



SLI

**SPECIALTY LIFE
INSURANCE**

**REINSTATEMENT AND
SMOKER CHANGE
APPLICATION**

Reinstatement and Smoker Change Application

Important Instructions for the Advisor

Use this application when applying for change to in force policies such as:

- Reinstatement
- Changes to non-smoker

1. The Notice of Disclosure must be given to the Insured.
2. Other than the Notice ALL pages of the Reinstatement and Smoker Change Application must be submitted to **Specialty Life**.
3. Complete page 4 for the following changes: Reinstatement and Smoker Change.

Notice Of Disclosures

NOTICE REGARDING MIB, INC.

Information regarding your insurability will be treated as confidential. **Specialty Life** may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

Personal information disclosed to MIB, Inc., may include your name, birth jurisdiction, occupation and any other information used to determine your insurability. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. MIB, Inc. receives personal information, and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws.

MIB, Inc. has agreed to protect such information in a manner that is substantially similar to **Specialty Life** and **ivari**'s privacy and security practices, and in accordance with applicable laws. As a U.S.-based company MIB, Inc. is bound by and such personal information may be disclosed in accordance with applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations, provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws. If you have any questions about MIB, Inc.'s commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy department at privacy@mib.com. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction.

The address of MIB, Inc.'s information office is **330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7, tel. no. 416-597-0590**.

Specialty Life and **ivari**, may also release information from 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. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

NOTICE REGARDING INVESTIGATIVE REPORTS AND COLLECTION

As part of our investigation and claim analysis, we may request an investigative report be completed. These reports, if requested, will be obtained from an investigative agency.

Personal information collected may include information about your character, general reputation, personal characteristics, finances, credit and lifestyle. A representative who is employed to make such reports may contact you in person or by telephone in connection with this investigation. For more details about these reports, you may write to **Specialty Life's Client Services Department** at 8000 Jane Street, Tower A, Suite 101, Concord, ON L4K 5B8.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Specialty Life and **ivari** collects, uses and discloses your personal information as described in the sections of this application regarding MIB, Inc., investigative reports and the personal information authorization. The personal information authorization section of this application can be found on page 7. In addition, we collect personal information about you from this application, any supplementary forms and questionnaires, as described in the above sections, and from the following **external sources**:

- Your file already established with **Specialty Life** and **ivari**; physicians and other medical and health care practitioner and providers; hospitals, clinics and other medical facilities; MIB, Inc. and other insurers and reinsurers; investigation agencies; motor vehicle and driver record authorities in any relevant jurisdictions; your independent insurance advisors, including the independent insurance advisor's report section of your application.

The information collected from these sources is used for the following **purposes**:

- **Evaluating your insurance application; servicing your policy; and investigation and claim analysis.** Your personal information may be shared with your independent insurance advisor and the managing general agencies, distributors and market intermediaries and their employees with which your advisor is associated for purposes identified above.

Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit payments. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. For example, personal information may be disclosed in response to demands or requests from government authorities, courts or law enforcement in these countries.

We may communicate with you about other insurance products and services. If we rely on a marketing service provider to communicate with you, we will disclose only your name, contact information, and your current insurance coverage, but not your health or financial information. Specialty Life and ivari each require its service providers to safeguard the confidentiality of personal information consistent with their privacy and security practices and in accordance with applicable laws.

Upon receiving your application, **Specialty Life** and **ivari** will add your personal information to your existing file, which will be accessible at their respective head offices. Your file will be accessible to only those employees and authorized representatives of **Specialty Life** and **ivari**, or **ivari's** reinsurers, responsible for administering your file, and other persons authorized by you or by law.

We have safeguards to protect your personal information; however, in the event of an unauthorized access, disclosure or use of your personal information, there is a possibility that you may experience: identity theft, negative effects on a credit record, financial loss, embarrassment or damage to reputation. If **Specialty Life** or **ivari** believe that you face a real risk of significant harm, **Specialty Life's Privacy Office** will notify you of the data breach and suggest steps to reduce your risk of harm.

Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: **Privacy Office, Specialty Life**, 8000 Jane Street, Tower A, Suite 101, Concord, Ontario L4K 5B8.

To review our privacy policy, visit slinsurance.ca. To review **ivari's** privacy policy, visit ivari.ca.

By signing and submitting your insurance application you give your consent to the collection, use and disclosure of your personal information as described above and elsewhere in your electronic insurance application.

