beneva

Individual insurance

Policy reinstatement

Version: April 2025

Beneva Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Instructions for advisors

Please complete this form to request a policy reinstatement. A fee of $25 is applicable for the reinstatement of a universal life insurance policy.

If the policy has more than two insureds, please complete a second form.

If there is more than one policyowner, EACH policyowner must sign Section M of this form.

To request a policy change or reinstatement for accident / sickness insurance products, please complete the appropriate form, either the Policy Change form for Individual Disability Plan (FIND0040A) and/or the Policy Change form for AcciGuard (FIND0039A).

A – General information

Policy number _____

A1 – Proposed insured(s)

- When the insured and the policyowner are the same person, the insured must be a Canadian resident.

Insured 1	Insured 2
First and last names (please print)	First and last names (please print)
Address (civic number, street)	Address (civic number, street)
City / Province	City / Province
Postal code / Telephone	Postal code / Telephone

A2 – Employment details

Insured 1	Insured 2
Profession / Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity)	Profession / Occupation and years of service (current employer) – provide details (if retired, indicate the last profession and field of activity)
Tasks involved in occupation	Tasks involved in occupation
Nature of employer's business	Nature of employer's business
$ Gross annual income / $ Net worth	$ Gross annual income / $ Net worth
$ Other income → Specify source	$ Other income → Specify source
Employer's name	Employer's name
Civic number and street name / Suite number	Civic number and street name / Suite number
City	City
Province / Postal code	Province / Postal code
Telephone (office)	Telephone (office)

A3 – Policyowner(s)

- The policyowner must be a Canadian resident. When the address of the policyowner 2 is different than policyowner 1, we consider that the mailing address corresponds to that of the policyowner 1.

Policyowner 1 (to be completed if change of address)	Policyowner 2 (to be completed if change of address)
	☐ Same address as Policyowner 1
First and last names (please print)	First and last names (please print)
Address (civic number, street)	Address (civic number, street)
City / Province	City / Province
Postal code / Telephone	Postal code / Telephone

B – Insurance in force (the section B must be completed at all times)

If you need more space, use section F.

1. Do you have existing individual insurance coverage? If so, complete the table below:

Insured 1: ☐ NO ☐ YES → If yes, provide the information below.
Insured 2: ☐ NO ☐ YES → If yes, provide the information below.

Insured no.	Company name	Amount	Type (Life, Disability, Critical Illness)	Year	Replacing in force insurance?		Purpose of insurance	
					Yes	No	Personal	Business
					☐	☐		
					☐	☐		
					☐	☐		

	Insured 1		Insured 2	
	Yes	No	Yes	No
2. Do you currently have one or more applications for insurance being assessed by another insurer? If yes, indicate the name of company, the total amount of insurance that will be put into force and the type of insurance. _____	☐	☐	☐	☐
3. In the last ten (10) years, have any of your applications for life, critical illness or disability insurance or requests for reinstatement been declined or deferred? If yes, provide the type of insurance, the date, and the reason. _____	☐	☐	☐	☐

4. If insurance for children:
   a) indicate the total amount of life insurance in force on the parents of the child: $ _____
   b) indicate the total amount of critical illness insurance in force on the parents of the child: $ _____
   c) specify if there are other children and if so, indicate:
      - the amount of life insurance in force on each one of them: $ _____
      - the amount of critical illness insurance in force on each one of them: $ _____

C – Purpose of insurance

C1 – Personal insurance

☐ Income/Loan protection ☐ Estate conservation ☐ Charitable donations

C2 – Business insurance

1. Purpose of insurance

☐ Buy/sell agreement ☐ Collateral loan (specify the amount: $ _____) ☐ Estate planning ☐ Key person protection
☐ Other (specify at no. 5)

2. How long has the business been in operation? _____

3. Financial information of the company covering the last two (2) years:

Year:	Y Y Y Y	Year:	Y Y Y Y
Assets:	$ _____	Assets:	$ _____
Liabilities:	$ _____	Liabilities:	$ _____
Shareholders' Equity:	$ _____	Shareholders' Equity:	$ _____
Net profit:	$ _____	Net profit:	$ _____
Fair market value:	$ _____	Fair market value:	$ _____

C2 – Business insurance (continued)

4. Are you the sole owner? ☐ **Yes** ☐ **No** If no, complete the following table for each shareholder.

Indicate the name, pourcentage (%) of shares as well as the amount of insurance in force and pending for each shareholder in the organization.

Name	% of shares	Insurance in force (business)	Insurance pending (business)
		$	$
		$	$
		$	$
		$	$

4.1 If the shareholders are not insured for the same amount, explain the reasons below.

5. Additional remarks

D – Personal history

This section must always be completed for each insured.

- IF THE PARAMEDICAL IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION D.

