



# prosperity Guaranteed or Simplified Issue Insurance Application

## General information

Policy no. \_\_\_\_\_

### 1 Proposed Insured

Mr.  Mrs.  Ms.  Miss  Dr.

First name		Middle initial	Last name	
Identification document†	Identification document number†	Document expiry date (DD/MM/YYYY)	Issuing jurisdiction and country	

† Please refer to an original, non-expired Canadian government issued photo I.D., such as passport, provincial health card (except in AB, PEI, ON and MB), driver's licence or Age of Majority.

2 Date of birth: (DD/MM/YYYY) \_\_\_\_\_ Sex at birth:  Male  Female Smoking class:  Smoker  Non-smoker

Country and province of birth: \_\_\_\_\_ SIN: \_\_\_\_\_ (optional)

Your Height: \_\_\_\_\_ FT \_\_\_\_\_ Inches **or** \_\_\_\_\_ centimetres Your Weight: \_\_\_\_\_ lbs **or** \_\_\_\_\_ kilograms

### 3 Current residential address: (Number and street name)

\_\_\_\_\_ Apt./Suite: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Mobile telephone: \_\_\_\_\_ Business telephone: \_\_\_\_\_

4 a) Are you a Canadian Citizen or Permanent resident (landed immigrant)?  Yes  No

If "no", i) how long have you been in Canada? \_\_\_ Month \_\_\_ Year

ii) what is the expiry date of your VISA? \_\_\_ / \_\_\_ / \_\_\_

iii) what is your legal status:  Caregiver  Work Visa (other than Seasonal worker)  Skilled workers

Post Graduate work permit  Provincial Nominee

b) Are you a resident for Canadian income tax purposes? .....  Yes  No

### 5 Policy Owner

The Policy Owner is the Proposed Insured and must be at least 18 years of age.

6 a) I understand the language in which the application was written in: .....  Yes  No

If "no", have the details of this application been fully explained to you in your language

and are they completely understood? .....  Yes  No

b) What language do you request related documents be in?  English  French

c) Is this insurance intended to replace an existing in-force life insurance policy? .....  Yes  No

If "yes", attach completed Replacement/Comparison Disclosure forms, LIRD (where applicable):

COMPANY	POLICY NUMBER	FACE AMOUNT	TYPE OF INSURANCE	REPLACING
		\$		
		\$		
		\$		

## 7 Beneficiary

If more than one Primary Beneficiary is named, then the proceeds are to be equally shared unless otherwise specified; the same applies to Contingent Beneficiaries.

### Primary/Contingent Beneficiaries:

- All Beneficiaries are deemed primary unless otherwise specified.
- If all Primary Beneficiaries predecease the Proposed Insured, the proceeds are payable to the Contingent Beneficiaries, if any or otherwise to the Owner or the Owner's estate.
- If no beneficiary is designated, then the proceeds are payable to the Owner, if living, or the Owner's estate, if deceased.

### Irrevocable/Revocable Beneficiaries:

- For applications signed in Québec, the designation of spouse (married or civil union) of the Owner as beneficiary is irrevocable unless otherwise specified.
- All other beneficiary designations in Québec and all beneficiary designations for policies issued elsewhere in Canada are revocable unless otherwise specified.
- If designating an Irrevocable Beneficiary, you are giving up substantial control over your policy. Once an Irrevocable Beneficiary has been designated, his/her consent will be required for future dealings with the policy (some exceptions apply in Québec).
- If designating a minor as Irrevocable Beneficiary, it is recommended that a trustee be appointed to avoid a payment into court (not applicable in Québec).

FIRST NAME, LAST NAME	DATE OF BIRTH (DD/MM/YYYY)	PRIMARY OR CONTINGENT*	REVOCABLE OR IRREVOCABLE	SHARE%	RELATIONSHIP TO PROPOSED INSURED

\*A Contingent Beneficiary is always revocable.

If a minor is designated, indicate trustee name and relationship to Proposed Insured (not applicable in Québec):

First name, Last name	Relationship to Proposed Insured

## 8 Insurance coverage

PLAN	FACE AMOUNT	MONTHLY PREMIUM
<b>prosperity Guaranteed Issue</b> Death Benefit: Years 1-2: Return of premium Years 3+: Full face amount	\$10,000	\$

PLAN	MINIMUM FACE AMOUNT	MAXIMUM FACE AMOUNT	FACE AMOUNT APPLIED FOR	MONTHLY PREMIUM
<b>prosperity Simplified Issue</b> Death Benefit: Years 1-2: Return of premium Years 3+: Full face amount	\$10,000	\$50,000	\$	\$

9 Premium Payment details

**Payment Type:** Monthly Pre-Authorized Debit Payments ("PAD"), initial premium to be paid by PAD withdrawal

The date of withdrawal will be the same as the policy effective date.

