Other) Face Amount $

Rider 1 - Proposed Insured 2 (ADB) Face Amount $

Rider 2 - Proposed Insured 2 (Other) Face Amount $

Section 5.1 - Request for Optional Policy

☐ Proposed Insured 1 Details:

☐ Proposed Insured 2 Details:

Section 6 - Beneficiary Information - Identify the person(s) who you wish to receive the proceeds.

If you are applying for life insurance or other benefit paid on death (e.g. Accidental Death Benefit and Return of Premium on Death):

- Complete Sections 6.1 and 6.2

Proceeds from any critical illness death benefit, e.g. Return of Premium on Death Benefit (ROPD) Rider will be paid to the Insured's estate unless a beneficiary has been designated in Section 6.2.

If you are applying for a living benefit (e.g., Critical Illness Benefit, Early Discovery Benefit, Maturity Benefit, Return of Premium on Surrender, Return of Premium on Expiry):

- Complete Section 6.3 if you are completing this application in Alberta, British Columbia, Manitoba, Ontario or Quebec; or
- Complete the Direction to Pay for Critical Illness Policies, form 630E, in the provinces not listed above.

We will pay the living benefit to the owner of the policy unless you name another person to receive the proceeds as described above.

Revocable and irrevocable beneficiaries

There are two types of beneficiaries: revocable and irrevocable

- A beneficiary designation is considered revocable, unless you make it irrevocable. This will allow the owner to change their beneficiary designation at any time without the current beneficiary(ies) consent.
- If you name a beneficiary as irrevocable, your ability to deal with the policy is limited. For example, you cannot change the beneficiary without their consent, unless permitted by law. You may also need the irrevocable beneficiary's consent to deal with the policy, e.g., surrender, assign, and transfer ownership.
- In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless otherwise stated.
- A minor child or your estate cannot give consent to make any changes on the policy if they are designated as an irrevocable beneficiary.
- A minor irrevocable beneficiary cannot consent to change of beneficiary and a parent guardian may not sign on behalf of a minor child for this purpose.

Payment of benefits when the beneficiary is a minor

- Except where Quebec law applies, we will pay benefits to the trustee for the minor beneficiary, if you have named one. If no trustee is named, we will make the payment as the law requires.
- Where Quebec law applies, we will pay the parent(s) of the minor beneficiary or Tutor duly appointed in law.

Multiple and contingent beneficiaries

- You can name a beneficiary "primary" or "contingent" ("subrogated" in Quebec).
- If you name more than one beneficiary, indicate the share of each beneficiary; otherwise they will share the benefit equally.
- Benefits will first be paid to all living primary beneficiaries. If a primary beneficiary dies before you, their share of the benefits will be paid equally to the surviving primary beneficiaries unless you state otherwise, or the law provides otherwise.
- If all primary beneficiaries die before you, the benefits will be paid equally to the contingent beneficiary(ies) unless you state otherwise.
- If no beneficiary is alive when the benefits become payable, the benefits will be paid to the owner if other than the insured, otherwise the owner's estate.
- If a beneficiary is disqualified from receiving the benefits for any reason, that beneficiary will be treated as if he/she died before you and the benefits will be dealt with in accordance with the law.

All beneficiary percentages must total 100%

Section 6.1 – Benefit paid on term life insurance death benefit

Proposed Insured 1		Legal Name (first, middle initial, last)	Relationship to Proposed Insured 1 (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	% share of benefits to be paid
Primary Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
					TOTAL	

Proposed Insured 1		Legal Name (first, middle initial, last)	Relationship to Proposed Insured 2 (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	% share of benefits to be paid
Contingent (Subrogated in Quebec) Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
					TOTAL	

Section 6.1 – Benefit paid on term life insurance death benefit

Proposed Insured 2		Legal Name (first, middle initial, last)	Relationship to Proposed Insured 1 (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	% share of benefits to be paid
Primary Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
					TOTAL	

Proposed Insured 2		Legal Name (first, middle initial, last)	Relationship to Proposed Insured 2 (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	% share of benefits to be paid
Contingent (Subrogated in Quebec) Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
					TOTAL	

Section 6.2 – Benefit paid on riders in the event of death

Proposed Insured 1	Legal Name (first, middle initial, last)	Relationship to Proposed Insured(s) (in Quebec, relationship to Owner)
Accidental Death Benefit (ADB)		
Critical Illness Return of Premium on Death (ROPD) Rider		

Proposed Insured 2	Legal Name (first, middle initial, last)	Relationship to Proposed Insured(s) (in Quebec, relationship to Owner)
Accidental Death Benefit (ADB)		
Critical Illness Return of Premium on Death (ROPD) Rider		

Section 6.3 – Benefit paid on critical illness living benefit

Proposed Insured 1	Legal Name (first, middle initial, last)	Relationship to Proposed Insured(s) (in Quebec, relationship to Owner)
Critical Illness Benefit		
Early Discovery Benefit		
Maturity Benefit		
Return of Premium on Surrender		
Return of Premium on Expiry		

Proposed Insured 2	Legal Name (first, middle initial, last)	Relationship to Proposed Insured(s) (in Quebec, relationship to Owner)
Critical Illness Benefit		
Early Discovery Benefit		
Maturity Benefit		

Section 7 - Insurance History - Complete for all Proposed Insureds.

Please provide details for "Yes" answers in space provided, and if necessary in Section 11 – Comments.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
1. Has any application, including any request to reactivate/reinstate any Life, Critical Illness, Long Term Care or Disability Insurance ever been declined, rated, postponed, cancelled, rescinded or modified in any way? (If yes, provide details in Section 11.)	☐	☐	☐	☐
2. a) Is this Insurance intended to replace or change any existing Life or Critical Illness Insurance with BMO Insurance or any other Company? If Yes, answer 2b. If Yes to 2a, and you are applying for **Life Insurance**, your advisor must provide you with a written analysis of the advantages and disadvantages of the proposed replacement. The Replacement Forms or Life Insurance Replacement Declaration (LIRD) must be submitted to Head Office with this application.	☐	☐	☐	☐
b) If this insurance applied for will replace an existing BMO Insurance policy, does the owner of the existing policy instruct BMO Insurance to cancel such policy on issuance of the policy applied for herein? If Yes to 2b, include policy # to be cancelled:	☐	☐	☐	☐
3. Do you have in effect or pending any of the following: Life Insurance, Critical Illness Insurance, Disability Insurance or Long Term Care Insurance? **(If Yes, complete the table below.)**	☐	☐	☐	☐

	Company	Type of Insurance Plan	Personal Amount	Business Amount	Yr. Issued (if in-force) or Yr. submitted (if Pending)
Proposed Insured 1					
Proposed Insured 2					

Section 8 - Personal Information - To be completed by Proposed Insured 1/Proposed Insured 2.