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
1. In the last five (5) years, have you used tobacco or consumed any product containing nicotine such as cigars, cigarillos, cigarettes, marijuana (cannabis) with tobacco, electronic cigarettes, vaping products, pipes, nicotine gum or patches?	☐	☐	☐	☐

If so, complete the following table:

Insured's name	Type	Quantity	Date of last use
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M
		☐ Day ☐ Month ☐ Year	Y Y Y Y M M

D – Personal history (continued)

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
2. a) Do you consume alcoholic beverages? One serving equals 341 ml or 12 oz. of beer, 45 ml or 1.5 oz. of spirits or 150 ml or 5 oz. of wine. If so, complete the following table:	☐	☐	☐	☐

Insured's name	Type	Number of drinks	Frequency
	Beer | Wine | Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	Beer | Wine | Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	Beer | Wine | Spirits		☐ Day ☐ Week ☐ Month ☐ Year
	Beer | Wine | Spirits		☐ Day ☐ Week ☐ Month ☐ Year

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
b) Has your consumption been higher in the past? If so, indicate type, number of drinks, frequency as well as the reason and date of the change in the habits. _____ _____	☐	☐	☐	☐
3. a) Do you consume cannabis products for recreational or medicinal purposes? Include all forms of cannabis, marijuana, and hashish. If so, complete the following table:	☐	☐	☐	☐

Insured's name	Forms	Quantity	Frequency	Use date	Type of usage
	Joint	Number of joints: _____	☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D	☐ Recreational ☐ Medicinal*
	☐ Edible products ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D	☐ Recreational ☐ Medicinal*
	Joint	Number of joints: _____	☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D	☐ Recreational ☐ Medicinal*
	☐ Edible products ☐ Oil ☐ Other		☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D	☐ Recreational ☐ Medicinal*

*If you were using it for medicinal purposes, complete the following table:

Insured's name	For what condition	Prescribed	Prescribing physician (name and address)
		☐ Yes ☐ No	
		☐ Yes ☐ No	

	Insured 1		Insured 2	
	Yes	No	Yes	No
3. b) Has your consumption been higher in the past two (2) years? If so, indicate form, quantity, frequency as well as the reason and date of the change in the habits. _____ _____	☐	☐	☐	☐

D – Personal history (continued)

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
4. In the last ten (10) years have you used drugs or narcotics that were not prescribed by a physician (e.g., cocaine, ecstasy, LSD, magic mushrooms, heroin, fentanyl, anabolic steroids, etc.)? If so, complete the following table:	☐	☐	☐	☐

Insured's name	Type of Drug or narcotics	Quantity per occasion	Frequency	Dates of use
			☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D
			☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D
			☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D
			☐ Day ☐ Week ☐ Month ☐ Year	from Y Y Y Y M M D D to Y Y Y Y M M D D

	Insured 1		Insured 2	
	Yes	No	Yes	No
5. With regard to your consumption of alcohol, cannabis or other drugs, have you been advised to reduce or cease your consumption, consulted a healthcare professional, had therapy or treatment or attended support group meetings? If so, please complete the appropriate questionnaire (drug or alcohol usage).	☐	☐	☐	☐
6. In the last three (3) years, have you been found guilty of two (2) or more violations of the Highway Safety Code? If so, indicate the dates, types of infractions and km per hour over the speed limit.	☐	☐	☐	☐
7. In the last ten (10) years: a) Have you been charged with or found guilty of impaired driving or has your driver's licence been suspended? If so, provide the reason, the date of the infraction and the date your licence was restored.	☐	☐	☐	☐
b) Have you been charged with or found guilty of any criminal offence or fraudulent transactions? If so, provide the circumstances, the date, the charge(s) and the sentence (start and end dates of probation, if applicable).	☐	☐	☐	☐
8. In the last five (5) years, have you declared personal or business bankruptcy or made a consumer proposal? If so, provide details below: ☐ Personal bankruptcy Amount: $ _____ ☐ Professional/commercial bankruptcy Amount: $ _____ ☐ Consumer proposal Date filed or proposed: Y Y Y Y M M D D Date of release: Y Y Y Y M M D D	☐	☐	☐	☐
9. In the last 12 months have you been on a flight other than as a passenger or do you intend to do so in the next 12 months? If so, specify your profession and complete the aviation questionnaire except crew member.	☐	☐	☐	☐
10. In the last 12 months, have you participated in activities such as motorized vehicle races, scuba diving, skydiving, flying ultralights, hang gliding, mountaineering or rock climbing, bungee jumping, off-trail skiing (heliskiing, catskiing, etc.), combat sports or any other hazardous sport or do you intend to do so in the next 12 months? If so, indicate the activity, complete the appropriate questionnaire.	☐	☐	☐	☐
11. During the next twelve (12) months, do you plan to travel or reside outside of Canada or the United States ? If so, indicate the departure and return dates, the destination (country, city) and the reason.	☐	☐	☐	☐

E – Medical history (do not provide any information about genetic testing)

- IF THE PARAMEDICAL IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION E.