If you wish a different withdrawal date, please indicate preferred date of withdrawal (*days 1-28 only*) \_\_\_\_\_

a) **Payment Options:**

Establish new banking information for Monthly Pre-Authorized Debit Payments

Banking information provided below:

Transit Number	Financial Institute Number	Account Number

Use existing banking information from *ivari* policy no.: \_\_\_\_\_

b) Is the payor the:  Insured/Owner  Beneficiary  Other

If "**Other**" provide:

Payor's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of birth: (DD/MM/YYYY) \_\_\_\_\_

Corporation Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

**10 Guaranteed Issue, Simplified Issue - Eligibility Questions**

All questions must be answered truthfully and honestly, any misrepresentations may void the policy contract.

**PROPOSED  
INSURED**  
YES NO

In the last twelve (12) months:

- a) Have you smoked or used cigarettes, cigars, pipe, chewing tobacco, shisha/hookah, cigarillos (small cigars), electronic cigarette (vape), nicotine patch, Nicorette chewing gum, snuff, betel nuts? .....
- b) Have you used marijuana/cannabis/cannabinoids more than twice a week? .....

**Do you want to answer the Simplified Issue Qualification questions?** .....

**10.1 Current status:**

- a) Are you living in a nursing or assisted living facility or do you require assistance for daily living activities? (i.e. washing, dressing, making and eating meals, using the bathroom and/or mobility) .....
- b) Have you been hospitalized for more than 48 hours in the past year? .....
- c) Have you been advised by a physician to have, or are you currently awaiting, surgery, a follow up consultation or investigation, or an organ transplant? .....
- d) Has any parent, brother or sister dead or alive been diagnosed with polycystic kidney disease, Huntington’s disease, Lynch Syndrome or hereditary non polyposis colon rectal cancer (HNPCC)? .....
- e) Do you consume on average of more than 3 alcoholic drinks daily, used any drugs (not including over the counter medications) other than as prescribed by a physician, been advised to seek treatment or counselling for alcohol or drug use or been a resident in treatment facility (excluding regular AA meetings or any other substance abuse support meetings)? .....

**10.2 In the past three (3) years have you been:**

- a) Referred to an oncologist (cancer specialist), nephrologist (kidney specialist), or a cardiologist (heart specialist) or seen a doctor for treatment or control for your diabetes (insulin or medication)? .....
- b) Treated for anxiety, depression, post-traumatic stress disorder (PTSD), bipolar disorder, schizophrenia, suicide attempt or any psychological disorder that required hospitalization or for which you took daily medication for more than 30 days? .....
- c) Told you have a terminal illness or that your insurance application has been declined? .....

**10.3 In the past ten (10) years have you been:**

- a) Told you have or you have been treated for any cancer or metastatic or recurrent cancer (excluding basal cell carcinoma), a malignant tumour, lymphoma or leukemia? .....

**10.4 In your lifetime, have you been diagnosed with and/or treated for any of the following conditions:**

- a) Heart failure, cardiomyopathy (enlarged heart), heart attack, heart surgery (CABG, coronary artery bypass graft, stent insertion, valve replacement or repair, angioplasty) angina, stroke, irregular heart beat requiring pacemaker insertion, more than 1 TIA (transient ischemic attack), Type 1 diabetes or diabetes treated with insulin, chronic liver disease, chronic kidney disease or Hepatitis C? .....
- b) Immunodeficiency virus (HIV); acquired immune deficiency syndrome (AIDS); AIDS-related complex (ARC) or a positive HIV test? .....
- c) Cystic fibrosis, chronic obstructive pulmonary disease (COPD) or any chronic lung condition (other than asthma) requiring daily medication and/or oxygen? .....
- d) Muscular dystrophy, myotonic dystrophy, or amyotrophic lateral sclerosis (Lou Gehrig’s disease or ALS), Huntington’s chorea, Alzheimer’s disease, dementia or any other neurological disorder? .....

**10.5 In your lifetime, have you:**

- a) Been convicted of a criminal offense or do you have charges pending including a DWI (driving while impaired)? Do not tell us about a single DWI charge if it was more than 1 year ago. ....

## Applicant's acknowledgement and authorization

I, the applicant stated in this Insurance Application (referred herein as "Proposed Insured"), have reviewed and discussed with my independent insurance advisor(s), all the terms and conditions of the insurance applied for, which have been explained to my satisfaction.