Please provide details for "yes" answers in space provided, and if necessary, in Section 11.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
1. Have you used any form of tobacco, marijuana, hash, nicotine products or nicotine substitutes:				
a) in the past 12 months?	☐	☐	☐	☐
b) in the past 24 months?	☐	☐	☐	☐
c) in the past 5 years?	☐	☐	☐	☐
2. Have you within the past 5 years flown as a pilot, student pilot, crew member or intend to do so? (If "yes", you will need to complete an	☐	☐	☐	☐
3. Have you within the past 5 years participated in or , , , , , , , , or any other similar sports of avocations or intend to do so? (If "yes", you will need to complete an Avocation Questionnaire)	☐	☐	☐	☐
4. Have you travelled, resided, or worked outside North America in the past 12 months, or have any plans to do so in the next 12 months? (If "yes", provide details below - use Section 11 if more space is needed), including length of time outside of North America, dates and purpose of trips.	☐	☐	☐	☐
5. Have you had:				
a) more than two moving violations in the past 3 years? (If "yes", give details including dates and type of violation.)	☐	☐	☐	☐
b) a licence suspension, DUI (Driving Under the Influence), or reckless driving conviction in the past 5 years?	☐	☐	☐	☐
c) a licence suspension, DUI (Driving Under the Influence), or reckless driving conviction in the past 10 years?	☐	☐	☐	☐
If you answer "yes" to a, b, or c, please provide your Driver's Licence Number:				
6. Have you ever been arrested, charged or convicted of any criminal offence? (If "yes", provide details in Section 11.)	☐	☐	☐	☐
7. Have you ever declared personal or corporate bankruptcy? (If "yes", when was it discharged.)	☐	☐	☐	☐

dd/mmm/yyyy dd/mmm/yyyy

Section 9 - Financial Information - Completion is mandatory.

	Proposed Insured 1	Proposed Insured 2
1. Total Assets		
2. Total Liabilities		
3. Net Worth		
4. Annual Earned Income		
5. Unearned Income		
Specify Source of Unearned Income		
6. If not gainfully employed, what is the gross amount of the family income?		
7. If not gainfully employed, what is the amount of in force insurance on the working spouse?		

8. Purpose of Insurance

☐ Income Replacement ☐ Personal ☐ Other

9. Source of Payment – (Select all that apply) Completion is mandatory.

☐ Self-employment income ☐ Employment income ☐ Retirement Income/Pension Income ☐ Grants/Scholarships

☐ Insurance Claim Payments ☐ Corporate ☐ Investment Income/Savings ☐ Sale of Assets

☐ Trust/Inheritance ☐ Gift ☐ Loan ☐ Lottery Winnings

☐ Proceeds from a legal case or action ☐ Other

10. Is there an existing or planned agreement that provides for anyone other than the Proposed Insured(s) or Owner(s) identified in Sections 4.1, 4.2, to obtain any legal interest, pay the premiums or have an ownership interest in any policy resulting from this application?

☐ Yes (if yes, provide details) ☐ No

Section 10 - Children's Term Rider

To be completed by the parent or legal guardian on behalf of all children applying for Term Insurance, who are between 15 days and up to and including 17 years old. The Beneficiary of this rider is the Owner unless stated otherwise.

	First and Last Name of Child	Relationship to Proposed Insured	Date of Birth (dd/mmm/yyyy)	Height	Weight
1				☐ cm ☐ ft/in	☐ kg ☐ lbs
2				☐ cm ☐ ft/in	☐ kg ☐ lbs
3				☐ cm ☐ ft/in	☐ kg ☐ lbs
4				☐ cm ☐ ft/in	☐ kg ☐ lbs

	1		2		3		4	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Has any child proposed for coverage above, within the past five years:								
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?	☐	☐	☐	☐	☐	☐	☐	☐
b) Been advised to have any diagnostic test, hospitalization or surgery which was not done?	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any child proposed for coverage above ever had or had indication of:								
a) Cancer, stroke, heart attack or heart disease?	☐	☐	☐	☐	☐	☐	☐	☐
b) Diabetes, glandular or thyroid disorder, enlarged lymph nodes, epilepsy, or any mental, nervous or neurological disorder?	☐	☐	☐	☐	☐	☐	☐	☐
c) Chest pain, angina, high blood pressure, heart murmur or other circulatory or blood disorders?	☐	☐	☐	☐	☐	☐	☐	☐
d) Kidney, urinary or reproductive disorder, or sexually transmitted disease?	☐	☐	☐	☐	☐	☐	☐	☐
e) Liver or gastrointestinal disorder, hepatitis or hepatitis carrier state?	☐	☐	☐	☐	☐	☐	☐	☐
f) Asthma, emphysema, or other respiratory disorder?	☐	☐	☐	☐	☐	☐	☐	☐
g) Loss of vision, amputation, deformity, arthritis or other musculo-skeletal disorder?	☐	☐	☐	☐	☐	☐	☐	☐
3. Has any child proposed for coverage above ever had or been told they have:								
a) Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	☐	☐	☐	☐	☐	☐	☐	☐
4. Is any child proposed for coverage above presently taking any medication?	☐	☐	☐	☐	☐	☐	☐	☐
5. Has any child proposed for coverage above:								
a) Ever had any application, including any request to reactivate/reinstate any Life, Critical Illness, Long Term Care or Disability Insurance ever been declined, rated, postponed, cancelled, rescinded or modified in any way?	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐
c) Within the past five years used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol use?	☐	☐	☐	☐	☐	☐	☐	☐
d) Ever had their driver's licence restricted, suspended, revoked or had three or more moving violations within the past three years?	☐	☐	☐	☐	☐	☐	☐	☐
If yes, provide drivers licence #								
6. Does any child proposed for coverage above intend to reside or travel outside of Canada for more than four consecutive weeks?	☐	☐	☐	☐	☐	☐	☐	☐

Give full details for all "Yes" answers to questions 1 to 6. Give dates, treatment, duration of illness, and names and addresses of all attending physicians and medical facilities. If you require additional space please use Section 11 - Comments.