Insured 1

1. a) Height _____ ☐ ft ☐ m
   Weight _____ ☐ lb ☐ kg

b) Weight loss of more than 10 lbs (4.5kg) in the last 12 months? ☐ No ☐ Yes
If yes, how much: _____ Reason(s): _____

c) Date and reason of last medical appointment: _____

d) Name and address of the physician or clinic consulted: _____

e) Treatments or exams performed and or medication prescribed: _____

f) Results: _____

g) Referred to another healthcare professional? If so, please explain: _____

h) Further exams or a follow-up recommended? If so, please explain: _____

i) Name and address of the physician or the clinic holding your medical file if different from the one mentioned above. ☐ None

_____

Insured 2

1. a) Height _____ ☐ ft ☐ m
   Weight _____ ☐ lb ☐ kg

b) Weight loss of more than 10 lbs (4.5kg) in the last 12 months? ☐ No ☐ Yes
If yes, how much: _____ Reason(s): _____

c) Date and reason of last medical appointment: _____

d) Name and address of the physician or clinic consulted: _____

e) Treatments or exams performed and or medication prescribed: _____

f) Results: _____

g) Referred to another healthcare professional? If so, please explain: _____

h) Further exams or a follow-up recommended? If so, please explain: _____

i) Name and address of the physician or the clinic holding your medical file if different from the one mentioned above. ☐ None

_____

For women only:	Insured 1		Insured 2	
	Yes	No	Yes	No
2. a) Are you currently pregnant? If so, please specify the number of weeks of pregnancy and your weight before pregnancy. _____	☐	☐	☐	☐
b) Do you have or ever had any pregnancy or childbirth complications (e.g., gestational diabetes, caesarean section, preeclampsia, ectopic pregnancy, premature labour, miscarriage, etc.)? If so, indicate the complications and the dates. _____ _____	☐	☐	☐	☐

E – Medical history (continued) (do not provide any information about genetic testing)

For every "Yes" answer in question 3, underline the condition(s) and provide details in Section F. Please specify the dates, diagnosis, exams, results, consultations, medications, and treatments as well as the contact information of the physicians and hospitals consulted.	Insured 1		Insured 2	
	Yes	No	Yes	No
3. Have you ever consulted for, been treated for, or showed signs or symptoms of the following conditions?				
a) **Cardiovascular system:** high blood pressure, high cholesterol, heart murmur, aneurysm, chest pain, heart attack (infarct), angina, palpitations, transient ischemic attack (TIA), cerebrovascular accident (CVA) or any other heart, blood vessel or circulation disorder?	☐	☐	☐	☐
b) **Respiratory system:** asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea, sarcoidosis, coughing up blood, shortness of breath or any other respiratory disorder?	☐	☐	☐	☐
c) **Digestive system:** Crohn's disease, ulcerative colitis, celiac disease, polyps, hepatitis (including hepatitis carrier), cirrhosis, pancreatitis, bleeding, ulcers or any other disorder of the esophagus, stomach, liver, pancreas, or intestines?	☐	☐	☐	☐
d) **Genitourinary system:** urine abnormalities, disorders of the kidney, urinary tract, bladder, prostate, or genital organs, including sexually transmitted diseases or abnormal PAP or PSA (prostate-specific antigen) tests?	☐	☐	☐	☐
e) **Endocrine system:** diabetes, glucose abnormalities, disorder of the thyroid, pituitary gland, adrenal gland or any other glandular or hormonal disorder?	☐	☐	☐	☐
f) **Musculoskeletal system:**				
1) Back or neck pain or disorder?	☐	☐	☐	☐
2) Arthritis, muscular dystrophy, fibromyalgia, pain, disease or disorder of the muscles, bones, ligaments, or joints such as the shoulders, elbows, wrists, hands, hips, knees, ankles, feet, etc.?	☐	☐	☐	☐
g) **Neurological system:** cerebral palsy, loss of consciousness, loss of balance or dizziness, paralysis, concussion, migraines, epilepsy/convulsions, numbness, tremors, weakness in extremities, loss of sensation, blurred vision, optic neurosis, multiple sclerosis, Huntington's chorea, amyotrophic lateral sclerosis (ALS), Parkinson's disease, loss of memory, Alzheimer's disease, degenerative disease or any other cognitive disorder or condition affecting the brain, the spinal cord or the nerves?	☐	☐	☐	☐
h) **Mental health, behavioural or developmental disorders:** Depression, anxiety, panic attacks, burnout, insomnia, bipolar disorder, psychosis, suicide attempt, eating disorder, attention deficit disorder with or without hyperactivity (ADD/ADHD), autism spectrum disorder, intellectual impairment, Down syndrome or any other developmental, behavioural, or mental health disorder?	☐	☐	☐	☐
i) **Immune system:** acquired immunodeficiency syndrome (AIDS), positive test results for human immunodeficiency virus (HIV), lupus, scleroderma, any unexplained lymph node infection or swelling or any other immune system disorder?	☐	☐	☐	☐
j) **Cancer or tumor:** leukemia, cancer, tumor, cyst, nodule, polyp, lump, or growth	☐	☐	☐	☐
k) **Breast disorder:** Lump, bump, cyst, or any other breast disorder?	☐	☐	☐	☐
l) **Eye, ear, nose, or throat disorders:** Partial or total blindness, macular degeneration, glaucoma, partial or total deafness, tinnitus, Meniere's disease, labyrinthitis or any other eye, ear, nose or throat disorder (excluding tonsillectomy, adenoidectomy, presbyopia and myopia)?	☐	☐	☐	☐
m) **Other conditions:** Skin disease or abnormal skin lesion, blood disorder such as persistent anemia, coagulation disorder or any other physical or mental disease or disorder not mentioned above? _____	☐	☐	☐	☐
4. **In the last five (5) years** (except for what you previously declared):				
a) Have you been admitted for more than 24 hours to a hospital, clinic, therapy center, convalescence home or any other healthcare facility (do not include childbirth)? If so, provide the dates, locations, reasons, and results. _____	☐	☐	☐	☐
b) Have you had a blood test, resting or stress electrocardiogram, echocardiogram, colonoscopy, X-ray, mammography, ultrasound, CT scan, MRI, biopsy, or any other test for diagnostic purposes? If so, specify the tests, dates, reasons, and results. _____	☐	☐	☐	☐
c) Have you been absent from work or been unable to perform your regular duties for more than one week due to an accident or illness? If so, specify the dates, reasons, and duration. _____	☐	☐	☐	☐

