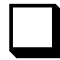
Unity Life of Canada

Application for Insurance: Life and Critical Illness

 Regular Application

PLEASE NOTE: PREMIUM SHOULD ONLY BE COLLECTED IF THE AMOUNT APPLIED FOR IS $500,000 OR LESS AND THE APPLICATION FOR TEMPORARY INSURANCE IS COMPLETED

Informal Inquiry

THIS IS NOT A FORMAL APPLICATION FOR LIFE INSURANCE

BROKER INSTRUCTIONS

1. **For timely issue and compensation payments:**
   - Ask all questions and record all answers completely and accurately.
   - Any changes to the information provided must be initialled by the client.
   - Ensure your name and broker code, along with the name of your GA/MGA is clearly marked on the broker's report.
   - Include any unusual details or subjective information you learn about your client in the Broker's Report or a cover memo to accompany the application.
   - You must complete and sign page 6, Broker's Report.

2. **Informal Inquiry** – If your client is a potential or previously substandard/declined risk or anyone over age 65:
   - Submit a fully completed application.
   - Do not arrange for any medical evidence.
   - Do not collect any money.
   - Do not issue the Temporary Insurance Agreement.

   Upon review of the application, we will advise of what evidence is required.

3. **Signatures:**
   - Parent or Guardian must sign any Application where the Proposed Insured is a minor under the age of 16. This includes cases where the applicant is a grandparent.
   - Children over age 16 must sign as the Proposed Insured where another person is taking out coverage on their life.
   - Corporate-Owned coverage – the Proposed Insured must sign by "Signature of Proposed Insured" and a signing officer of the company must sign by "Signature of Owner(s)". This applies even where the Proposed Insured and signing officer are the same.
   - Authorization for Pre-authorized Cheque Plan – This must be signed by the Payor or "Depositor" if other than Proposed Insured.
   - Joint Life – A separate application must be completed for each Proposed Insured.
   - Multi Life – A separate application must be completed for each Proposed Insured.

4. **Health Questions**
   - Questions 14 through 18 must be completed by all applicants.
   - Questions 19 onwards must be completed by all LifeCare applicants. For other applicants, questions 19 onwards may be omitted if a paramedical or medical examination is being arranged.

FOR HEAD OFFICE USE ONLY

112 St. Clair Avenue West, Toronto, Ontario M4V 2Y3
(416) 960-3463 1-800-267-8777 (416) 960-4000
www.unitylife.ca

LONG-E JUN2003

1. **Proposed Insured**

❑ F
❑ M

TITLE FIRST MIDDLE LAST ALTERNATE NAME GENDER

DATE OF BIRTH (M/D/Y) AGE COUNTRY OF BIRTH (**If not Canada, please advise when landed immigrant status was granted**)

ADDRESS STREET CITY PROVINCE POSTAL CODE

HOME PHONE NO. BUSINESS PHONE NO. MOBILE PHONE NO. E-MAIL ADDRESS

SOCIAL INSURANCE NUMBER DRIVER'S LICENCE NO.

OCCUPATION (Please give specific duties) ANNUAL INCOME TOTAL NET WORTH

EMPLOYER & ADDRESS LENGTH OF EMPLOYMENT

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

If the beneficiary predeceases the Insured, the insurance proceeds are payable to the Contingent Beneficiary if any, or to the estate of the owner.

A. The Beneficiary for life coverage is as stated below.
B. The Beneficiary of any children's rider will be the owner of the policy, unless otherwise stated below.
C. For LifeCare Plan/Rider, the beneficiary is the Proposed Insured, unless otherwise stated below.
D. For LifeCare Plan, the beneficiary for Return of Premium on Death is the Owner, unless otherwise stated below.