Question No.	First and Last Name (Proposed Life Insured)	Details

Section 11 - Comments - To be completed by Proposed Insured 1/Proposed Insured 2.

If additional space is needed, Proposed Insured 1 and, if applicable, Proposed Insured 2 must provide details on a separate sheet which is signed and dated.

I have read and reviewed the questions, answers and information, set out in Sections 1 through 11 and the answers and information are true and complete and have been correctly recorded.

Initials

Proposed Insured 1	Proposed Insured 2

NOTE: Sections 14 through 21 - To be completed by Proposed Insured 1 and Proposed Insured 2 with a BMO Insurance representative or a medical professional. You will be contacted to arrange a mutually convenient time.

Section 12 - Payments & Authorizations - Identify how and how frequently the proposed owner(s) shall pay.

Section 12.1 - Method of Payment

Initial Payment Paid:

- ☐ Annually by cheque (We will obtain this from you later)
- ☐ Monthly by Pre-authorized Debit (PAD) (Complete Section 12.2)
- ☐ Credit card **(For first annual payment only)** (Complete Section 12.3)

Subsequent Payments Paid:

- ☐ Annually by cheque
- ☐ Monthly by Pre-authorized Debit (PAD) (Complete Section 12.2)

Section 12.2 - Monthly Pre-Authorized Debit (PAD) Authorization

I would like to set up my PAD Agreement in the following manner:

☐ Create new PAD Agreement using either:
- ☐ The Account information shown on VOID cheque attached; or
- ☐ A bank letter of direction (a line of credit account cannot be used)

☐ Add to existing PAD Agreement – BMO Insurance Policy # _____

Withdrawal Day (choose from the 1st to the 28th) _____

All payors must agree to all of the following terms in order to use the PAD payment option.

- BMO Life Assurance Company (Company) may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from the bank account indicated in this application for insurance;
- For the purpose of this agreement, all pre-authorized debits will be treated as Personal under the Canadian Payments Association rules (this means having 90 calendar days from the date any payment is processed to claim reimbursement for any unauthorized payment);
- The withdrawal amount is considered to be variable under the Canadian Payment Association rules;
- Any notices to be sent under this agreement may be sent to the proposed owner/owner's most recent address that the Company has on record at the time the notice is sent;
- The Company may charge a fee and may cancel the PAD for any withdrawal that is not honoured;
- This authorization may be cancelled at any time upon the Company's receipt of written notice by the payor;
- Any cancellation of this pre-authorized withdrawal will not affect the agreement between them and the Company whatsoever with respect to any insurance coverage so long as payment is provided by an alternate acceptable method.
- All persons whose signatures are required to sign on this account have signed below, including any required joint account holder.
- **To waive the requirement that BMO Life Assurance Company notify them of:**
  - **This authorization before the first payment is processed,**
  - **Any subsequent payments, and**
  - **Any changes to the amount or date of the payment initiated by them or the Company.**

Payors have certain recourse rights in the event that a debit does not comply with this agreement. Payors have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. Payors may obtain a sample cancellation form or more information on rights to cancel this Authorization by contacting their financial institution or by visiting www.cdnpay.ca.

Contact us at any time: BMO Life Assurance Company 60 Yonge Street Toronto, ON M5E 1H5 1-877-742-5244; Fax 416-596-0348

Date Signed _____ (dd/mmm/yyyy)

Signature(s) (for a joint account, all depositors must sign) X _____

X _____

Section 12.3 - Credit Card Authorization - For first annual payment only.

☐ Master Card ☐ Visa

Card Number |_|_|_|_|—|_|_|_|_|—|_|_|_|_|—|_|_|_|_| Expiry Date (mm/yy) mm/yy

AUTHORIZATION

I (we), the undersigned credit card holder(s), authorize BMO Insurance, in the event my (our) application for insurance is approved by BMO Insurance, to charge my (our) first annual premium payment only, to the credit card account, as indicated above.

Upon receipt of this form, BMO Insurance will request necessary authorization from the issuer of your credit card. If necessary authorization is obtained from the issuer, your account will be debited accordingly. Payment to BMO Insurance by the issuer pursuant to the above will constitute and represent "an amount paid" and, as such, is governed by the provisions of this Application.

_____ X _____

Cardholder Name Cardholder Signature

Note: Cardholder(s) must be one of Proposed Insured 1 or Proposed Insured 2.

The Advisor Report must be completed before submitting the application to Watermark. This is your electronic signature to allow us to proceed with the application.

Section 13 - Advisor Report

Legal Name of Proposed Insured 1 (first, middle initial, last)	Date of Birth (dd/mmm/yyyy)
Legal Name of Proposed Insured 2 (first, middle initial, last)	Date of Birth (dd/mmm/yyyy)

Section 13.1 - Advisor Certification

The foregoing answers are correct to the best of my knowledge. By entering my name and advisor code below, I confirm that:

1. I am the soliciting Advisor and I am duly licensed to write this Application in the jurisdiction where the transaction occurred.
2. I have provided an Advisor Disclosure Statement to the owner, advising:
   a) About the company(s) that I currently represent;
   b) That I receive compensation (such as commissions) for the sale of life and health insurance products;
   c) That I may receive additional compensation in the form of bonuses, conference programs or other incentives; *or*
   d) Of any conflicts of interest I may have with respect to this transaction
3. In the event that this application for insurance is intended to replace or change any existing Life Insurance, it is a term to term replacement and I have personally discussed the advantages and disadvantages of replacement with my client.
4. I obtained the Proposed Insured(s) agreement to collect and share personal information in taking this application.

Section 13.2 - Advisor Information

		%	dd/mmm/yyyy
Full Name (Servicing Advisor)	Advisor Code No.	Percentage Split	Date (dd/mmm/yyyy)
		%	
Full Name	Advisor Code No.	Percentage Split	
MGA Company Name	MGA Code No.		
MGA Case Coordinator/Administrator Name			

Section 13.3 - Special Instructions

Outline any information which may help in the underwriting of the risk and processing of this Application for Insurance. (e.g., Save Age, Backdating, Underwriting requirements ordered)

Section 14 - NOTICE, REPRESENTATIONS, ACKNOWLEDGEMENTS, AUTHORIZATIONS AND SIGNATURES

14.1 - IMPORTANT NOTICE: The information contained in this application and other information BMO Insurance may collect in connection with the application is required by BMO Insurance for insurance purposes, including activities, such as: considering and processing the application and administering any policy if issued and investigating coverage and claims (the "Insurance Purposes"). Further information about the Insurance Purposes and BMO Insurance's privacy practices are set out in the notice on Privacy and Personal Information and MIB Inc. provided at the time of Application.