E – Medical history (continued) (do not provide any information about genetic testing)

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
d) Have you ever consulted a chiropractor, physiotherapist, occupational therapist, osteopath, acupuncturist, podiatrist, audiologist, psychologist, or any other healthcare professional? If so, complete the following table:	☐	☐	☐	☐

Insured's name	Health care professional	Reason/ diagnosis	Date of first consultation	Date of last consultation	Number of consultation per year	Date of last symptoms

Provide the details of all "Yes" answers. If you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
5. Do you currently take medication, or have you previously taken medication for more than 21 consecutive days in the last 12 months (other than those mentionned above)? If so, specify the name, dosage, reason and the start and end dates of treatment. _____	☐	☐	☐	☐
6. Have you been advised to undergo treatment, surgery, diagnostic exams, or tests which have not yet been performed or for which you are awaiting results? If so, give details. _____	☐	☐	☐	☐
7. Do you have any symptoms, signs, or discomfort for which you have not yet consulted? If so, provide details. _____	☐	☐	☐	☐
8. Family history: a) Has your father, mother, a brother, or sister (living or deceased) ever been diagnosed with one or more of the following conditions: polycystic kidney disease, Huntington's chorea, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), multiple sclerosis, familial adenomatous polyposis, muscular dystrophy, or any other hereditary disease? If so, complete the following table:	☐	☐	☐	☐

Insured's name	Relationship	Condition	Age at onset	Current age	Age at death	Cause of death

	Insured 1		Insured 2	
	Yes	No	Yes	No
b) Has your father, mother, a brother, or sister (living or deceased) ever been diagnosed before age 60 with one or more of the following conditions: heart disease, cerebrovascular accident, cancer (specify the type) or diabetes? Don't indicate family history of high blood pressure or high levels of cholesterol. If so, complete the following table:	☐	☐	☐	☐

Insured's name	Relationship	Condition	Age at onset	Current age	Age at death	Cause of death

F – Details and additional information

Question No.	Insured's first name	**Details** Specify the disorder(s) or condition(s) and provide details, including the dates, diagnosis, exams, results, consultations, medications, and treatments as well as the contact information of the physicians and hospitals consulted.

G – Child rider / Children's endorsement

Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.

1. _____ Y Y Y Y M M D D ☐ M ☐ F
   a) First and last names | b) Date of birth | c) Sex
   _____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
   d) Relationship to policyowner(s) | e) Height | f) Weight
   _____ _____ Y Y Y Y M M D D
   g) Name of attending physician and/or hospital | h) Address | i) Date of last consultation
   _____
   j) Indicate the reason, the results and the recommended treatments if applicable

2. _____ Y Y Y Y M M D D ☐ M ☐ F
   a) First and last names | b) Date of birth | c) Sex
   _____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
   d) Relationship to policyowner(s) | e) Height | f) Weight
   _____ _____ Y Y Y Y M M D D
   g) Name of attending physician and/or hospital | h) Address | i) Date of last consultation
   _____
   j) Indicate the reason, the results and the recommended treatments if applicable

3. _____ Y Y Y Y M M D D ☐ M ☐ F
   a) First and last names | b) Date of birth | c) Sex
   _____ _____ ☐ ft ☐ m _____ ☐ lbs ☐ kg
   d) Relationship to policyowner(s) | e) Height | f) Weight
   _____ _____ Y Y Y Y M M D D
   g) Name of attending physician and/or hospital | h) Address | i) Date of last consultation
   _____
   j) Indicate the reason, the results and the recommended treatments if applicable