DISCLOSURE OF COMPENSATION

The insurance product you are being offered is supplied by **Specialty Life** and **ivari**, each a company licensed to conduct business in all provinces and territories of Canada. The independent insurance advisor/distributor soliciting this insurance application is a licensed insurance advisor representing **Specialty Life** and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with **Specialty Life** and **ivari**, the advisor/distributor or any other person or entity as a condition of this application.

Policy Insured Information (Please Complete)

This is a: Change to Non-smoker Reinstatement Policy number(s)

1. Title Mr. Mrs. Ms. Miss

First Name

Middle Initial

Last Name

2. Sex at Birth: Male Female

Date of Birth* (DD/MM/YYYY)

3.

Street Address

Apartment #

City

Province

Postal Code

Home Telephone

Work Telephone

Mobile Telephone

4. I understand the language in which this application is written: Yes No
If "no", have the details of this application been fully explained to you in your preferred language and are they completely understood? Yes No

5. What is the Insured's Canadian residency status?

Canadian Citizen Permanent Resident Landed Immigrant Student Visa Work Visa Other:

How long have you been residing in Canada?

Policy Owner Contact Information (Please Complete)

The Owner is the Insured unless indicated otherwise:

Owner's Legal name (First, middle initial, last)

How should we contact you if we have a question about this specific request?

Email My advisor Other

Street Address

Apartment #

City

Province

Postal Code

Home Telephone

Work Telephone

Mobile Telephone

Is this a new address? Yes No If "yes", provide previous address.

Street Address

Apartment #

City

Province

Postal Code

Home Telephone

Work Telephone

Mobile Telephone

Change to Non-Smoker

Complete this section along with the Insurability questions

Insured name (First, middle initial, last)

Please indicate all policies you wish to change

Policy number(s):

Have you smoked or used any of the following products in the last 12 months: cigarettes, cigars, pipe, chewing tobacco, shisha/hookah, cigarillos (small cigars), electronic cigarette, nicotine patch, nicorette chewing gum, snuff, betel nuts, and marijuana? (If yes, smoker rates apply) Yes No

Reinstatement

Complete this section for all product reinstatement requests

For Standard and Preferred Protection:

Complete this section along with the Insurability questions

(Reinstatement process cannot be started for Standard or Preferred Protection unless ALL questions are answered)

Lapsed Policy number:

Reinstate the Policy in accordance with its provisions. Back premiums of \$

Cheque made payable to Specialty Life attached

Withdrawal from bank account upon approval of reinstatement (Complete Pre-Authorized Debit (PAD) see below for additional instructions for pre-authorized debit)

If PAD is requested, please complete a new Pre-Authorized Debit (PAD) and attach a VOID cheque, pre-printed with the payor's name or a bank Letter of Direction.

Transit number

Financial Institution

Account Number

Use existing PAD from Specialty Life policy number:

The date of withdrawal will be the same as the Policy Issue date. If the PAD date falls on a non-business day or statutory holiday, the PAD will be drawn on the next business day.

Preferred date of withdrawal (days 1-28 only)

STANDARD PROTECTION AND PREFERRED PROTECTION - Please complete this section

For all eligibility questions, "You" and "Your" refers to the Insured.