14.2 - REPRESENTATIONS AND ACKNOWLEDGEMENTS: "I" (being the proposed undersigned owner, or insured, of the policy either individually or collectively) by signing below represent and confirm that:

1. I have read and understood all of the questions in this application form, and in any supplemental questionnaires, submitted to BMO Life Assurance Company (BMO Insurance) as part of this application for life insurance (the "Application") and that I intend to submit the Application for insurance.
2. I have reviewed all of my answers and statements recorded in the Application and the answers provided are true and complete and were provided by me to my advisor (or some other authorized person acting on behalf of my advisor) for the Insurance Purposes. In addition, I understand that any statements that I make during a telephone conversation or visit with a medical professional or other representative are also part of my Application and will also be used for the Insurance Purposes.
3. I understand that the information and answers provided in the Application will be relied upon by BMO Insurance in assessing the Application, and issuing any policy. I was present when the answers to the questions related to me were collected and I provided the answers.
4. BMO Insurance may void any policy it issues based on the Application if any of the information or answers provided in the Application is incomplete or incorrect.
5. I will notify BMO Insurance immediately if any of the answers or information provided in the Application is discovered to be untrue or changes in the period before approval of the issuance of and delivery of the policy applied for. I will notify BMO Insurance if there is a change in my residency status for tax purposes.
6. I have received sufficient and satisfactory information concerning the product(s) I am applying for before signing this Application, and I understand that the life insurance advisor may be paid on a commission basis.
7. I also understand that there are variables (e.g., type and performance of investments, cost of insurance, policy loans, payments and withdrawals, etc.) that can affect the policy's performance and that changes in these variables can affect the policy's non-guaranteed benefits and values, and I further understand that benefits and values set out in any illustration are not guaranteed and are based on assumptions that are likely to change.
8. I (being the proposed owner) will be deemed to have accepted the terms of the policy and any endorsements, additions and amendments attached to it, issued based on this Application if I do not return the policy to BMO Insurance within 10 days of delivery.

14.3 - AUTHORIZATIONS AND SIGNATURES: "I" (being the proposed undersigned owner or insured of the policy either individually or collectively) by signing below indicate that:

1. I consent to the collection, use and disclosure of my personal information by BMO Insurance and its sub-contractors for the Insurance Purposes.
2. I consent to BMO Insurance obtaining a credit bureau report, conducting a criminal records check and obtaining information relating to my driving history , as required, for the Insurance Purposes
3. I authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, and insurance company, advisor or broker or its affiliate, the MIB Inc., and any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide and exchange all such information and records with BMO Insurance or its reinsurers.
4. I consent to the testing of specimens(s) provided by me, which may include AIDS Virus (HIV) antibody/antigen testing, unless I expressly revoke this consent.
5. I consent to BMO Insurance releasing the results of any tests, reports and personal information gathered about me to its reinsurers and other authorized insurers, to my personal physician, and to the MIB Inc.
6. I understand that if the proposed insured is not the only proposed insured or is different than a proposed owner(s), that the personal information (including health information) of the proposed insured will be shared with any additional proposed life insured or policy owner and I consent to this.
7. I have read, understood and agree to the collection, use and disclosure of my personal information as set out in the Privacy and Personal Information and MIB Inc. Notice provided to me at the time of Application.

By signing below I understand and agree to the statements in the section above and consent to the collection and disclosure of my personal information as described.

X	/ /
Proposed Insured 1	Date (dd/mmm/yyyy)
X	/ /
Proposed Insured 2	Date (dd/mmm/yyyy)
X	/ /
Witness / Name of Witness (please print)	Date (dd/mmm/yyyy)

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Section 15 - AUTHORIZATION TO SHARE INFORMATION

Authorization to Share information - **PLEASE COMPLETE ON ALL APPLICATIONS** - Do not detach.

You and your refer to the person(s) to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. Us and our refer to BMO Life Assurance Company (BMO Insurance). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, public or private health or social services establishments, clinics and other medically related facilities, insurance companies, MIB, Inc., your advisor or its affiliate and any other organization, institution, association or person that has information, records or knowledge of you or your health or of your children or their health (if applicable), to share or exchange information with us or our reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal information to MIB, Inc. Note: A parent or legal guardian signing on behalf of a minor must indicate relationship. A copy of this authorization shall be as valid as the original.

/ /			X
Date (dd/mmm/yyyy)	Province Signed	Print Name of Proposed Insured 1	Proposed Insured 1

/ /			X
Date (dd/mmm/yyyy)	Province Signed	Print Name of Proposed Insured 2	Proposed Insured 2

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1) Complete Section 16 through Section 19
2) Section 20 and Section 21 to be left with the Insured(s)
3) Collect wet signatures in Section 11, Section 12 (if required), Section 14, Section 15 and Section 17

Section 16 - Verification of Identity

An appropriate form of valid government issued identification is required to verify the identity of Proposed Insured 1/Proposed Insured 2/Proposed Owners. Passport, Driver's Licence, and Provincial Health Card (except in Quebec, Manitoba, Ontario and P.E.I.) are acceptable.

Proposed Insured 1 /Owner	Document name **(Photo ID)**	Place of Issue	Document reference #	Expiry Date (dd/mmm/yyyy)
Proposed Insured 2 /Owner	Document name **(Photo ID)**	Place of Issue	Document reference #	Expiry Date (dd/mmm/yyyy)

Section 17 - Medical Information

Section 17.1 - Family History

Have any of your natural parents, brothers or sisters either living or dead, ever suffered from any of the following conditions: diabetes, cancer, high blood pressure, stroke, heart disease, kidney disease, polycystic kidney disease, Huntington's Chorea, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), muscular dystrophy, cystic fibrosis, mental illness or suicide, multiple sclerosis, motor neuron disease or any other inherited disease? Complete for all family members.