	Yes	No
4. Please answer the following for all children to be insured: a) Was any child born prematurely (less than 37 weeks of pregnancy)? Answer only if child is less than 6 years old. If so specify, the child's name, the number of weeks of pregnancy and the child weight at birth. _____	☐	☐
b) Do any have ever consulted for, been treated for or had signs or symptoms with any of the following conditions : heart murmur, heart or blood vessel disorder, leukemia, cancer, tumor, diabetes, disorder of the kidney, cystic fibrosis, muscular dystrophy, Down syndrome, physical or intellectual deficiency, developmental or behavioral disorder including autism spectrum disorder or any other congenital illness or disorder? If so, specify the child's name, the condition, the date of diagnosis, the treatment and the name and contact information of the physician. _____	☐	☐
c) Are any suffering or ever suffered from any other illness or disorder that required hospitalization, consultation with a specialist or medication for more than 21 consecutive days? If so, specify the child's name, the condition, the date of diagnosis, the treatment and the name and contact information of the physician. _____	☐	☐
d) Do any have signs currently signs or symptoms for which a physician has not yet been consulted or for which he was advised to consult a specialist or been advised to undergo exams, diagnostic tests, treatments or surgery which have not yet been performed or for which he is awaiting results? If so, specify the child's name and details accordingly. _____	☐	☐

	Yes	No
e) Do any have a family member (father, mother, brother or sister, living or deceased) ever been diagnosed with one more of the following conditions: diabetes, cancer, muscular dystrophy, Huntington's Chorea, polycystic kidney disease or any other hereditary disease? If so, specify the child's name who is concern (relationship), the condition (if cancer, provide the localization) and age at onset. _____ _____ _____	☐	☐
f) Do any currently hold a life (LIFE) or critical illness (CI) insurance contract or have a pending application for any of these types of insurance? if so, for each child specify the child's name, type of product, insured amount, company name, issued date or indicate pending if applicable. _____ _____ _____	☐	☐
g) Do any ever had life or critical illness insurance application been declined, modified, deferred or rated with a higher premium? If so, specify the child's name, the date and the reason. _____ _____ _____	☐	☐

H – Disability rider

Disability Rider (Term life insurance only)

- The monthly indemnity amount requested must be determined following a needs analysis and based on eligible loans and monthly payments. The benefit payable in the event of a total disability claim may differ from the amount requested, as mentioned in Section N (article 5).
- Certain occupations are not insurable. Please refer to the *List of non-insurable occupations* (MIND0250A). Note that a spouse on parental leave must have a regular occupation insurable according to our criteria to be eligible for a maximum amount of $1,000.

	Insured 1	Insured 2
1. Eligibility		
a) Are you a stay-at-home spouse? If YES, maximum amount of up to $1,000 and duration of 2 years. Note: eligible only if the spouse is covered under the present policy.	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you a spouse on parental leave? If YES, maximum amount of up to $1,000 and duration of 2 years. Note: eligible only if the spouse is covered under the present policy.	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you currently work at least 21 hours per week? If NO, not eligible for disability rider.	☐ Yes ☐ No	☐ Yes ☐ No
d) Do you work 8 months or more a year for at least 21 hours a week? If NO, not eligible for disability rider.	☐ Yes ☐ No	☐ Yes ☐ No
2. Home-based work (or from the home(s) of your clients) What percentage of your time do you work from home (or from the home(s) of your clients)?	_____ %	_____ %
3. Disability rider (only one option can be chosen per insured)		
- With guarantee – Proof of loan upon purchase (submit proof of loan with the application)	☐	☐
- Without guarantee – Proof of loan upon claim	☐	☐
4. Insurance need (based on needs analysis)	$/month	$/month
5. Amount requested (min. $300, max. 1.5% of the life insurance amount requested without exceeding $3,500)	$/month	$/month
6. Duration	☐ 2 years ☐ 5 years ☐ up to age 65	☐ 2 years ☐ 5 years ☐ up to age 65
7. a) Are the loans for which the disability insurance amount is requested already covered by another disability insurance policy?	☐ Yes ☐ No	☐ Yes ☐ No
b) If yes, will this insurance be replaced?	☐ Yes ☐ No	☐ Yes ☐ No

I – Declaration of tax residence of policyowner(s) (self-certification)

(applicable to whole life insurance, enhanced term-100 life insurance and universal life insurance products)

The policyowner(s) must be tax resident(s) of Canada in order for an insurance policy to be reinstated. The information provided in the Declaration of Tax Residence section must be correct and complete. The policyowner(s) must provide Beneva Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to become incomplete or inaccurate (for example, changing a bank account for one in a financial institution in a country other than Canada, changing an address for an address in a country other than Canada, etc.).

The policyowner is a corporation or other type of entity:

For **whole life insurance** or **enhanced term-100 life insurance,** the Declaration of Tax Residence must be completed on the form *Declaration of Tax Residence (Self-Certification) – Entity* (FRA1748A).
For **universal life insurance** the Declaration of Tax Residence must be completed on the form *Verification of the Identity of Corporations and Other Entities* (FRA1235A).

