Simple just got simpler!

from Unity Life

E-Z Term - Simplified Issue Non-Med up to $250,000 Face Amount

10-Year Renewable & Convertible Term with no medicals and no blood tests!

Your client can apply for an E-Z Term policy in two ways:

- ✓ Filling out the new E-Z Term Application

  or

- ✓ Applying online at www.unitylife.ca/XpressInsure

With either option all clients need to do is answer "No" to the questions on the app. No medical exam, no APS, no blood or urine samples and no underwriting!

Plan Details

- Renewable to age 75 and convertible to age 65
- Issue Ages 18 – 65 (based on age last)
- Minimum Face Amount: $25,000
- Maximum Face Amount based on Issue Age:

  18 – 40 : $250,000
  41 – 50 : $200,000
  51 – 60 : $150,000
  61 – 65 : $100,000
- Policy Fee: $35
- Same compensation as our Preferred Term 10 plan

For more details contact Unity Life Central Operations at one of the numbers listed below.

Unity Life of Canada

910 – 191 The West Mall, Toronto, Ont. M9C 5K8
(416) 960-3463 1-800-267-8777 Fax: (416) 960-4021
www.unitylife.ca

Unity Life of Canada

E-Z TERM APPLICATION

1. LIFE TO BE INSURED

Name: ______ Last First Middle

☐ Male ☐ Female Date of Birth Age

Place of Birth: ______

If not Canada, show date landed immigrant status was received: ______

Social Insurance Number: ______

Occupation: ______

Employer: ______

Total Life Insurance now in force: $ ______

2. OWNER – If not the Life to be Insured

Name: ______ Last First Middle

OR

Company Name: ______

Relationship to Life to be Insured ______

Address: ______ Street Address

______ City Province Postal Code

Telephone Numbers (include area code):

Residence ______ Business ______

Cellular ______

E-mail ______

2. BENEFICIARY (Revocable unless otherwise indicated)

In Quebec, a spouse will automatically be considered as irrevocable unless otherwise indicated.

Beneficiary: ______ Relationship: ______

3. ADDRESS

Residence of Life to be Insured

______ Street

______ City Province Postal Code

Telephone numbers (include area code):

Residence ______ Business ______

Cellular ______ E-mail ______

4. COVERAGE APPLIED FOR

Plan ______ Face Amount ______ Premium $ ______

Mode of Payment: ☐ Annual ☐ Semi-Annual ☐Monthly PAC ☐1st ☐ 8th ☐ 15th ☐ 22nd

(If PAC, attach a void sample cheque)

5. ADDITIONAL INFORMATION

1. Have you used any substance or product containing tobacco, nicotine or marijuana within the past 12 months? ☐ Yes ☐ No
2. Will this insurance result in the termination or reduction in value of any existing insurance? ☐ Yes ☐ No

6. BUILD CHART

NOTE: Please refer to the following chart for your height and weight.

Is your weight greater than that shown for your height? ☐ Yes ☐ No

Height		Weight	
Imperial	Metric (cm)	Imperial (lbs.)	Metric (kg)
4' 10"	145	150	68
4' 11"	148	155	70
5' 0"	150	161	73
5' 1"	153	166	75
5' 2"	155	173	79
5' 3"	158	179	81
5' 4"	160	184	84
5' 5"	163	189	86
5' 6"	165	195	89
5' 7"	168	200	91
5' 8"	170	206	94
5' 9"	173	213	97

Height		Weight	
Imperial	Metric (cm)	Imperial (lbs.)	Metric (kg)
5' 10"	175	218	99
5' 11"	178	224	102
6' 0"	180	230	105
6' 1"	183	238	108
6' 2"	185	244	111
6' 3"	188	251	114
6' 4"	190	258	117
6' 5"	193	264	120
6' 6"	195	271	123
6' 7"	198	279	127
6' 8"	200	285	130
6' 9"	203	293	133

7. PERSONAL DECLARATION

1) Has any application for insurance been rated, declined or modified in any way? ☐ Yes ☐ No