### Declaration

I have read all of the questions and answers in this application and I 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 knowledge and belief.**

### ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge and agree that:

- 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.
- This application does not include any "Temporary Insurance Agreement"
- No information acquired by any representative of *ivari* will be binding on *ivari* unless set out in writing in this application.
- Any policy issued on this application will not take effect unless all of the following conditions are satisfied:
  - the full amount of the first premium is received by *ivari* during the lifetime of the Proposed Insured under the policy;
  - the policy is delivered to the owner during the lifetime of the Proposed Insured under the policy;
  - all statements and answers given in this application continue to be true and complete on the date of delivery of the policy; and
  - no change has taken place in the insurability of the Proposed Insured between the time this application is completed and the time the policy is delivered to the Owner.
- Only the president together with a vice-president or corporate secretary of *ivari* has the authority to bind *ivari* or to make any change in this application or any policy issued. *ivari* will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend or modify any of the terms or provisions in this application or any policy issued. However, *ivari* may make certain changes to this application as provided for in your policy contract. The Owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements or amendments.
- 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 issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
- All premium payments must be made payable to *ivari*.
- I have received and fully understand the contents of the Disclosure of Compensation, where applicable.

### PERSONAL INFORMATION AUTHORIZATION

I have read and fully understand the contents of the notices regarding, investigative consumer reports and collection, use and disclosure of personal information (collectively, the "notices") and acknowledge and consent to the collection, use and disclosure of my personal information by *ivari* and its affiliates for the purposes identified in those notices. I further understand and consent to *ivari* disclosing my personal information to Third Party Administrators as described above in the notices.

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

I certify that the information given in this application is correct and complete. I agree to immediately notify *ivari* of any errors, omissions or changes in the information provided in this application. As the policy owner, I acknowledge that I have an obligation under the Income Tax Act to notify *ivari* of any changes in my tax residency status. I acknowledge that the information contained in this application and information regarding my policy, contract and account may be reported to Canada Revenue Agency (CRA).

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

### OPTIONAL CONSENTS

I consent to receiving promotional messages from *ivari* by email, text or other electronic means and I authorize *ivari* to share my personal information (as described in the Notice of Disclosures) with third party marketing providers.  Yes  No

By providing my email address, I consent to *ivari* using my email address to grant me online access to *ivari's* client portal where I can view information about my *ivari* policy, if issued.

Owner's email address:

I authorize *ivari* to share my personal information, (as described in the Notice of Disclosures) with Everest so that I can access Everest Concierge Funeral Services.  Yes  No

You may withdraw your consent at any time by contacting us at *ivari*: 500-5000 Yonge Street, Toronto, ON M2N 7J8. Telephone: 1-800-846-5970 or Fax: 416-883-5520 or 1-877-767-0477

Check here to indicate that you acknowledge having reviewed and read the "Notice of Disclosures" page and the "Applicant's acknowledgement and authorization" page.

Signed at (city) \_\_\_\_\_ in the province of \_\_\_\_\_ on \_\_\_\_\_ (DD/MM/YYYY)

Signature of PROPOSED INSURED/OWNER  
POLICY NO.

Witness to signature(s)

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## Client authorization for Pre-Authorized Debit (PAD) payment program

I authorize *ivari* to make automatic withdrawals from my bank account at the financial institution identified in the insurance application, for insurance premiums which become due on or after the date this authorization is signed. If the bank or financial institution does not honour an automatic premium withdrawal when first presented for payment, *ivari* may attempt to withdraw that payment again within 5 days. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I or *ivari* may end this agreement at any time by giving 10 days written notice. I understand that canceling this authorization may result in loss of insurance coverage unless *ivari* receives another form of payment. Any refund of premium made pursuant to this authorization shall be paid to the owner.

I certify that all required signatures for the authorization of the withdrawals are present in this authorization. I further authorize such financial institution to deal with these withdrawals as if authorized directly by me/us. I understand and agree to all of the terms and conditions printed on the next page, which my advisor has reviewed with me/us.

I hereby direct *ivari* to proceed as indicated in the Premium Payment Details under Payment Options section of the insurance application. The initial premium/PAD start date will be the Policy effective date.

Date signed: (DD/MM/YYYY) \_\_\_\_\_

\_\_\_\_\_  
Payor name shown on bank records

\_\_\_\_\_  
Signature of Payor

\_\_\_\_\_  
Signature of Proposed Insured/Owner, if not the Payor

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## Terms and conditions of participation in the Pre-Authorized Debit (PAD) payment program

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### EFFECTIVE DATE

I understand and agree that the fully completed authorization on the previous page will take effect for the policy applied for, on the latest of the following dates:

- a) The date the authorization is received by the Head Office of *ivari*;
- b) The date the full amount of the first premium for the policy is received by *ivari's* Head Office; and
- c) The date when the policy applied for is first placed in full force and effect by *ivari*.