Policyowner 1 (individual)	Policyowner 2 (individual)
Check (✓) all options that apply to you:	**Check (✓) all options that apply to you:**
☐ I am a tax resident of Canada	☐ I am a tax resident of Canada
☐ I am a tax resident of a jurisdiction other than Canada → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is required.**	☐ I am a tax resident of a jurisdiction other than Canada → **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is required.**

J – Identity of the policyowner(s) (applicable for universal life insurance)

This section must be completed by the financial security advisor/representative. If he/she is not participating in this policy reinstatement, do not complete this section.

For universal life (UL) insurance: The financial security advisor/representative must verify the identity of each **policyowner** as required by the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* (the Act).

How are you verifying the identity of each policyowner (for UL insurance)?

Check the box(es) that apply:

☐ **In the physical presence of each person:** using an **authentic (original), valid and unexpired (if applicable) government-issued photo identification document** → If you check this box, indicate below for each person, the identification document that has been reviewed, its number, its expiration date (if applicable) and jurisdiction. If the document selected below is "Other photo identification document admissible by Law", please specify the type of document verified. In Quebec, you are not allowed to request the client's Health Card, but you can accept it only if the client offers it to you. In the provinces of Ontario, Manitoba, Nova Scotia and Prince Edward Island, the use of a Health Card for identification purposes is prohibited.

☐ **Using the dual process method (if verification done remotely or if identification document not valid):** using two legible, valid and up-to-date documents from two different, independent and reliable sources → **If you check this box, the form *Dual process method for identity verification – Individual – Financial security advisor/Representative declaration* (FRA1913A) is required.**

Policyowner 1	Policyowner 2
Name of the policyowner (as appearing on the document)	Name of the policyowner (as appearing on the document)
The policyowner must be a Canadian resident.	The policyowner must be a Canadian resident.
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo
☐ Other photo identification document admissible by law (specify):	☐ Other photo identification document admissible by law (specify):
Document number / Jurisdiction	Document number / Jurisdiction
Y Y Y Y M M D D	Y Y Y Y M M D D
Document expiration date	Document expiration date

K – Third-party determination (applicable for universal life insurance)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, the financial security advisor / representative must take reasonable measures to determine, with regard to the present reinstatement request, if the policyowner(s) is (are) acting on behalf of a third party (individual or entity).

When you must determine whether a "third party" is involved, it is not about who "owns" the money, but rather about who gives instructions to deal with the money. If the individual in front of you is acting on someone else's instructions, that someone else is the third party.

When the premium payer is a different person or entity than the policyowner(s), the payer is considered a third party and the section below must be completed.

Is (are) the policyowner(s) acting on behalf of a third party (individual or entity) or is there a third party to this contract?

☐ Yes → complete the "Third party identification" section below.
☐ No
☐ It is impossible to determine whether the policyowner(s) is (are) acting on behalf of a third party, but I have reasonable grounds to believe that he/she (they) is (are) → complete the "Third party identification" section below.

Is the person or entity paying the premiums/amounts in the insurance contract different from the policyowner(s)?

☐ Yes → complete the "Third party identification" section below.
☐ No

Third-party identification (if applicable)

Name of the third party

Y Y Y Y M M D D
Date of birth (if third party is an individual)

Full permanent address of the third party

Telephone number of the third party

Principal business or occupation: provide complete and detailed information, including the job title, the field of activity, the name of the employer and the employment status (employee, executive, owner, self-employed, etc.); if retired, provide the details on the last occupation prior to retirement.

Relationship between the third party and the policyowner(s)

If the third party is an entity:
Business number
Place of issuance of its certificate of constitution

If you cannot determine if the policyowner is acting on behalf of a third party, but have reasonable grounds to suspect that he is, provide the reasons in the space below:

L – Payment of premiums

L1 – General information

Total premium amount for this policy reinstatement request: $ _____

Method of payment

If there are more than six (6) outstanding monthly premiums, the only acceptable method of payment is by cheque (payable to Beneva Inc.).

☐ Enclosed cheque for the amount of $ _____ Date of cheque Y Y Y Y M M D D
Cashed on reception of this reinstatement request. The reinstatement becomes effective on the date the request is accepted by Beneva Inc.

☐ Pre-authorized debit drawn from the same bank account associated with the policy number mentioned in section A of this form

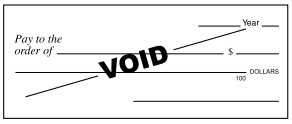
☐ Pre-authorized debit drawn from a new bank account (complete Section L2 and attach a cheque specimen)

L2 – Pre-authorized debit agreement

1. I hereby authorize Beneva Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one-time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify Beneva Inc. before the renewal date of the contract of insurance.
3. I understand that depending on the product chosen, a monthly payment will result in a higher annualized premium.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), Beneva Inc. is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform Beneva Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month on the day selected in this Policy Reinstatement form or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. **I agree and understand that Beneva Inc. will not notify me before each withdrawal.**
9. In the event that I instruct Beneva Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing Beneva Inc. with thirty (30) days' notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
11. I understand that Beneva Inc. reserves the right to terminate this Agreement upon fifteen (15) days' notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with Beneva Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by Beneva Inc.
13. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Beneva Inc.
Premium Accounting
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a specimen cheque, on which you have written "VOID", for the account to be debited.