2) Have you had your driver's license suspended or been convicted of 3 or more moving violations in the past 3 years? ☐ Yes ☐ No

3) In the past 3 years have you engaged in aviation activity other than as a passenger, or other hazardous sports or activities or do you intend to do so in the future? ☐ Yes ☐ No

4) Other than for colds, flu or annual physical examinations, have you consulted your usual medical advisor within the past 6 months? ☐ Yes ☐ No

5) Have you ever had, or been told you had, or received treatment or advice for:

   a) abnormal blood pressure, coronary artery disease, elevated cholesterol, chest pain, palpitations or any other disease or disorder of the heart, blood vessels or cardiovascular system? ☐ Yes ☐ No

   b) epilepsy, seizures, brain disorder, stroke, transient ischemic attack (TIA), or any other disease or disorder of the nervous system? ☐ Yes ☐ No

   c) anxiety, depression or any emotional, behavioural, mental or nervous disorder? ☐ Yes ☐ No

   d) any disease or disorder of the stomach, intestines, liver or pancreas? ☐ Yes ☐ No

   e) cancer, tumour or any other growth or malignancy? ☐ Yes ☐ No

   f) diabetes; kidney, bladder or urinary disorder; prostate disorder; thyroid disorder; anemia, hepatitis or hepatitis-carrier state or any other blood or glandular disorder? ☐ Yes ☐ No

   g) AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, or any other immunological disorder? ☐ Yes ☐ No

6) Have you ever required hospitalization for any nose, throat, eyes, ears, lung or any other respiratory disorder? ☐ Yes ☐ No

7) Within the past 10 years have you used cocaine or other illegal drugs or received treatment or counseling for excess alcohol use or abuse or drug abuse? ☐ Yes ☐ No

8) Other than for minor ailments and surgery, have you in the past 5 years been under observation, had medical or surgical advice or treatment, had any abnormal medical test results or been hospitalized for any disease or disorder not mentioned above? ☐ Yes ☐ No

9) Have any of your first degree relatives (parents and siblings) had a history of heart disease, kidney disease, diabetes, cancer, stroke, Huntington's Chorea, or any hereditary disease prior to reaching their age 60? ☐ Yes ☐ No

10) Have you resided in Canada for less than 12 months? ☐ Yes ☐ No

8. AUTHORIZATION

Each undersigned agrees that: (a) the statements and answers contained in all Parts of the Application and any other evidence of insurability are true and complete and form the basis of the contract of insurance applied for or issued; (b) the contract will not take effect until the policy has been delivered to the Proposed Life Insured/Owner (or in the province of Quebec, the date the policy is issued) and the first premium has been paid to the Insurer or its agent with no change in the insurability of each Proposed Life Insured from the time of completion of the application to the time of delivery of the policy; (c) no person other than the President or Vice President together with the Secretary or Actuary of the Insurer has the power to change or modify the policy or contract on behalf of the Insurer or to waive the Insurer's rights or requirements and any such change, modification or waiver must be in writing, signed by such officers.

Each undersigned acknowledges receipt of a form describing the Medical Information Bureau (M.I.B.) AND AUTHORIZES M.I.B. to give the Insurer and its reinsurers any information in its files. Each undersigned authorizes any licensed physician, medical practitioner, hospital, clinic or medically related facility, insurance company or other organization, institution or person having records or knowledge of the health of any Proposed Life Insured to provide same to the insurer. A photographic copy of this authorization shall be as valid as the original.

The language of the policy and all correspondence shall be the same as that of the application unless requested otherwise.