### GENERAL

I also understand and agree to all of the following terms and conditions:

- a) I certify that the information provided with respect to the PAD account is accurate. I will provide *ivari* with a new pre-printed sample cheque if the PAD account is changed.
- b) The amount drawn on the PAD account shall be a total of all amounts required to pay the applicable premium payments for the policy.
- c) The authorization shall apply to the policy.
- d) The authorization and all its terms and conditions are subject to all of the terms and provisions of the applicable policy.
- e) If *ivari* has not received a premium payment within the time required, for example, your PAD is not honoured; we will try to re-draw your payment within 5 business days. If your premium payment is still not honoured, or for any other reason, then the policy will lapse and become null and void.
- f) I consent to disclosure of any personal information that may be contained on this authorization to *ivari's* designated financial institution to the extent necessary for the purposes described in the authorization and these terms and conditions.

### TERMINATION

The authorization will be terminated only on the earliest of the following dates:

- a) Either I or *ivari* provide(s) written notice to the other within 10 days to that effect; **or**
- b) The policy to which the authorization applies is no longer in full force and effect.

The revocation of the authorization does not affect your rights under the policy.

Any cancellation of this automatic withdrawal arrangement will not affect the agreement between me/us and *ivari* whatsoever with respect to any contract for goods or services, so long as payment is provided by an alternate method. I am responsible for maintaining the agreement between me/us and *ivari* and understand that failure to provide alternative methods of payment may lead the policy to lapse and become null and void.

I may revoke my/our authorization at any time, provided written notice is received no less than 10 days before the next scheduled payment date. To obtain a sample cancellation form, or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca). You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any withdrawal that is not authorized or is inconsistent with this authorization. To obtain a form for a reimbursement claim or for more information on your recourse rights, you may contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca). In addition, I may contact *ivari* to make enquiries, obtain information or seek recourse with respect to any PAD issued by *ivari*, as indicated below.

*ivari*  
500-5000 Yonge Street  
Toronto, ON M2N 7J8  
Tel: 1-800-846-5970

## Notice of Disclosures

Thank you for applying for insurance with *ivari*.

Please make sure that you have read this application carefully and that you understand all of it. Once we receive your application, we will assess your eligibility as Proposed Insured. We base this eligibility on the information you provide to us in this application. Once we have determined the degree of risk, we will let you know if the insurance you applied for can be issued. Questions? Please contact your independent insurance advisor or write to us at **Client Services Department, ivari, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8.**

### NOTICE REGARDING INVESTIGATIVE CONSUMER REPORTS AND COLLECTION

As part of our claim analysis, we may request an investigative consumer report or credit report be completed. These reports, if requested, will be obtained from an investigative or consumer reporting agency or from a credit bureau.

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 us at the Client Services department address noted above.

### NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

*ivari* collects, uses and discloses your personal information as described in the sections of this application regarding investigative consumer reports and the personal information authorization. The personal information authorization section of this application can be found on page 5. In addition, we collect personal information about you from this application, as described in the above sections, and from the following **external sources**:

- Physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities and other insurers and reinsurers; investigation, consumer and credit reporting 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 herein.

We collect your SIN for tax reporting purposes to the Canada Revenue Agency in accordance with federal legislation. Your banking information will 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 have a contractual relationship with certain third party service providers for the purposes of offering you optional services or benefits. These third party service providers are obligated to maintain the confidentiality of personal information consistent with *ivari's* privacy and security practices, in accordance with applicable laws and in a manner consistent with the use for which it was collected. We will disclose only your name, contact information, and current insurance coverage, but not your health or financial information. In particular:

- We may rely on a marketing service provider to communicate with you about other insurance products and services.
- To be eligible for this optional Everest service and for the purposes of offering you additional services or benefits, your personal information will be shared with and used by Everest and its affiliates ("Everest").

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

Upon receiving your application, *ivari* will establish and maintain a file containing your personal information, which will be accessible at our head office. Your file will be accessible to only those employees and authorized representatives of *ivari* responsible for administering your file, and other persons authorized by you or by law. *ivari* may, from time to time, retain the services of third parties to assist in administering *ivari* insurance policies ("Third Party Administrators"). These Third Party Administrators will use your personal information only for the purposes of providing services to *ivari* and no other purposes. *ivari* requires its Third Party Administrators to safeguard the confidentiality of personal information consistent with its privacy and security practices and in accordance with applicable laws.

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 Officer, *ivari*, 500-5000 Yonge Street, Toronto, Ontario M2N 7J8. To review our privacy policy, visit **[ivari.ca](http://ivari.ca)**.

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 *ivari* believes that you face a real risk of significant harm, *ivari's* Privacy Office will notify you of the data breach and suggest steps to reduce your risk of harm.

### DISCLOSURE OF COMPENSATION

The insurance product you are being offered is underwritten by *ivari*, 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 *ivari* and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with *ivari*, the advisor/distributor or any other person or entity as a condition of this application.



500-5000 Yonge Street, Toronto, ON M2N 7J8 • Telephone: 1-800-846-5970