_____
Name of Financial Institution

_____
Address, City, Province and Postal Code of the Branch

Branch	Financial Institution Number	Account Number

Authorization

Is the account joint? ☐ **Yes** ☐ **No**

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of Account Holder or Authorized Person (in capital letters)	X Signature	Date
	X	Y Y Y Y M M D D
Name of Account Holder or Authorized Person (in capital letters)	X Signature	Date

M – Notice to proposed insured(s) and policyowner(s)

Notice regarding the investigative consumer report

For the insurance applications to be processed, all insurance companies, including Beneva Inc., may ask for a personal investigative consumer report in order to obtain information through personal interviews with neighbours, friends, associates and other designated people. The investigative consumer report may concern your reputation, lifestyle and finances. A representative of a consumer reporting agency may visit you or call you.

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including Beneva Inc. (Beneva), work with an organization called the MIB, LLC (MIB).

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva[1]. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g. : pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g. : preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers
- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:
Personal Information Protection Officer

Beneva
625 rue Jacques-Parizeau
Quebec QC G1R 2G5

ResponsablePRP@beneva.ca.

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at www.beneva.ca.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services.

For the sole use of Beneva financial advisors (BFA)

Consent to receive personalized product offers and advice on products and services (optional)

I consent to the necessary collection, use and disclosure of my personal information by Beneva to service providers as well as websites and applications belonging to third parties to receive personalized offers and advice on products or services.

I understand that I may withdraw my consent by calling 1 844 781-0860 or visiting Beneva.ca

☐ Policyowner 1 ☐ Policyowner 2

1. The term "Beneva" refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. Affiliates of Beneva Inc. designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L'Unique General Insurance Inc. and Unica Insurance Inc.

N – Declarations

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor / representative, during a personal meeting or a RECORDED telephone conversation with a paramedical company or another authorized person representing or acting for Beneva Inc. The undersigned agree that the additional questionnaire shall be deemed to form part of this application and that the information it contains shall be used to draw up a contract with Beneva Inc. The undersigned further agree to review such information upon receipt of the contract and to inform Beneva Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that all information that they divulged during a RECORDED telephone interview to a paramedical company or another authorized person representing or acting for Beneva Inc., including but not limited to, their medical history and state of health, is deemed to form part of this application and that this information shall be used to draw up a contract with Beneva Inc. The undersigned agree that any recording, transcription or other notation of such information by Beneva Inc. or on behalf of Beneva Inc. shall be considered to be accurate, complete and binding as if given in writing to you.
3. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the requested contract), the contract shall be void with respect to such insured.
4. Agree that, if a temporary insurance agreement has been drawn up for life insurance, the amount payable under the aforesaid temporary insurance agreement and such other temporary insurance agreement as may be drawn up by Beneva Inc. for each insured life shall be limited to the lesser of $500,000 or the total face amount requested in the insurance applications.
5. Agree that, if a conditional insurance policy is drawn up for critical illness insurance, the amount payable shall be the lesser of the face amount requested in this insurance application or $500,000 less all other face amounts under any critical illness insurance pending or in effect with Beneva Inc.
6. Agree that this application, as well as the attached temporary insurance agreement relating to life insurance and the attached conditional insurance policy relating to critical illness insurance, if any, are subject to the laws of the province where the policyowner resides when the policy is issued, subject to applicable laws.
7. Agree that, under the Term Plus product, the benefit payable in the event of a total disability, when the disability rider without guarantee – Proof of loan upon claim has been selected, or, when the monthly indemnity is more than $2,000, shall be based on the total amount of eligible monthly payments for all eligible loans in effect at the time of total disability, regardless of the monthly amount that is underwritten in the present application. The benefit payable shall not exceed the monthly amount that is underwritten in the present application, subject to the terms of the contract. When the disability rider without guarantee – Proof of loan upon claim has been selected, if there is no eligible monthly payment in effect at the time of total disability, the undersigned agree that the liability of Beneva Inc. shall be limited to the refund of premiums received since the loan or loans were discharged, on the understanding that this refund shall not exceed a period of eighteen (18) months prior to the date the total disability benefit was requested.
8. Agree that they have received the advisor's explanations concerning the possibility of a tax rule change that certain changes, which require evidence of insurability, may cause, if any. As such, the entire policy could be subject to the tax rules in effect as of January 1st 2017, if it is not already the case.
9. Declare having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applicants. This is the case for the electronic application, which is used to assess a person's risk profile in order to provide the best possible premium. The undersigned agree that submitting an application initiates this process.
10. Declare having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.
11. Declare that the information provided in this application with respect to universal life insurance (if applicable) concerning their contact information, identification information, occupation (including job title, field of activity, name of employer and employment status) and the purpose of insurance, is accurate, complete and has been correctly indicated, and they agree to promptly notify their financial security advisor/representative of any change in this information. In such a case, the financial security advisor/representative will forward the updated information to Beneva Inc. without delay.
12. Declare that the information provided in the Declaration of Tax Residence section is correct and complete and agree to provide Beneva Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to become incomplete or inaccurate.
13. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the insurance application with Beneva Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.
14. Declare having been made aware of the personal information protection notice as well as of all other notices sent to the applicant(s) and the owner(s) as well as having accepted the terms and conditions herein.