Proposed Insured 1		**Proposed Insured 2**	
Yes	No	Yes	No
☐	☐	☐	☐

Proposed Insured 1	Proposed Insured 2	Relationship to Life Insured	Illness (if cancer indicate type)	Age at Onset	Age if Living	Age at Death	Cause of Death
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Section 17.2 - Physician

	Proposed Insured 1	Proposed Insured 2
Name of your Personal Physician (if no personal physician, please provide details regarding last physician seen)		
Address of your Personal Physician		
Telephone Number of Physician		
How long has the above been your Physician?		
Date (dd/mmm/yyyy) and reason of your last consultation		
Treatment (medication, special tests) and results.		
Does this physician have your complete medical file? If not, provide the name(s) and address(es) of other Physicians who have treated you.	☐ Yes ☐ No	☐ Yes ☐ No

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Section 17.3 - Medical History

All questions must be answered "yes" or "no". If a response is "yes", circle the relevant condition. Complete details must be provided including, doctor's names, relevant dates, treatments, referrals and results. If additional space is required, please use Section 17.5 and, if necessary, provide further details on a separate sheet which must be signed and dated by the Proposed Insured.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
1. Have you ever had, been told you may have, received or been advised to receive treatment, medication or medical attention or testing for any disorder affecting the:				
a) **Cardiovascular system** and **blood** such as: heart attack, stroke, T.I.A., leukemia, blood clot, high blood pressure, angina or chest pain, palpitations, heart murmur, shortness of breath, irregular heart beat, high cholesterol, anemia or any other disorder of the heart or blood vessels?	☐	☐	☐	☐
b) **Respiratory system** such as: asthma, emphysema, chronic bronchitis, chronic cough, persistent hoarseness, tuberculosis, pleurisy, sleep apnea, spitting of blood or any other disorder of the lungs, nose or throat?	☐	☐	☐	☐
c) **Nervous system** such as: burnout, psychiatric disorder, chronic fatigue, anxiety, depression, dizziness, fainting, convulsions, numbness, tingling, loss of balance, weakness of the extremities, paralysis, optic neuritis, epilepsy, Parkinson's disease, Alzheimer's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), motor neuron disease, cerebral palsy, Down's Syndrome, mental retardation, impairment or loss of sight, hearing or speech or any other disorder of the brain or spinal cord?	☐	☐	☐	☐
d) **Gastrointestinal system** such as: ulcer, colitis, Crohn's, hepatitis or hepatitis carrier state, jaundice, bleeding from the intestine or rectum, diarrhea lasting more than five days or any other disorder of the stomach, intestines, gall bladder liver or pancreas?	☐	☐	☐	☐
e) **Musculoskeletal system** such as: arthritis, sciatica, Polio, Fibromyalgia, rheumatism, gout, disc problems, loss of limb, amputation, paralysis, deformity or any other disorder of the muscles, joints, bones, neck or back?	☐	☐	☐	☐
f) **Urinary or Reproductive systems** such as: blood, pus or sugar in the urine, albumin, nephritis, sexually transmitted disease or abnormal mammogram or PSA results or any other disorder of the prostate, ovary, uterus, breast, kidney, bladder or ureter?	☐	☐	☐	☐
g) **Glandular system** such as: diabetes, swollen glands or lymph nodes, or any other disorder including the thyroid, pituitary, breast or other glands?	☐	☐	☐	☐
h) **Skin** such as: moles, skin lesions, dysplastic nevi syndrome or any other disorder of the skin?	☐	☐	☐	☐
i) **Immune system** such as: Lupus, AIDS (Acquired Immunodeficiency Syndrome) or a positive HIV test, multiple chronic or unexplained infections?	☐	☐	☐	☐
2. Have you ever had any cancer, tumour, cyst, polyp, lump or growth not mentioned above? If yes, please specify:	☐	☐	☐	☐
3. Have you taken any medication(s) in the last 5 years? If yes, indicate medication, dosage(s) and reason:	☐	☐	☐	☐
4. Have you had or been recommended to have a Computer Tomography Scan (CT Scan) or Magnetic Resonance Imaging (MRI)?	☐	☐	☐	☐
5. Are you aware of any symptoms or conditions for which you have not yet sought treatment or seen a medical practitioner?	☐	☐	☐	☐

Please provide details for any "yes" answers above in space provided, and if necessary, in Section 17.5 below.

Question No.	Name of Life Insured	Name of Physician	Details: Including dates, treatments, referrals and results.

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Section 17.3 - Medical History

Please provide details for any "yes" answers in space provided below, and if necessary, in Section 17.5 below.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
6. In the past 5 years, other than as mentioned above, have you ever had, been or been recommended to have:				
a) an Electrocardiogram, Chest X-ray, Blood test, biopsy or any other test, surgery or hospitalization medical procedure? If yes, indicate test, reason, results, dates and doctor's name(s).	☐	☐	☐	☐
b) testing to indicate exposure to the HIV (AIDS) virus? If yes, indicate dates and type of test.	☐	☐	☐	☐
c) hospitalized? If yes, indicate reason, results dates and doctor's name(s).	☐	☐	☐	☐
7. In the past 5 years have you ever had any illness, procedure, accident, injury, consulted a doctor, or have you ever been advised to be under treatment by diet, drugs or any means other than mentioned above? If yes, specify details including diagnosis, treatment, reason, date, results and doctor's name(s).	☐	☐	☐	☐
8. Have you been absent from work for more than 7 days within the last 6 months because of sickness or injury?	☐	☐	☐	☐
9. Have you been absent from work for more than a two week period due to disability within the past two years?	☐	☐	☐	☐
10. **Smoking:** Note: the answer to this question will determine whether smoker of non-smoker premium rates apply.				
a) Have you **ever** used any tobacco or nicotine product including cigarettes, cigars, cigarillos, pipe, chewing tobacco, marijuana and/or nicotine substitutes such as nicotine patch or nicotine gum or any other smoking cessation products? If yes, indicate which one(s), daily quantity used, length of use and date last used.	☐	☐	☐	☐
b) Have you used any of the above in the past 12 months? If yes, indicate which one(s), daily quantity used and date last used.	☐	☐	☐	☐
c) Have you used any of the above in the past 24 months? If yes, indicate which one(s), daily quantity used and date last used.	☐	☐	☐	☐
d) Have you used any of the above in the past 5 years? If yes, indicate which one(s), daily quantity used and date last used.	☐	☐	☐	☐
11. Do you presently drink alcoholic beverages? If yes, indicate usual weekly quantity and type of beverage (e.g. wine, beer, spirits) If no, indicate reason & date last used.	☐	☐	☐	☐
12. In the last 10 years have you ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug including marijuana, cocaine, amphetamines, barbiturates, etc. not prescribed by a physician? If yes, indicate type, dates used, frequency and daily quantity.	☐	☐	☐	☐
13. Have you ever decided or been advised to reduce your intake of alcohol or drugs, received or been recommended to receive counselling or treatment or belonged to an organization because of the use of alcohol and/or drug use? If yes, indicate type of alcohol (beer, wine, spirits) or drug, quantity used, frequency, dates used, date last used, name of organization and doctor's name(s), address(es).	☐	☐	☐	☐

Please provide details for any "yes" answers above in space provided, and if necessary, in Section 17.5 below.