- 1 Have you smoked or used any of these products in the last twelve (12) months: cigarettes, cigars, pipe, chewing tobacco, shisha/hookah, cigarillos (small cigars), electronic cigarette, nicotine patch, Nicorette gum, snuff, betel nuts, and marijuana? If yes – Smoker rates apply Yes No
- 2 Are you incapable of performing two (2) or more of the basic activities of daily living such as: feeding, dressing, washing, toileting and getting up? Yes No
- 3 Are you currently residing in an assisted living or nursing residence? Yes No
- 4 Are you on a waiting list for an organ transplant or the recipient of an organ transplant (excluding corneal transplants and skin grafts)? Yes No
- 5 Have you ever been diagnosed with a terminal illness? (Terminal illness means an illness, disease or condition that would reasonably be expected to cause death within the next twelve (12) months). Yes No
- 6 Have you ever had, or been told you have, or received treatment or advice for:
 - a) Congestive heart failure or cardiomyopathy (enlarged heart)? Yes No
 - b) Immunodeficiency virus (HIV), including abnormal or inconclusive results from an HIV test; acquired immune deficiency syndrome (AIDS); AIDS related complex (ARC)? Yes No
 - c) Muscular dystrophy or Amyotrophic Lateral Sclerosis (Lou Gehrig's disease or ALS), Huntington's chorea? Yes No
 - d) Cystic fibrosis or any chronic respiratory condition which requires treatment with oxygen (excluding sleep apnea)? Yes No
 - e) More than one occurrence of cancer (excluding basal cell carcinoma)? Yes No
 - f) Alzheimer's or dementia? Yes No
- 7 Have you had diabetes that was diagnosed more than ten (10) years ago and is treated with insulin? Yes No
- 8 Have you within the last five (5) years been convicted of any criminal offence or have any criminal charges pending? Yes No
- 9 Have you within the last three (3) years had, or been told to have, or received treatment or medical advice for:
 - a) Cancer, including but not limited to leukemia and lymphoma, (excluding basal cell carcinoma)? Yes No
 - b) Diabetic complications resulting in amputation? Yes No
 - c) Peripheral vascular or peripheral arterial disease, poor circulation in the legs or feet? Yes No
 - d) Chronic kidney disease or do you have a family history of polycystic kidney disease? Yes No
 - e) Chronic Liver disease, such as, but not limited to hepatitis B or C, cirrhosis or alcoholic hepatitis? Yes No
 - f) Cardiac chest pain? Yes No
- 10 Have you within the last three (3) years had, or been diagnosed with, undergone investigations for which the results were abnormal, or been hospitalized for, or currently have any of the following conditions:
 - a) Aneurysm which has not been surgically corrected? Yes No
 - b) More than one (1) TIA (transient ischemic attack)? Yes No
 - c) Heart attack, bypass surgery, stent insertion, arteriosclerosis, open heart surgery, angina, stroke? Yes No
- 11 Have you, in the past twenty-four (24) months:
 - a) Used any hard drugs such as heroin, cocaine, crack, amphetamines, LSD, ecstasy, psychoactive drugs, narcotics, barbiturates, opiates (except as prescribed by a physician), or other similar agents? Yes No
 - b) Been a resident in a drug or alcohol treatment facility? Yes No
- 12 Have you, within the last twelve (12) months:
 - a) Had your medication for diabetes or high blood pressure changed (dosage, addition of another medication, or insulin)? Yes No
 - b) Other than as part of a routine physical with a blood test, urinalysis, electrocardiogram (ECG), or a Stress Test: have you been advised to have treatment, advice, consultation, or medical testing such as: a biopsies test, a computer tomography scan (CT Scan), a Coronary Calcium Scan, a Magnetic Resonance Imaging (MRI) (excluding for osteoarthritis, strain, sprain) and or any other testing which has not yet been completed or for which you have not yet received the results or for which the result were abnormal? Yes No
- 13 Are you currently awaiting a scheduled surgery, or have you done any other medical test or procedure which has not yet been completed, or for which you have not yet received the results? Yes No
- 14 Is your weight greater than as shown in the chart below for your height? Yes No

Height		Weight	
Ft	Cm	Lbs	Kg
4'8"	142	215	98
4'9"	145	220	100
4'10"	147	224	102
4'11"	150	230	104
5'0"	152	235	107
5'1"	155	240	109
5'2"	158	245	111

Height		Weight	
Ft	Cm	Lbs	Kg
5'3"	160	250	113
5'4"	163	257	117
5'5"	165	264	120
5'6"	168	271	123
5'7"	170	279	127
5'8"	173	287	130
5'9"	175	295	134

Height		Weight	
Ft	Cm	Lbs	Kg
5'10"	178	303	137
5'11"	180	311	141
6'0"	183	319	145
6'1"	185	327	148
6'2"	188	335	152
6'3"	191	343	156
6'4"	193	351	159

Height		Weight	
Ft	Cm	Lbs	Kg
6'5"	196	359	163
6'6"	198	365	166
6'7"	201	372	169
6'8"	203	380	172
6'9"	206	388	176

PREFERRED PROTECTION

Only complete this section if the Insured answered **NO** to all questions in the **Standard Protection Plan** section.

