P.A.G.E.

Protection for the entire family
Affordable rates
Global coverage
Easy application

HUMANIA ASSURANCE MD®

INSTRUCTIONS FOR THE ADVISOR

- Write legibly in blue or black ink.
- The application must be signed by the person to be insured and the policy owner if other than the person to be insured.
- The application must be dated the day it is signed by the person to be insured.
- You must include a P.A.G.E. sales illustration with this application.
- For replacements, you must include with this application the appropriate replacement forms, completed and signed.
- If the mode of payment is by pre-authorized debit, be sure to complete part 16 (PDA) and attach a **SAMPLE VOID CHEQUE**.
- Be sure to detach **page 17** of this application and leave it with the person to be insured.

❑ P.A.G.E. N° Application:_______________ ❑ Change to P.A.G.E. policy N°:_______________

Depending on the context, masculine includes feminine and the singular includes the plural.

PART 1 – The person to be insured

First name:_______________ middle name:_______________ last name:_______________

Sex (M/F):_______________ Marital Status:_______________ S.I.N.: ___-___-___

Birth: _______________ (Place: province/state/country) D M Y Age

Mailing Address:_______________ Postal code

Residence Address:_______________ Postal code

Residence telephone:_______________ Work telephone:_______________ Language: ❑ French ❑ English

Is the person to be Insured a permanent resident of canada? ❑ Yes ❑ No If no, provide details:

Your current immigration status in Canada _______________ Previous country of residence _______________

Does the person to be Insured speak and/or read english or french fluently ? ❑ Yes ❑ No **If no, please do not proceed with this application.**

PART 2 – Insured Spouse

First name:_______________ Last name:_______________

Sex (M/F):_____ Marital Status:_______ S.I.N.: ___-___-___ Birth: _______________ (Place) D M Y Age

PART 3 – Insured Children

First name	Last name	Sex	Date of birth		
		M/F	D	M	Y

PART 4 – Policyowner (if other than the Principal Insured)

❑ Other (please specify below)

a) First and Last Name:_______________ Relationship to Insured:_______________

b) Sex (M/F):_______________ Date of Birth:_______________ Age:____

c) S.I.N.:_______________

d) Address:_______________ Postal code:_______________

e) Telephone N°:_______________

❑ Company Owned (please specify below)

a) Name of Company:_______________ Relationship to Insured:_______________

b) Incorporation N°:_______________

c) Postal Address:_______________ Postal code:_______________

d) Authorized Signatories:_______________ Title:_______________

_______________ Title:_______________

_______________ Title:_______________

PART 5 – Beneficiary Designation

In the province of Québec, unless specified below, the beneficiary is irrevocable in the case of a spouse related by marriage or civil union and revocable in all other cases.

In Quebec, any amount to be paid to a minor child as beneficiary will automatically be paid in his name to the parent(s) or to its legal tutor.

A. Death Benefit

All death benefits are payable to the Policyowner, or to the estate of the Policyowner, unless otherwise specified below. If the Insured is under age 18, the beneficiary will be the Policyowner, unless otherwise specified below.

If the Policyowner is a company or corporation, any return of premium amount is payable solely to the Policyowner.

Complete name ______________ Date of Birth ______________ Relationship to Insured ______________ % Share______ ❑ Revocable ❑ Irrevocable

Complete name ______________ Date of Birth ______________ Relationship to Insured ______________ % Share______ ❑ Revocable ❑ Irrevocable

B. Premium refund every 15 years or at age 65

All return of premium amounts are payable to the Policyowner, unless otherwise specified below.

Complete name ______________ Date of Birth ______________ Relationship to Insured ______________ ❑ Revocable ❑ Irrevocable

C. Other Benefits

All benefits in case of disability, dismemberment or loss or use, hospitalization, fracture or reimbursement of medical fees are payable solely to the Principal Insured.

If the Principal Insured is under age 18, benefits are payable to the Policyowner.

Nova-Scotia only

I understand that the effect of my designating a beneficiary irrevocably is that, under the provisions of the Insurance Act, while the beneficiary is living, I may not alter or revoke the designation without the consent of the beneficiary and I may not assign, exercise rights under or in respect of, surrender or otherwise deal with the contract without the consent of the beneficiary.