_____ This _____ day of _____ of year _____

Signed at (city and province) Date

X _____ **X** _____

Signature of insured 1 Signature of insured 2

X _____

Signature of the father, mother or legal guardian of the minor child (children's insurance)

X _____ **X** _____

Signature of policyowner 1 – only necessary if not an insured Signature of policyowner 2 – only necessary if not an insured

If the policyowner is an entity:

_____ **X** _____

Name and Title of Authorized Signatory Signature

_____ **X** _____

Name and Title of Authorized Signatory Signature

O – Authorizations

Your authorizations are necessary in order to provide and administer your products and services.

1. Authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. Authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. Authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. Authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

Insured 1

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured 1 (please print)	X Signature of insured 1	Y Y Y Y M M D D Date
If a minor insured: Name of mother, father or legal guardian (please print)	X If a minor insured: Signature of mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

Insured 2

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured 2 (please print)	X Signature of insured 2	Y Y Y Y M M D D Date
If a minor insured: Name of mother, father or legal guardian (please print)	X If a minor insured: Signature of mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

P – Financial security advisor's / representative's report

P1 – Information about financial security advisor / representative

The following information is necessary for this form to be processed and for commissions to be paid.

Name of service advisor (in capital letters)	Agency	Code of financial security advisor / representative
Share % (multiples of 5%)	Telephone number	
Name of other advisor sharing commission (if applicable) (in capital letters)	Agency	Code of financial security advisor / representative
Share % (multiples of 5%)	Telephone number	
Name of other advisor sharing commission (if applicable) (in capital letters)	Agency	Code of financial security advisor / representative
Share % (multiples of 5%)	Telephone number	

P2 – Signature of financial security advisor/representative

I confirm that I have provided an "Advisor Disclosure Statement" to the policyowner(s) disclosing the following:

- the name of the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and critical illness insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflicts of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this *Policy Reinstatement* form has been signed.

I hereby declare that all information in this Policy Reinstatement form is true and complete to the best of my knowledge.

If I am not the service advisor for this policy, I declare that I have informed the policyowner(s) of that fact and of the identity of his/her (their) service advisor as it appears in Section N1.

Identity verification of the policyowner(s)

(applicable for universal life insurance)

I have verified the identity of the person(s) who signed this form as policyowner(s) using a method permitted in accordance with the requirements of the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations.

Third-party determination

(applicable for universal life insurance)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, I have taken reasonable measures to determine if the policyowner(s) is(are) acting on behalf of a third party.

Ongoing monitoring of business relationships

(applicable for universal life insurance)

When the person(s) who has(have) signed this form as policyowner(s) notifies (notify) me of an update to their contact information, identification information, occupation (including job title, field of activity, name of employer and employment status) or the purpose of insurance, I agree to inform Beneva Inc. without delay.

Name of financial security advisor / representative (please print)

Code of financial security advisor / representative

X

Signature of financial security advisor / representative

Y Y Y Y M M D D

Date

Comments and details of financial security advisor / representative

This notice must always be given to the policyowner.

Notice to proposed insured(s) and policyowner(s)

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including Beneva Inc. (Beneva), work with an organization called the "MIB, LLC (MIB)".

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing **Canadadisclosure@mib.com** or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva 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. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

Policy number _____

Authorization

1. I authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. I authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. I authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. I authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim. I achnowledge having read the 4 authorizations above-mentionned and agree to them.

_____	**X** _____	Y Y Y Y M M D D
Name of insured (please print)	Signature of insured	Date
_____	**X** _____	Y Y Y Y M M D D
If a minor insured: Name of the mother, father or legal guardian (please print)	If a minor insured: Signature of the mother, father or legal guardian (indicate relationship to the insured)	Date

Policy number _____

Authorization

1. I authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. I authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. I authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. I authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim. I achnowledge having read the 4 authorizations above-mentionned and agree to them.

_____	**X** _____	Y Y Y Y M M D D
Name of insured (please print)	Signature of insured	Date
_____	**X** _____	Y Y Y Y M M D D
If a minor insured: Name of the mother, father or legal guardian (please print)	If a minor insured: Signature of the mother, father or legal guardian (indicate relationship to the insured)	Date