- 1 Have you ever had, or been told to have, or received treatment or advice for diabetes with one (1) or more of the following conditions: coronary artery disease (with the exception of high blood pressure and or cholesterol controlled with medication or diet), chronic kidney disease or numbness or tingling in the hands and or feet (neuropathy)? Yes No
- 2 Have you been told you have or received treatment or advice for diabetes for more than fifteen (15) years? Yes No
- 3 Have you:
 - a) within the last ten (10) years had or been told you have Cancer including but not limited to leukemia, and lymphoma (excluding basal cell carcinoma) Yes No
 - b) been in complete remission from Cancer including but not limited to leukemia and lymphoma (excluding basal cell carcinoma) for less than ten (10) years? Yes No
- 4 Have you, within the last five (5) years had or been told to have or received treatment for:
 - a) Manic depression, Bipolar disorder, schizophrenia, one or more suicide attempts or ideation? Yes No
 - b) Cardiac chest pain? Yes No
- 5 Have you within the last five (5) years had or been diagnosed with, undergone investigation and for which the results were abnormal or been hospitalized or currently have any of the following conditions:
 - a) Bone marrow transplant? Yes No
 - b) Chronic obstructive pulmonary disease (COPD)? Yes No
 - c) Multiple Sclerosis? Yes No
 - d) Heart attack, bypass surgery, stent insertion, arteriosclerosis, open heart surgery, angina or stroke? Yes No
- 6 In the last five (5) years have you:
 - a) Been advised to have or received or sought treatment or counselling for drug dependency or the use/abuse of alcohol or chemicals or been convicted of driving under the influence (not including 24 hours suspension) or refusal to take a breathalyzer test? Yes No
 - b) Used any hard drugs such as heroin, cocaine, crack, amphetamines, LSD, ecstasy, psychoactive drugs, narcotics, barbiturates, opiates, (except as prescribed by a physician) or other similar agents? Yes No
 - c) Usage of prescribed narcotics or any opiates for chronic pain control? Yes No
- 7 Have you:
 - a) within the last two (2) years piloted an aircraft other than as a commercial /major airline carrier? Yes No
 - b) within the last twelve (12) months been involved or intend to be involved within the next twelve (12) months, with hazardous sports, such as; out of bound skiing, ski jumping, bungee jumping, base jumping, motorized vehicle racing, cliff diving, scuba diving (deeper than 100 ft. or 30 metres), sky diving, parachuting, sky surfing, hang-gliding and mountain climbing? Yes No
- 8 With the exception of travelling within North America, do you have any plans to travel or reside outside of Canada for more than eight (8) weeks in the next twelve (12) months? Yes No
- 9 Do you have any immediate family members (father, mother, brother or sister) who have been diagnosed with Huntington's Disease or do you have two (2) or more immediate family members (father, mother, brother or sister) who have been diagnosed with Cancer, Alzheimer's Disease, motor neuron disease Amyotrophic Lateral Sclerosis (ALS), multiple sclerosis, stroke or heart attack at age 60 or younger? Yes No
- 10 Is your weight greater than as shown in the chart below for your height? Yes No

Height		Weight	
Ft	Cm	Lbs	Kg
4'8"	142	178	81
4'9"	145	184	83
4'10"	147	191	87
4'11"	150	198	90
5'0"	152	204	93
5'1"	155	211	96
5'2"	158	218	99

Height		Weight	
Ft	Cm	Lbs	Kg
5'3"	160	225	102
5'4"	163	233	106
5'5"	165	240	109
5'6"	168	247	112
5'7"	170	255	116
5'8"	173	263	119
5'9"	175	270	122

Height		Weight	
Ft	Cm	Lbs	Kg
5'10"	178	278	126
5'11"	180	286	130
6'0"	183	294	133
6'1"	185	303	137
6'2"	188	311	141
6'3"	191	320	145
6'4"	193	328	149

Height		Weight	
Ft	Cm	Lbs	Kg
6'5"	196	337	153
6'6"	198	346	157
6'7"	201	355	161
6'8"	203	364	165
6'9"	206	373	169

Applicant's Acknowledgement

I/We, the applicant(s) and Owner(s) stated in this Reinstatement and Smoker Change Application, have reviewed and discussed with my/our independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my/our satisfaction.

Declaration

I/We have read all of the questions and answers in this application and I/we understand the meaning and importance of them. The statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief.

ACKNOWLEDGEMENT AND AGREEMENT

I/We acknowledge and agree that:

1. This application consists of pages 1–8, any supplement to it (if applicable) and any other declaration made in connection with this application. Together all of this information will form the basis for any policy/coverage issued.
2. This application does not include any "Temporary Insurance Agreement".
3. No information acquired by any representative of **Specialty Life** and **ivari** will be binding on **Specialty Life** and **ivari** unless set out in writing in this application.
4. Any policy change issued on this application will not take effect unless all of the following conditions are satisfied:
 - a) the full amount of the first premium is received by **Specialty Life** during the lifetime of the Insured under the policy;
 - b) this policy change is delivered to the Owner during the lifetime of the Insured under the policy;
 - c) all statements and answers given in this application continue to be true and complete on the date of delivery of the policy; and
 - d) no change has taken place in the insurability of the Insured between the time this application is completed and the time the policy change is delivered to the Owner*.
5. Only the president together with a vice-president or secretary of **ivari** has the authority to bind **Specialty Life** or **ivari** or to make any change in this application or any policy change issued. **Specialty Life** and **ivari** will not be bound by any promise or representation made by any other person. No insurance advisor or distributor is authorized to waive, amend or modify any of the terms or provisions in this application or any policy change issued. However, **ivari** may make certain changes to this application as provided for in your policy contract. The Owner accepting delivery of the policy change constitutes approval of its provisions and ratification of any additions, endorsements or amendments.
6. If the answer to any question(s) in this application is misstated or omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy change issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
7. All premium payments must be made payable to **Specialty Life Inc.**
8. I/We have received and fully understand the information set out in the Notice of Disclosures page, which has been left with me, including the Disclosure of Compensation, where applicable.

* Delivery requirements differ in Quebec

Personal Information Authorization

I/We have read and fully understand the contents of the notices regarding MIB, Inc., investigative reports, and consent to the collection, use and disclosure of personal information (collectively, the "Notices") and acknowledge and consent to the collection, use and disclosure of my/our personal information by **Specialty Life** and **ivari** and their affiliates for the purposes identified in those Notices.

For the purpose evaluating my/our insurance application, servicing my/our policy, and investigation and claim analysis, I/we authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or any other organization, institution, association or person identified in the Notices that now has or may in future have any information concerning me/us or my/our health to disclose to **Specialty Life** and **ivari**, their authorized representatives and **ivari**'s reinsurers, upon the request of **Specialty Life** or **ivari**, any such information for the purposes identified in the Notices.

I authorize **Specialty Life** to make a brief report of my personal health information to MIB, Inc.

I/We certify that the information given in this section is correct and complete. I/We agree to immediately notify **Specialty Life** or **ivari** of any errors, omissions or changes in the information provided under this application. As the policy Owner(s), I/we acknowledge that I/we have an obligation to notify **Specialty Life** of any changes in my/our tax residency status.

A photocopy of this authorization shall be as valid as the original.

Authorization to disclose information to your independent insurance advisor or managing general agencies, distributors and marketing intermediaries and their employees and agents:

By agreeing to the authorization below, you are giving us permission to disclose your personal information to your independent insurance advisor, managing general agencies, distributors and market intermediaries and their employees and agents who may use it to help you with your insurance options. This information could include: your medical history and any other facts about your life declared in this application that have affected the assessment of your insurance request. The information will be shared only with the insurance advisor indicated below. You may also cancel this authorization at any time by calling us at **1-844-515-5433**. This authorization will remain in effect for 45 days after we issue a policy or send you a letter indicating that your insurance request has been declined.

Signed at (city) In the Province of on (DD/MM/YYYY)

Signature of Insured Signature of OWNER, if not the Insured

Witness to signature(s)

Irrevocable Beneficiary Signature (if applicable) Assignee Signature (stamp required if Assignee is a financial institution)

Policy Owner's Consent to Receive Emails

By providing my email address I consent to Specialty Life and ivari using this contact information to provide me with information about my coverage. I understand that I may withdraw my consent at any time. Owner Email Address

I also consent to Specialty Life and ivari sending information to the above email address to advise me of products and services offered by ivari or Specialty Life from time to time, who may rely on marketing service providers to do so. I understand that this is an optional purpose and I may withdraw my consent at any time.

I may withdraw either or both consents by contacting: Specialty Life Inc. 8000 Jane Street, Tower A, Suite 101, Concord ON L4K 5B8 www.slinsurance.ca

Independent Insurance Advisor's Report

Does the independent insurance advisor have a family relationship with the Insured? Yes No

If Yes, please explain relation to Insured:

I/We hereby declare that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I am/we are not aware of additional information material to the Insured except as stated in the Special Instructions section.

Commission Split (please print names): By signing below, I/we acknowledge that I/we have disclosed, where applicable, the following items to the Owner of the policy resulting from this application:

- a) The Company or companies I/we represent
b) That I/We will receive compensation in the form of bonuses (such as commissions or salary); and
c) That I/We have disclosed any conflicts of interest that I/We may have with respect to this transaction.
d) I/We attest that I have followed the Specialty Life/ivari Code of Ethical Market Conduct in all aspects of this sale of

Advisor 1: Code: % Advisor Signature:
Advisor 2: Code: % Advisor Signature:

Special Instructions

Large empty box for special instructions.