Type of Coverage (Specify A,B,C,D as above)	**Name**	**Relationship to Insured**	**% Share**	Date of Birth (D/M/Y)	**Revocable or Irrevocable*** (R or I)	**Primary or Contingent Beneficiary** (P or C)

E. Trustee for minor beneficiary

Name: FIRST LAST RELATIONSHIP TO INSURED TO AGE

3. **Owner (if other than Proposed Insured)**

NAME RELATIONSHIP

BILLING ADDRESS (IF DIFFERENT THAN ABOVE) ATTENTION

4. **Insurance Applied For:**

Plan Of Insurance	**Face Amount**	**Premium**
		$
For Preferred Products Only: If the Proposed Insured qualifies for a better class than applied for, please select one of the following: ❑ reduce the premium, or ❑ increase face amount accordingly.		
❑ WP ❑ ADB ❑ Child Rider ❑ Indexing ❑ Other ____________ For LifeCare only: ❑ Juvenile Rider ❑ ROP/RPU Rider		
Dividend Option: ❑ Remain on Deposit ❑ Pay to Owner ❑ Paid up Additions ❑ 1yr Term Additions ❑ Premium Reduction ❑ Other ____________		
❑ Annual ❑ Semi-Annual ❑ PAC Select Withdrawal Date (1st, 8th, 15th and 22nd available) ______ Modal Premium ❑ If VOID cheque attached, draw first premium from stated account.		
Please provide special dating request: ____________	Amount Paid with this Application	**$**

5. **Special Instructions** (include any additional plan or policy information that may be required)

6. **Is the application for temporary insurance being completed?** ❑ Yes ❑ No
Premium CANNOT BE ACCEPTED if the total amount applied for exceeds $500,000 or the life to be insured is age 65 or over, or does not qualify for Temporary Insurance.
Premium CANNOT BE ACCEPTED if this is an informal inquiry.

7. **Insurance Information:** ❑ None OR

Year Issued Pending	Type of Insurance (Life/Critical Illness/Disability)	Company	Amount	ADB Amount	Personal Or Business

8. **Are you replacing existing insurance with this application?** ❑ Yes ❑ No
If "Yes", state company, amount and plan and complete the Comparison Disclosure Statement.

9. **Has any application for life, critical illness or DI insurance on your life ever been:** ❑ Rated ❑ Declined ❑ Modified in any way

If "YES", specify company, date and final decision
If "NO", indicate here ❑

10. **Details of any insurance applied for within the last 12 months** (state company, amount and status): ❑ None

11. **Children's Coverage**

a) Child's Name (First, Middle and Last)	Plan of Insurance	Date of Birth	Gender	Height ❑ ft/in ❑ cm	Weight ❑ lbs. ❑ kg

Complete for ALL children

b) Has any insurance application on any child been declined, postponed or modified in any way? ……………………… ❑ Yes ❑ No

c) Have any of the children been diagnosed with or had any indication of, or treatment for blindness, deafness, cancer, congenital heart disease, juvenile diabetes, kidney failure, paralysis or required an organ transplant?……………… ❑ Yes ❑ No

d) Have any of the children been diagnosed with or had any indication of, or treatment for Autism, Cerebral Palsy, Muscular Dystrophy, Down's Syndrome, developmental or mental retardation, or any other congenital or neurological disorder? ❑ Yes ❑ No

e) Do any of the children have any physical or mental impairment or have they had an illness, impairment or injury other than indicated that has required treatment or operation? ………………………………………………………………………. ❑ Yes ❑ No

f) Are any of the children currently on medication or has any treatment or diagnostic test been advised that has not been completed? ……………………………………………………………………………………………………… ❑ Yes ❑ No

g) Do any of the children reside at a different address from the Proposed Insured? …………………………………..…. ❑ Yes ❑ No

h) Please provide details to all 'yes' answers above, including the name and address of the medical advisor(s).

Child's Name	Question #	Details

12. **Name/address/phone # of usual medical advisor**: ______________________________

Date/reason last consulted ______________________________ No. of years attended ______________

Any treatment or medication given, or recommended? ______________________________ ❑ None

13. Height ____________ Weight ____________ Weight change in past year ______________________ ❑ None

Reason for weight change ______________________________

PLEASE GIVE FULL DETAILS TO ANY QUESTION ANSWERED "YES" IN THE SPACE PROVIDED ON PAGE 4.
(Questions 14 to 18 inclusive must be completed at all times; all questions must be completed for LifeCare applications.)