Question No.	Name of Life Insured	Name of Physician	Details: Including dates, treatments, referrals and results.

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Section 17.4 - Medical History If Over Age 70

If the Proposed Insured 1 or Proposed Insured 2 is 70 or older, complete the following section. Otherwise, proceed to the next section.

	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
1. Do you require or obtain assistance with:				
a) bathing?	☐	☐	☐	☐
b) meal preparation?	☐	☐	☐	☐
c) taking medication?	☐	☐	☐	☐
d) using transportation?	☐	☐	☐	☐
e) shopping/banking?	☐	☐	☐	☐
f) other? Please specify: _____	☐	☐	☐	☐
2. Do you drive a vehicle? If not, why? Any restrictions?	☐	☐	☐	☐
3. Have you fallen during the past two years? If yes, provide frequency and details.	☐	☐	☐	☐
4. With whom do you reside and how long has this been your living arrangement?	☐	☐	☐	☐
5. Do you use a cane, walker, wheelchair, oxygen supply or other device to assist you? If yes, please provide details.	☐	☐	☐	☐

Please provide details for any "yes" answers above in space provided, and if necessary, in Section 17.5 below.

Question No.	Name of Life Insured	Name of Physician	Details: Including dates, treatments, referrals and results.

Section 17.5 - Details of and Comments on Medical History

Please use the space below to provide details for the **MEDICAL INFORMATION** question(s) in Sections 17 to which you answered "Yes".

I have read and reviewed the questions, answers and information, set out in Sections 16 and 17 and the answers and information are true and complete and have been correctly recorded.

Initials

Proposed Insured 1	Proposed Insured 2

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Section 18 - Paramedical/Medical Exam - Proposed Insured 1

Legal Name of Proposed Insured 1 (first, middle, last)	Date of Birth (dd/mmm/yyyy)
Advisor Name	MGA Name

Physical Measurements

1. Height (without shoes) ft/in _____ Weight: lbs. _____
   m/cm _____ kg _____
   Males only: Chest (full inspiration) in _____ Males and Females Abdomen (waist): in _____
   cm _____ cm _____
   Chest (full expiration) in _____
   cm _____

   Did you weigh and measure? ☐Yes ☐No

   Has there been a weight change in the past 12 months? ☐Yes ☐No If yes, ☐Gain ☐Loss

   If yes, how much? _____ Reason? _____
   If applicant exceeds the limits of the scale, please arrange for weight measurement with an appropriate scale.

2. Blood Pressure (sitting.....without exercise)

	1	2	3
Systyolic			
Diastolic			

   Take at least two readings, repeat in 5 minutes if > 140/90

   Was a large cuff used? ☐Yes ☐No

3. Pulse rate at rest _____ Irregularities, if any _____

4. Does the applicant appear unhealthy, greater than stated age or have any obvious mental or physical impairments? ☐Yes ☐No
   If yes, provide details in Examiner's Notes section.

5. Are you aware of any additional history? ☐Yes ☐No If yes, provide details in Examiner's Notes section.

6. Urinalysis, if positive indicate results.

Blood	Albumin	Sugar
☐ Negative	☐ Negative	☐ Negative
☐ Positive	☐ Positive	☐ Positive

Tests performed and/or specimens sent under separate cover:

Specimen	LabOne	Other (specify)	Barcode Label
☐ Urine	☐	☐	
☐ Blood	☐	☐	

Tests:
☐ ECG - Resting
☐ ECG - Stress
☐ Chest x-ray
☐ Other (specify)

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Section 18 - Paramedical/Medical Exam - Proposed Insured 1

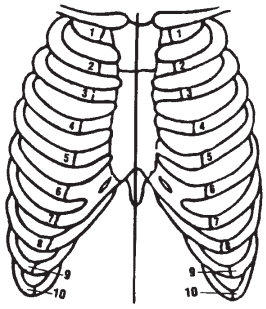
Physician's Report:

		Yes	No
1.	Is there any past or present evidence of abnormality of:		
a)	The Cardiovascular Systems?	☐	☐
	Heart sounds	☐	☐
	Heart size	☐	☐
	Pulse (rhythm, character)	☐	☐
b)	The Respiratory System (lungs, chest deformity, emphysema, rales etc.)	☐	☐
c)	Head and Neck (throat, mouth, vision, hearing, speech, thyroid etc.)	☐	☐
d)	Abdomen (viscera, genitalia, hernia or evidence of surgery)	☐	☐
e)	Was a rectal examination performed? If not, please state reason.	☐	☐
	_____		
f)	Skin, Lymph nodes, Breasts, Muscles, Bones or Joints	☐	☐
g)	Nervous system (reflexes, weakness, tremors)	☐	☐
2.	Has the Proposed Insured ever consulted with your office professionally?	☐	☐

Heart Chart (chart & form – examiner's report to be added):

Heart: Is there any: Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

Description: Location	Apex	Aortic	Pulm	Other
Constant	☐	☐	☐	☐
Inconstant	☐	☐	☐	☐
Transmitted	☐	☐	☐	☐
Localized	☐	☐	☐	☐
Systolic	☐	☐	☐	☐
Presystolic	☐	☐	☐	☐
Diastolic	☐	☐	☐	☐
Soft (Gr. 1-2)	☐	☐	☐	☐
Mod. (Gr. 3-4)	☐	☐	☐	☐
Loud (Gr. 5-6)	☐	☐	☐	☐
After exercise or change of location, murmur is:				
Increased	☐	☐	☐	☐
Absent	☐	☐	☐	☐
Unchanged	☐	☐	☐	☐
Decreased	☐	☐	☐	☐



Indicate:
Apex by: **X**
Murmur area by: △
Point of greatest intensity by: ○
Transmission by: →
Comments and impressions:

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Section 18 - Paramedical/Medical Exam - Proposed Insured 1

Examiner's Notes:

1. Are you related to or do you know the Proposed Insured 1 personally? ☐Yes ☐No

2. Are you aware of any information that could influence the Proposed Insured's 1 insurability? ☐ Yes ☐ No If yes, please provide details.

