

SPECIALTY LIFE

Provided by: Specialty Life Inc.

Underwritten by: Chubb Life Insurance Company of Canada (“Chubb Life”)



Final Expense Application



Personal Information

Mr. Rev. Dr. Mrs. Ms. Miss.

First name Middle name Last name

Date of Birth Year Month Day

Gender Male Female Applicant occupation

Do you smoke? Yes No
Defined as any use of a substance or product containing tobacco, nicotine, or marijuana in the last 12 months.

Age of Eligibility: 18 to 74 inclusive

Address

City Province Postal code

Contact details

E-mail address Phone number

Phone type: Home Cell

Specialty Life Inc. will be sending your policy and receipt by email to your email address listed above.

- I consent to Specialty Life Inc. and Chubb Life sending information to this email address to promote products and services offered by Chubb Life. I understand that I may withdraw my consent at any time.
- I consent to Specialty Life Inc. and Chubb Life using this contact information to provide me with updates about my coverage. I understand that I may withdraw my consent at any time.

Insurance Details

Benefit amount Premium amount Monthly Annually

Is the insurance applied for intended to replace an existing individual life insurance? Yes No If Yes, in Special Instructions, please give details of existing insurance and reasons for replacement and complete the applicable disclosure form.

I hereby name the following revocable beneficiary(ies) for any benefits payable as a result of my coverage. If you have named a minor as a beneficiary you may wish to appoint a trustee.

Name of Beneficiary	Relationship to Insured	Age	%Share	Primary or Contingent?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Primary <input type="radio"/> Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Primary <input type="radio"/> Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Primary <input type="radio"/> Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Primary <input type="radio"/> Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Primary <input type="radio"/> Contingent

Special Instructions:

Payment Method

Specialty Life Inc. uses payment-card industry (PCI) compliant encryption to protect the confidentiality of your personal and banking information.

Billing Frequency Monthly Annually

Form Of Payment

Pre-Authorized Debit (PAD)

Financial institution :

Account Number

Transit Number

Are you the bank Account holder? Yes No

If No, please state name of account holder:

Withdrawal date requested (1st- 28th)

If paying by cheque, make cheque payable to Specialty Life Inc.

Withdrawals from my account may be for variable amounts, as they may change in accordance with my insurance contract. I waive the right to pre-notification at least 10 days before my first PAD. I hereby authorize Specialty Life Inc. and the financial institution designated to make monthly (or annually if selected) automatic withdrawals from my bank account on or about the requested withdrawal date of each month for monthly insurance premiums (or annually if selected) due on or after the date of authorization. I waive the right to receive further notice of the amount and date of each automatic withdrawal from my account. I acknowledge that my financial institution may treat any withdrawal pursuant to this authorization as a personal withdrawal as defined by the Canadian Payments Association in Rule H-1. This authorization is to remain in effect until Specialty Life Inc. receives written notification from me of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address of Specialty Life Inc., Head Office. To obtain a sample cancellation form, or to obtain more information on your right to cancel a PAD agreement, contact your financial institution or visit cdnpay.ca. You have certain recourse rights if any PAD does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit cdnpay.ca

Signature of account holder:

Date Signed:

Advisor Disclosure

I declare that I am acting as a licensed advisor to sell this product underwritten by Chubb Life and provided by Specialty Life Inc. It is my duty to disclose any conflict of interest to you, and I confirm that should any such conflict of interest exist, I have disclosed it to you in writing. I am remunerated by commissions, either directly or indirectly, by Specialty Life Inc. or Chubb Life. Should you require any further information regarding my business practices or relationships, please feel free to contact me.

Receipt for Premium Payment

Specialty Life Inc. acknowledges having received the sum of \$ _____ for Specialty Life Final Expense Insurance on the life of Proposed insured _____ for a face amount of \$ _____ to be paid Monthly Annually

The acceptance of this sum of money does not obligate Chubb Life to issue an insurance contract.

Signed at _____, this _____ day of _____, 20_____

Agent's Signature x _____ Agent's Name (printed): _____

Agent's Phone Number: _____

Specialty Life Final Expense Plan underwritten by Chubb Life Insurance Company of Canada

For more information on Product Conditions, please visit www.specialtylifeinsurance.ca

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ACCEPTANCE AGREEMENTS AND DECLARATIONS

In undertaking this insurance agreement, you agree to and authorize the following:

I confirm that I read and understand English and/or French

I declare that to the best of my knowledge the answers that I have provided are true and accurate, and have been correctly recorded, and together with any other forms signed by me in connection with this application for insurance form the basis for any policy issued.

I understand that any coverage arising from this application may not be valid if there's any incorrect answer or misrepresentation in the application.

I hereby designate the person or persons named as beneficiary to receive the proceeds of my Insurance upon my death.

I understand that all benefits payable are subject to the general terms, conditions, definitions, exclusions and limitations outlined in the policy.

PRIVACY NOTICE: I understand that the information provided by me on this form and otherwise in respect of my application, is required by Chubb Life Insurance Company of Canada (the "insurer"), its reinsurers and authorized administrators to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existings insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a file to which access will be restricted to authorized employees and agents of the insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers and any of their providers, of Chubb Life may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the the date of signing of this form and understand that such consent will remain in place until such time as I may revoke it.

EFFECTIVE DATE OF COVERAGE: I understand that coverage becomes effective immediately once my application is submitted and premiums deducted either annually or on a monthly basis on the date of the month that I have designated has been received by Specialty Life Inc. and honored by me.

I understand that premiums will increase as I get older. I will enter a new premium rate level every 5 years starting at age 25. If I apply just before I am entering a new rate level, the rate that I pay will be guaranteed for the first year of coverage. It is also guaranteed that, if paid continuously and not subject to re-issue, and my rate would increase - it would always be lower than a newly issued policy on the life of an insured at the same age.

I understand that the death benefit is limited to the sum of all premiums if I die before the second anniversary of the policy. I understand that there will be no reimbursement of premiums if the accidental death benefit is paid.

I understand that the benefit paid from an accidental death is four (4) times the benefit amount.

I understand that no insurance agent, person, or entity other than Chubb Life is authorized to modify, cancel or waive a question or provision of this applicattion, nor a provision of the contract or other document that is part of the contract. I understand that any notice to or knowledge of an insurance agent is not notice to or knowledge of Chubb Life unless stated in writing and made part of this application.

Signed at _____, this _____ day of _____, 20 _____

Insured's signature x _____

Advisor Report

Is the Advisor related to the Insured? Yes No If Yes, Please explain relation: _____

Commission split: (Please print names)

Name of agent 1 _____ % Code _____ Signature _____

Name of agent 2 _____ % Code _____ Signature _____