		YES	NO
14.	Have you used any substance or product containing tobacco, nicotine or marijuana within the past 12 months……………………	❑	❑
	within the past 24 months……………………	❑	❑
	If "YES" , amount used daily ______________________		
15.	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? (If "YES", complete appropriate questionnaire)………………………	❑	❑
16.	Have you had your driver's license suspended or been convicted of 3 or more moving violations in the past ❑ 3 years, ❑ 5 years, ❑ 10 years (If "YES", provide details and indicate Driver's Licence Number) ………………………	❑	❑
17.	Have you ever been charged or convicted of any criminal offense? ………………………	❑	❑
18.	Are you planning to travel or live outside of North America for more than one month? ……………………… (If "YES", give details on frequency, location and length of stay)	❑	❑
19.	Have you ever had, or been told that you had, or received treatment or advice for:		
	a) abnormal blood pressure, coronary artery disease, elevated cholesterol, heart murmur, transient ischemic attack (TIA), stroke or any other disorder or disease of the heart, blood vessels or cardiovascular systems? ………………………	❑	❑
	b) cancer, tumour, polyp or any other growth or malignancy? ………………………	❑	❑
	c) diabetes, thyroid disorder, anemia, hepatitis, or hepatitis carrier state, or any other blood or glandular disorder? …………..	❑	❑
	d) any nose, throat, lung or any other respiratory disorder? ………………………	❑	❑
	e) any disorder of the stomach, intestines, rectum, liver or pancreas? ………………………	❑	❑
	f) any injury to or disease of the bones, muscles, joints, eyes, ears or skin? ………………………	❑	❑
	g) Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease), Motor Neuron Disease, Huntington's Chorea, Multiple Sclerosis, epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system? ………………………	❑	❑
	h) anxiety, depression, chronic fatigue, suicide ideation, or any emotional, behavioural, mental or nervous disorder? …………	❑	❑
	i) abnormal PSA, mammogram, or PAP smear or any disease or disorder of the kidney, bladder, or genital organs or system?	❑	❑
	j) AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, or any other immunological disorder?………………………	❑	❑
20.	Have you at any time been under observation, had medical or surgical advice or treatment, or been hospitalized for any disease or disorder not mentioned above? ………………………	❑	❑
21.	Have any of your immediate family members (father, mother, siblings) had heart disease, stroke, cancer (specify type), diabetes, kidney disease, mental illness, alcoholism, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease), Parkinson's Disease, motor neuron disease, multiple sclerosis, Alzheimer's Disease, or any other hereditary disease?	❑	❑

If yes, complete section below and indicate family member, condition, age at onset and, if applicable, age at death.

Family Member	Age if Living	Age at Death	If Living – Details of any Health Conditions If Deceased – Cause of Death	Age at Onset
Mother				
Father				

		YES	NO
22.	Do you drink alcoholic beverages? (If "YES", indicate weekly quantity and type) ………………………	❑	❑
23.	Have you been treated for or received advice pertaining to your use of drugs or alcohol? ………………………	❑	❑
24.	Have you used heroin, narcotics, barbiturates, psychoactive drugs, cocaine or similar agents? ………………………	❑	❑
25.	Have you requested or received a pension, benefit or payment because of an injury or illness? ………………………	❑	❑
26.	Are you now under observation or taking treatment? ………………………	❑	❑

	YES	NO
27. Are you aware of any symptoms or complaints regarding your health which you have not yet consulted a physician or received treatment or has any treatment been recommended or scheduled which has not yet been completed? ……………….	❑	❑

Details of "YES" answers (Identify question and give FULL details including date, duration, treatment given, tests done, name & address of Dr./hospital etc.)

AMENDMENTS BY THE COMPANY (to be completed by Head Office)
An informal inquiry will only be considered as a regular application for insurance if a policy is issued by the Company.

AGREEMENT AND 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 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 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.

I AGREE AND UNDERSTAND THAT IT MAY BE NECESSARY TO OBTAIN ADDITIONAL PERSONAL INFORMATION IN CONNECTION WITH THIS APPLICATION AND IF SO, I AUTHORIZE UNITY LIFE OF CANADA TO OBTAIN THE USUAL CONSUMER REPORT OR A MOTOR VEHICLE REPORT/DRIVER RECORD.

