TURBO APPLICATION TO: Unity Life of Canada, Toronto, Ontario, Canada(The Insurer). The undersigned applies for insurance to be issued on the basis of statements and answers to the following questions on all parts of the application and any other evidence of insurability.

1. PROPOSED LIFE INSURED

a) NAME
b) BIRTHDATE (M/D/Y)
c) AGE
d) ADDRESS (including Postal Code)
e) BIRTHPLACE
f) GENDER M / F
g) E-MAIL ADDRESS
h) S.I.N.
i) OCCUPATION
j) EMPLOYER
k) ANNUAL EARNED INCOME
l) ESTIMATED NET WORTH

2. OWNER (if other than Proposed Life Insured)

a) NAME
b) MAILING ADDRESS
c) RELATIONSHIP TO PROPOSED LIFE INSURED
d) E-MAIL ADDRESS

3. INSURANCE a) PLAN OF INSURANCE
b) FACE AMOUNT
c) MODE OF PREMIUM PAYMENT ❑ Annual ❑ Semi-Annual ❑ P.A.C. If P.A.C. choose withdrawal date 1st – 28th ________
d) PREMIUM PAID WITH APPLICATION $________
e) RIDERS: ❑ WP ❑ ADB ❑ CTR(please include child(ren)'s name(s), D.O.B, gender & face amount on Agent's Report or Supplemental Application)
f) DIVIDEND OPTION: ❑ Remain on Deposit ❑ Pay to Owner ❑ Paid up Additions ❑ 1yr Term Additions ❑ Premium Reduction ❑ Other ________

4. BENEFICIARY (Revocable unless otherwise indicated) ❑ Revocable ❑ Irrevocable

Name
Relationship to the Insured

5. APPLICABLE TO THE PROPOSED INSURED (Please give details of ALL 'Yes' answers)

		YES	NO
a)	Have you used any form of nicotine product in the ❑ past 12 months? ❑ past 24 months?	❑	❑
b)	Have you ever been told that you have or been treated for diabetes, cancer, heart disease, alcoholism, drug abuse or high blood pressure?	❑	❑
c)	Will this insurance result in the termination or reduction in value of any existing insurance? (If yes, follow replacement procedures)	❑	❑

Please provide details of "yes" answers ________

6. UNDERWRITING CONTACT INFORMATION

a) Home Phone ( )
b) Business Phone ( )
c) Call me at ❑ home ❑ business
d) Best Day ________ Best Time________
e) Special Instructions (Please use Agent's Report for additional space) ________

____

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

AGENT'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 **(including preferred Paramedical company)**

I/We the writing Agent(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.

____
AGENT'S SIGNATURE

AGENT'S NAME: GA NAME:

AGENT'S CODE: 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 tumor 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 3.

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 3, 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

AUTHORIZATION

I hereby authorize any licensed Physician, Medical Practitioner, Hospital or Clinic or other Medical or Medically Related Facility, Insurance Company, The Medical Information Bureau (M.I.B.) or other Organization, Institution or person that has any record or knowledge of me or my health to give Unity Life of Canada and its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

Date Signature of Proposed Life Insured

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 2.

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 Agent ____

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 agent Signature of Agent

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.