3. Your classification as an insurance risk for the Proposed Insured 1 is:
   - ☐ Average of better
   - ☐ Below average, please provide details _____
   - ☐ Poor, please provide details _____

4. Was a third party, such as a translator, present during this examination? ☐ Yes ☐ No If yes, please indicate why and relationship to the Proposed Insured 1.

Examiner's Notes:

Signed at: _____ Date: _____ (dd/mmm/yyyy) Time: _____

Examiner's Signature: X _____

Examiner Information: PLEASE PRINT

Examiner's Name: _____ Company: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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Section 19 - Paramedical/Medical Exam - Proposed Insured 2

Legal Name of Proposed Insured 2 (first, middle initial, last)	Date of Birth (dd/mmm/yyyy)
Advisor Name	MGA Name

Physical Measurements

1. Height (without shoes) ft/in _____ Weight: lbs. _____
   m/cm _____ kg _____
   Males only: Chest (full inspiration) in _____ Males and Females Abdomen (waist): in _____
   cm _____ cm _____
   Chest (full expiration) in _____
   cm _____

   Did you weigh and measure? ☐Yes ☐No

   Has there been a weight change in the past 12 months? ☐Yes ☐No If yes, ☐Gain ☐Loss

   If yes, how much? _____ Reason? _____
   If applicant exceeds the limits of the scale, please arrange for weight measurement with an appropriate scale.

2. Blood Pressure (sitting.....without exercise)

	1	2	3
Systyolic			
Diastolic			

   Take at least two readings, repeat in 5 minutes if > 140/90

   Was a large cuff used? ☐Yes ☐No

3. Pulse rate at rest _____ Irregularities, if any _____

4. Does the applicant appear unhealthy, greater than stated age or have any obvious mental or physical impairments? ☐Yes ☐No
   If yes, provide details in Examiner's Notes section.

5. Are you aware of any additional history? ☐Yes ☐No If yes, provide details in Examiner's Notes section.

6. Urinalysis, if positive indicate results.

Blood	Albumin	Sugar
☐ Negative	☐ Negative	☐ Negative
☐ Positive	☐ Positive	☐ Positive

Tests performed and/or specimens sent under separate cover:

Specimen	LabOne	Other (specify)	Barcode Label
☐ Urine	☐	☐	
☐ Blood	☐	☐	

Tests:
☐ ECG - Resting
☐ ECG - Stress
☐ Chest x-ray
☐ Other (specify)

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Section 19 - Paramedical/Medical Exam - Proposed Insured 2

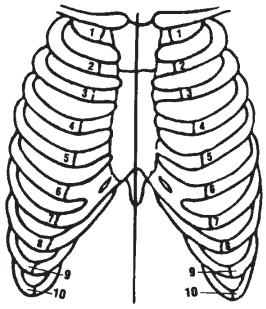
Physician's Report:

		Yes	No
1.	Is there any past or present evidence of abnormality of:		
a)	The Cardiovascular Systems?	☐	☐
	Heart sounds	☐	☐
	Heart size	☐	☐
	Pulse (rhythm, character)	☐	☐
b)	The Respiratory System (lungs, chest deformity, emphysema, rales etc.)	☐	☐
c)	Head and Neck (throat, mouth, vision, hearing, speech, thyroid etc.)	☐	☐
d)	Abdomen (viscera, genitalia, hernia or evidence of surgery)	☐	☐
e)	Was a rectal examination performed? If not, please state reason.	☐	☐
	_____		
f)	Skin, Lymph nodes, Breasts, Muscles, Bones or Joints	☐	☐
g)	Nervous system (reflexes, weakness, tremors)	☐	☐
2.	Has the Proposed Insured ever consulted with your office professionally?	☐	☐

Heart Chart (chart & form – examiner's report to be added):

Heart: Is there any: Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

Description: Location	Apex	Aortic	Pulm	Other
Constant	☐	☐	☐	☐
Inconstant	☐	☐	☐	☐
Transmitted	☐	☐	☐	☐
Localized	☐	☐	☐	☐
Systolic	☐	☐	☐	☐
Presystolic	☐	☐	☐	☐
Diastolic	☐	☐	☐	☐
Soft (Gr. 1-2)	☐	☐	☐	☐
Mod. (Gr. 3-4)	☐	☐	☐	☐
Loud (Gr. 5-6)	☐	☐	☐	☐
After exercise or change of location, murmur is:				
Increased	☐	☐	☐	☐
Absent	☐	☐	☐	☐
Unchanged	☐	☐	☐	☐
Decreased	☐	☐	☐	☐



Indicate:
Apex by: **X**
Murmur area by: △
Point of greatest intensity by: ○
Transmission by: →
Comments and impressions:

Section 19 - Paramedical/Medical Exam - Proposed Insured 2

Examiner's Notes:

1. Are you related to or do you know the Proposed Insured 2 personally? ☐ Yes ☐ No

2. Are you aware of any information that could influence the Proposed Insured 2's insurability? ☐ Yes ☐ No
   If yes, please provide details.

   _____

3. Your classification as an insurance risk for the Proposed Insured 2 is:
   - ☐ Average of better
   - ☐ Below average, please provide details _____
   - ☐ Poor, please provide details _____

4. Was a third party, such as a translator, present during this examination? ☐ Yes ☐ No If yes, please indicate why and relationship to the Proposed Insured 2.

   _____

Examiner's Notes:

Signed at: _____ Date: _____ (dd/mmm/yyyy) Time: _____

Examiner's Signature: X _____

Examiner Information: PLEASE PRINT

Examiner's Name: _____ Company: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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Section 20 - Temporary Accidental Death Benefit Agreement

Please detach and give to Owner.

Important: No Temporary Accidental Death Benefit coverage shall take effect except as stated in this Agreement.