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 Insured to provide same to the Insurer. A photographic copy of this authorization shall be as valid as the original.

If any payment has been made with this application, the amount of such payment has been accurately recorded in the form of Temporary Insurance Agreement and Receipt included on page 7 of this application booklet, and such form has been dated and signed by the broker and delivered to the undersigned. The undersigned acknowledge(s) that, regardless of the amount of the coverage applied for and the amount of any such payment, **the maximum coverage available as temporary insurance is $500,000 for Life Insurance and $500,000 for Critical Illness Insurance.**

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

Unity Life of Canada will review the application to ensure that the Proceeds of Crime (Money Laundering Act) regulations have been satisfied. In the event they have not been satisfied:

a) this application will be rejected forthwith, and
b) any temporary insurance applied for or issued will be void from inception.

Dated at ________________________ this __________ day of ________________________ , ____________.

____ Signature of Proposed Insured

____ Signature of Owner(s)

____ Witness to all signatures

____ Broker

APPLICATION FOR TEMPORARY INSURANCE (Not available for Informal Inquiries)

No broker or agent is authorized to waive, amend or modify any of the terms or provisions in this Application for Temporary Insurance or in the Temporary Insurance Agreement (TIA). Temporary Insurance will only be given if all of the following questions are answered "No" and will only be valid and enforceable if such answers are true.

To be answered by the Proposed Insured	Yes	No
1. Have you ever been treated for or had any indication, signs/symptoms of cancer, cysts, polyps, tumour, stroke, heart disease, disorder of the immune system, positive HIV test, blood vessel disease, diabetes, elevated blood pressure, chronic kidney, liver, lung or neurological diseases?	❏	❏
2. 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?	❏	❏
3. Has sickness or injury prevented you from performing your regular activities or caused you to be absent from work for more than 7 consecutive days at any time during the last 6 months?	❏	❏
4. Are you age 65 or over?	❏	❏
5. Has any application for insurance on your life ever been rated, declined or modified in any way?	❏	❏
6. 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 Proposed 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 Page 1, but such temporary insurance shall not exceed the amount of $500,000 for Life Insurance or $500,000 for Critical Illness Insurance 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 and payment of at least 1/12 of the annual premium must be paid on that same date. If the Proposed Insured dies by an act of intentional self destruction Unity Life of Canada's liability is limited to a refund of the payment made. There is no coverage under this agreement if the Proposed Insured is diagnosed with any form of cancer or benign brain tumour or the date of any sign/symptom, or any medical consultation or test, that leads to any diagnosis of any form of cancer or benign brain tumour occurs within 90 days of the application for Temporary Critical Illness insurance.

I agree to the terms and conditions of the Temporary Insurance Agreement set out on page 7.

Dated at ________________________ this __________ day of ________________________ , ____________.

____ Signature of Proposed Insured

____ Signature of Owner(s)

AUTHORIZATION FOR PRE-AUTHORIZED CHEQUE PLAN **PLEASE ATTACH A SPECIMEN CHEQUE**

Subject to conditions on Page 7, 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

BROKER'S REPORT (to be fully completed)

1. Have you released the Temporary Life Insurance Agreement? ❑ Yes ❑ No If no, do not detach Temporary Insurance Receipt.
   NOTE: Premium cannot be accepted if the amount exceeds $500,000 for Life or CI, or the life to be insured is age 65 or over, or does not qualify for Temporary Insurance.

2. Please mark requirements requested:
   ❑ Paramedical ❑ Medical ❑ Urine Specimen (including HIV) ❑ Blood Chemistry Profile (BCP)
   ❑ Resting ECG ❑ Stress ECG ❑ Chest X-Ray

   Name and address of Physician or Paramedical Service ______________________

   Date arranged for ______________________

3. An Inspection Report may be conducted for consideration of this application. Please provide:

   Who should be contacted? ______________________ Best time to call ______________________

4. a) Personal finances of Proposed Insured: Net Worth ______________________

   Earned Income ______________________ Unearned Income and Sources ______________________

   b) Business finances (complete only for business insurance): Nature of Business ______________________