Dated at ______________________ this ________ day of ______________________ , ___________

______________________ Signature of Proposed Life Insured

______________________ Signature of Owner(s)

______________________ Witness to all signatures

BROKER'S REPORT

Please Print

1. Are you related to the Proposed Insured? (If Yes, please state relationship) ❑ Yes ❑ No
2. Main Purpose of Insurance ______
3. Was a Financial Needs Analysis Completed? ❑ Yes ❑ No If no, why not? ______
4. Remarks/Recommendations ______

______

I/We the writing Broker(s) to the best of my/our knowledge and belief affirm that:

a) The answers in this Application are true representations of the facts stated and I am not aware of additional information material to the Proposed Life Insured except as stated above in the space marked "Remarks / Recommendations".

b) I/We am/are properly licensed to do business in the province of ______
Licence No. ______

c) If replacement is intended I/We declare that all rules and regulations relevant to replacement have been complied with.

Broker's Signature ______ Broker's Name (Please Print) ______ Broker's Code ______

MGA/GA Name ______ MGA/GA Code ______

APPLICATION FOR TEMPORARY INSURANCE

Do Not Detach

To be answered by the Proposed Life Insured

		Yes	No
1.	Have you ever been treated for or had any indication of heart or blood vessel disease, diabetes, elevated blood pressure, chronic kidney, liver or lung disease?	❑	❑
2.	To the best of your knowledge and belief, have you had any symptoms of or treatment for cancer, cysts or tumour within the last 4 years?	❑	❑
3.	Have you had any symptoms of or treatment for any medical condition that resulted in hospitalization (other than normal childbirth) within the last 2 years?	❑	❑
4.	Have you been absent from work for more than 7 days within the last 6 months because of sickness or injury?	❑	❑
5.	Are you age 65 or over?	❑	❑
6.	Has any application for insurance on your life ever been rated, declined or modified in any way?	❑	❑
7.	Are you aware of any symptoms for which you have not yet sought treatment or for which treatment is planned or pending?	❑	❑

THE TEMPORARY INSURANCE AGREEMENT WILL ONLY BE GIVEN IF ALL OF THE ABOVE QUESTIONS ARE ANSWERED "NO" AND WILL ONLY BE VALID AND ENFORCEABLE IF SUCH ANSWERS ARE TRUE.

An applicant is only eligible to be considered for temporary insurance where the total amount of insurance under all plans being applied for from the Insurer is $500,000 or less and the Proposed Life Insured is under the age of 65 years. When temporary insurance is available and the Insurer agrees to grant temporary insurance, the amount of such temporary insurance provided will be the aggregate of the amounts applied for under the Basic Plan and Term Riders shown on Part 1, but such temporary insurance shall not exceed the amount of $500,000 in cases where the aggregate applied for exceeds that amount. This Application for Temporary Insurance may be completed only at the time of completion of the Life Insurance Application, Part 1, and payment of at least 1/12 of the annual premium must be paid on that same date. If the Proposed Life Insured dies by an act of intentional self destruction Unity Life's liability is limited to a refund of the payment made.

I agree to the terms and conditions of the Temporary Insurance Agreement set out on page 4.

Dated at ______ on ______
Day Month Year

Signature of Owner (if other than Proposed Life Insured) ______ Signature of Proposed Life Insured ______

AUTHORIZATION FOR PRE-AUTHORIZED CHEQUE PLAN

Please Attach a Specimen Cheque

Subject to conditions on Page 4, I/We authorize the financial institution indicated below to make payments to the Insurer, for the purpose of paying premiums and making payments of specified amounts on loan indebtedness. I/We agree that any request for payment submitted on this basis will be treated as if I/We had personally signed the request. Any delivery of this authorization to the financial institution constitutes delivery by Me/Us.

Name(s) of Depositor(s) ______
(as shown on bank records) Date Signature(s) of Depositors

PRE-AUTHORIZED CHEQUE PLAN CONDITIONS — Detach and give to Owner if PAC Authorization has been completed

1. The deduction day for the pre-authorized cheque plan withdrawal will be the policy anniversary day, unless otherwise agreed upon.
2. Unity Life requires 10 days written notice of any changes in account information. A new specimen cheque is required for change in financial institution.
3. The pre-authorized cheque plan may be terminated:
   a) By the payor(s) or Unity Life subject to 10 days written notice to the other.
   b) Immediately by Unity Life, if any cheque is not honoured on presentation, or if Unity Life has refunded the amount of such cheque to the named financial institution upon request.
4. Except as provided above, the pre-authorized cheque plan shall not restrict any right or privileges contained in the policy(ies).
5. The expression "cheque" used in this request and in these conditions includes any magnetic or computer produced paper tape that is or purports to be a direction to credit an amount to Unity Life and to debit such amount to the account indicated on Page 3.