This temporary accidental death benefit is to provide limited coverage as described below while your Application is being processed. Coverage under this temporary accidental death benefit does not guarantee approval of your Application. Any change in insurability while your Application is being processed may also affect whether or not your Application is approved.

In the event of the accidental death of a life to be insured while this benefit is in force, who qualifies for this temporary accidental death benefit, BMO Life Assurance Company (BMO Insurance) will pay the temporary accidental death benefit amount. Payment will be made in accordance with the beneficiary designation(s) in the Application and, in cases of joint lives to be insured, the plan for which application has been made.

Benefit Cost

BMO Insurance agrees to provide a Temporary Accidental Death Benefit to the Proposed Insured(s) subject to the terms, exclusions and other provisions set forth below. This Temporary Accidental Death Benefit is provided in consideration of your application for life insurance with BMO Insurance.

Terms:

BMO Insurance will pay to the designated beneficiary the amount of the temporary accidental death benefit as outlined below upon the death of the Proposed Insured(s) if we receive proof satisfactory to us that:

a) the death of the Proposed Insured(s) resulted directly and independently of all other causes from injury caused by accident and that such death was caused solely by external, violent and unforeseen circumstances; and
b) both the injury and death must have occurred while this Agreement was in force; and
c) death, injury, or accident did not result from an excluded cause or event (see Exclusions).

Conditions for Termination:

a) Termination date is the 90th day after the date this application is signed unless terminated earlier in either b) or c) below.
b) This Agreement terminates automatically when the policy(ies) applied for become(s) effective, a counteroffer is tendered to your advisor, or on the termination date, which ever comes first.
c) BMO Insurance may terminate this Agreement at any time prior to the above indicated termination date. Notice will be mailed to the Owner to the mailing address designated on this Application. The termination date is the day following the mailing of the notice by BMO Insurance.

Effective Date:

The temporary accidental death benefit under this Agreement is effective when this Application has been fully completed, and we or our service provider has received the signed application.

Temporary Accidental Death Benefit Coverage:

The maximum amount of coverage on the Proposed Insured(s) under this benefit is limited to the lesser of:

a) The amount of insurance applied for, or
b) $1,000,000.

Exclusions:

BMO Insurance will not pay any benefit if the death of the Proposed Insured(s) results either directly or indirectly from any of the following causes:

a) suicide or self-inflicted injury while the Proposed Insured(s) is sane or insane;
b) any cause while the Proposed Insured(s) blood contains more than 80 milligrams of alcohol per 100 millilitres of blood or while the Proposed Insured(s) is under the influence of or had administered any toxic substance, narcotic or prescription drug available unless taken in strict accordance with the prescription of a physician or dentist;
c) any cause during a civil disorder or war, whether declared or not, or as a result of the Proposed Insured(s) committing or attempting to commit an assault or criminal offence;
d) any cause while the Proposed Insured(s) is serving on any active duty in any armed forces;
e) any cause while the Proposed Insured(s) is travelling, flying or descending in or from any kind of aircraft of which the Proposed Insured(s) is a pilot, officer or crew member, or in which the Proposed Insured(s) is giving or receiving any kind of training or instruction or had any duties;
f) any cause while the Proposed Insured(s) is participating in racing, scuba-diving, sky-diving, parachuting, hanggliding, rock or mountain-climbing or bungee jumping;
g) any cause where the injury occurs in the workplace and while the Proposed Insured(s) is working as a high steel construction worker, an underground miner, an oil rig worker, a power line worker or a logger.

No representative of BMO Life Assurance Company (BMO Insurance) is authorized to modify this Agreement.

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Section 21 - PRIVACY AND PERSONAL INFORMATION AUTHORIZATION AND MIB INC. NOTICE

Please detach and give to Proposed Insured(s)

In this Privacy and Personal Information Authorization, "You" and "Your" mean either the proposed owner or proposed insured, of the policy either individually or collectively. "We" and "Our" mean BMO Life Assurance Company.

We understand that the privacy of your personal information is important to you and we assure you that it's equally important to us. Personal information is fundamental to our business as it allows us to evaluate, issue and administer the policy you have applied for.

When We receive Your Application (which includes the application for insurance and any supplemental forms), We will establish and maintain a confidential file which will contain Your personal information including any health information and Your Application and any related contracts for insurance.

We collect your personal information and maintain this confidential file in order to:

(1) determine your eligibility for our products and services;

(2) confirm your identity and the accuracy of the information that You have provided to Us;

(3) issue, service, and administer Your contract of insurance, even after Your contract has ended;

(4) assess any claim for benefits under Your contract;

(5) comply with legal and regulatory requirements.

In order to assess this Application as part of Our underwriting process, We may obtain a credit bureau report, conduct a criminal records check and obtain information relating to Your driving history in connection with this Application. Access to Your file, and Your personal information, is limited to:

(1) BMO Insurance employees;

(2) Your insurance advisor and the managing general agent that Your advisor is associated or connected to;

(3) Our reinsurers;

(4) Our third party service providers related to the administration, processing and servicing of your contract;

(5) Those other third parties that You authorize or those authorized by law;

(6) Where necessary, Your named beneficiary(ies) in the event of a claim.

You may access Your file and request corrections to Your personal information by sending a written request to:

Privacy Officer
BMO Insurance
60 Yonge St,
Toronto, ON M5E 1H5

For more information, or to review our Privacy Code, please visit www.bmoinsurance.com

MIB Inc. Notice:

Except as required by law, information regarding Your insurability will be treated as confidential. BMO Insurance or its reinsurers may however, make a brief report to the MIB Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If a person named in this Application applies to another MIB Inc. member for life or health insurance, or a claim for benefits is submitted to such a company, MIB Inc. will, upon request, supply that insurance company with the information in its file.

BMO Insurance or its reinsurers may also release information in its file to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from You, MIB Inc. will arrange disclosure of any information it may have in Your file. If You question the accuracy of information in the MIB Inc.'s file, you may contact MIB Inc. and seek a correction.

The address of MIB Inc.'s information office is:

MIB Inc.
330 University Avenue, Suite 501, Toronto ON M5G 1R7
Telephone (416) 597-0590
http://www.mib.com

BMO Insurance

BMO Life Assurance Company
60 Yonge Street, Toronto, Ontario, Canada M5E 1H5
Tel 416-596-3900 • Fax 416-596-4143 • Toll Free 1-877-742-5244

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