   Percentage of business owned by the Proposed Insured __________ How long has this business been operating? __________

   Total Assets $__________ Total Liabilities $__________ Net Worth $__________

   Gross Sales:
   Last Year $__________ Year Before $__________

   Net Income After Taxes:
   Last Year $__________ Year Before $__________

   Are other business owners being insured? ❑ Yes, by (name of carrier) ______________________

   ❑ No. If no, why not? ______________________

   c) Has the Proposed Insured ever declared bankruptcy? ❑ Yes ❑ No Details ______________________

5. If the Proposed Insured is a homemaker, how much is the spouse insured for? ______________________

6. Who initiated this application? ______________________

7. Did you see the Proposed Life/Lives Insured? ❑ Yes ❑ No If no, explain why not ______________________

8. Are you related to the Proposed Insured? ❑ Yes ❑ No

9. How well do you know the Proposed Life/Lives to be Insured? ❑ Just met ❑ Casually ❑ Well

10. Did you complete any Needs Analysis for this Application? ❑ Yes ❑ No

11. Premium Calculations

    Basic Annual Premium $__________
    Total First Year
    Annual Premium $__________

    Annual Policy Fee $__________
    ❑Annual ❑ Semi-Annual
    ❑ Monthly P.A.C.

    Other (specify) $__________
    Amount Paid
    with Application $__________

12. Have you provided the owner(s) with a copy of the policy illustration? ❑ Yes ❑ No

13. **Notes to the Underwriter** (include how amount was determined, comment on special circumstances relevant to the Proposed Insured and include information regarding optionals requested or special quotes)

    ____
    ____
    ____
    ____
    ____

14. I am familiar with the duty of care requirements for agents and brokers and have satisfied them. I certify that I have seen proof of age of the child(ren) covered under this application.

    Name of Broker of Record (please print) ______________________ _______% Code No. __________

    Name of Broker of Record (please print) ______________________ _______% Code No. __________

    Name of General Agent ______________________ Code No. __________

    Signature of Broker(s) of Record______________________ Date: __________

TO BE RETAINED BY CLIENT

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 of Canada 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 of Canada subject to 10 days written notice to the other.
   b) Immediately by Unity Life of Canada, if any cheque is not honoured on presentation, or if Unity Life of Canada 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 included any magnetic or computer produced paper tape that is or purports to be a direction to credit an amount to Unity Life of Canada and to debit such amount to the account indicated on Page 5.

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 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) There is no coverage under this agreement: a) if there is fraud or material misrepresentation in the answers to the Temporary Insurance Agreement questions, the application form, or any other questionnaire completed in connection with the application for insurance; or b) the Proposed Insured suffers a critical illness, death or disability directly or indirectly caused by a drug or alcohol-related condition, or by self-inflicted injury or sickness, while sane or insane; or c) the Proposed Insured is diagnosed with any form of cancer or benign brain tumour or the date of any sign/symptom, or any medical consultation or test, that leads to any diagnosis of any form of cancer or benign brain tumour occurs within 90 days of the application under the critical illness definition; or d) the Proposed Insured is diagnosed with any other defined critical illness and death occurs from this illness within 30 days of the diagnosis.
b) There is no coverage under this agreement if the Proposed Insured is aged 65 or over, or 30 days of age or less.
c) There is no coverage under this agreement if the cheque submitted as payment is not honoured on presentation.
d) No person has the authority to modify or waive any requirements or conditions of this agreement.

AMOUNT OF COVERAGE - $500,000 MAXIMUM FOR EACH OF EITHER LIFE OR CRITICAL ILLNESS APPLICATIONS
If the Proposed Insured dies while this temporary insurance is in effect when applying for Life Insurance, or incurs a Critical Illness while this temporary insurance is in effect when applying for Critical Illness Insurance, the Company will pay, upon approval of a claim, to the designated beneficiary THE LESSER OF (a) $500,000, or (b) the amount of all benefits applied for in the Application, including any accidental or supplemental benefits if applicable. 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 of Canada, 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 GIVE TO THE 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, Ontario M4V 2Y3