TEMPORARY INSURANCE AGREEMENT AND RECEIPT — Detach and give to Owner if TIA has been completed

TERMS, LIMITATIONS AND CONDITIONS

PREMIUM – NO COVERAGE will take effect under this Agreement unless the advance payment is at least equal to one-twelfth of the total annual premium.

DATE COVERAGE BEGINS

Temporary Life Insurance under this Agreement will begin on the date of this Agreement but only if this Application has been completed on the same day.

DATE COVERAGE TERMINATES – 90 DAY MAXIMUM

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

a) 90 days from the date of this Agreement, or
b) the date that insurance takes effect under the policy applied for, or
c) the date a policy, other than applied for, is offered, or
d) the date the Company mails notice of termination of coverage to the owner's mailing address designated in this Application.

The Company may terminate coverage at any time.

SPECIAL LIMITATIONS

a) Whether the proposed insured is sane or insane, this Agreement does not provide benefits, for any disability insurance or suicide.
b) There is no coverage under this agreement if the cheque submitted as payment is not honoured on presentation.
c) No person has the authority to modify or waive any requirements or conditions of this agreement.

AMOUNT OF COVERAGE - $500,000 MAXIMUM FOR ALL APPLICATIONS AND AGREEMENTS

If the Proposed Life Insured dies while this temporary insurance is in effect, the Company will pay, upon approval of a claim, to the designated beneficiary the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits if applicable, or (b) $500,000. This total benefit limit applies to all insurance applied for under this and any other current applications to the Company and any other Temporary Life Insurance Agreement with the Company.

It is acknowledged that the sum of $ ______________________ was paid to the Company at the time of the completion of this application.

Date ______________________ Signature of Broker ______________________

DISCLOSURE STATEMENT FOR THE PROVINCE OF B.C. — Detach and present to Proposed Insured

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by Unity Life, a company licensed to carry on business in British Columbia.

In relation to any application you make for the acquisition of life insurance, annuities or other financial products,

a) I am acting as a licensed insurance broker on behalf of the company,
b) I will be entitled to receive commission from the company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or an on-going service commission; and
c) There is no condition associated with this transaction requiring that you must transact additional or other business with either the Company or myself.

______________________ ______________________

Name and address of Broker Signature of Broker

IMPORTANT M.I.B. PRE-NOTICE — Detach and present to Proposed Insured

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information on its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7. Telephone (416) 597-0590.

We, or our reinsurers, may also release information in your file to other life insurance companies to whom you may apply for life, disability or health insurance or to whom a claim for benefits is submitted.

IMPORTANT NOTICE CONCERNING FILES AND PERSONAL INSURANCE — Detach and present to Proposed Insured

In order to ensure the confidentiality of the personal information held concerning you, Unity Life of Canada will establish a Life Insurance file in which the information concerning your application for insurance will be placed, as well as information concerning any insurance claim. Only Unity Life of Canada, its employees, reinsurers and professional consultants, who will be responsible for underwriting, administration and claims, or any other person whom you authorize, in writing, or persons required by law will have access to this file. Your file will be kept by Unity Life of Canada and you are entitled to consult personal information contained in the file, and if applicable, to have it rectified by submitting a written request to the following address:

Vice President and Assistant Secretary
Unity Life of Canada
112 St. Clair Avenue West, Toronto, ON M4V 2Y3
(416) 960-3463 1-800-267-8777 Fax: (416) 960-4000 www.unitylife.ca