Signature of Policyowner: ______________________________

Signature of Policyowner: ______________________________

PART 6 – Existing Insurance

a) Is there any existing life or disability insurance in force or pending with Humania Assurance or any other company? Yes ❑ No ❑

b) Is this application intended to replace an existing insurance policy or a pending application with Humania Assurance or another insurance company? Yes ❑ No ❑

c) Please give details below of all existing and pending life or disability insurance:

Name of company	Person insured	Type of insurance (life/DI)	Date issued	Total amount of coverage	Replacing Yes	Replacing No
					❑	❑
					❑	❑
					❑	❑

PART 7 – Coverage applied for

If an **illustration signed by the Policyowner** is attached, do not complete this section

❑ Smoker ❑ Non-smoker

	Benefit	Premium
ADMINISTRATION FEE (includes medical certificate)		$________

DISABILITY INSURANCE ❑ Taxable ❑ Non-taxable

	Waiting Period (days)	Benefit	Premium
❑ **Total disability resulting from an accident - non-integrated** ■			
❑ 12 months ❑ 24 months ❑ 5 years ❑ at age 65	________	$________	$________
❑ Partial disability (Waiting period 30 days, benefit period 6 months, benefit amount 50% of total disability)			$________
❑ **Total disability resulting from an accident - integrated (supplemental)** ■			
❑ 12 months ❑ 24 months ❑ 5 years ❑ at age 65 (max. $800)	________	$________	$________
❑ Partial disability (Waiting period 30 days, benefit period 6 months, benefit amount 50% of total disability)			$________
❑ **Total disability resulting from an illness - non-integrated** ●			
❑ 12 months ❑ 24 months ❑ 5 years	________	$________	$________
❑ Partial disability (Waiting period 30 days, benefit period 6 months, benefit amount 50% of total disability)			$________
❑ **Total disability resulting from an illness - integrated (supplemental)** ●			
❑ 12 months ❑ 24 months ❑ 5 years	________	$________	$________
❑ Partial disability (Waiting period 30 days, benefit period 6 months, benefit amount 50% of total disability)			$________

OTHER BENEFITS

		Benefit	Premium
❑ **Hospitalization** ❑ Accident ❑ Accident or illness ●	**Daily benefit**	$________	$________
❑ **Reimbursement of expenses** ❑ Accident ❑ Accident or illness ●			
❑ Individual ❑ Couple ❑ Single parent ❑ Family			$________
❑ **Accidental death or dismemberment** Death benefit ❑ $25,000 ❑ $50,000 ❑ $100,000			
Dismemberment or loss of use benefit up to ❑ $100,000 ❑ $200,000			$________
❑ **Life insurance** ●	**Death benefit**	$________	$________
❑ **Accidental fracture** ❑ Up to $5,000 ❑ Up to $10,000			
❑ Individual ❑ Couple ❑ Single parent ❑ Family			$________
	Sub-total		$________
❑ **Return of premium benefit** ❑ every 15 years ❑ at age 65			$________
❑ **Waiver of premium benefit on the Principal Insured (Not available if disability insurance has been selected)**			$________
	Total premium		$________

NOTICE: Confidential information: reproduction or distribution of this page without written authorization of the persons to be insured is strictly prohibited.

PART 8 – General information Complete only if at least one ■ or ● coverage is chosen

IN THE PAST 5 YEARS:

	Principal Insured Yes	Principal Insured No	Insured Spouse Yes	Insured Spouse No	Insured Children Yes	Insured Children No
a) Have you been the subject of an extra premium, a reduction in coverage, a postponement or a refusal of a policy, a coverage or a reinstatement? If so, indicate the type of insurance, the insurer and dates involved and the reasons given.	❑	❑	❑	❑	❑	❑
b) Do yo drink or did you drink alcoholic beverages? If so, indicate the frequency, type of beverages and quantity per week. ______	❑	❑	❑	❑	❑	❑
c) Do you currently use or have you used drugs or narcotics without a medical prescription? If so, please complete the questionnaire on the use of drugs.	❑	❑	❑	❑	❑	❑
d) Have you been charged with a criminal act, including impaired driving, or has your driving license been suspended? If so, please complete the questionnaire on automobile driving.	❑	❑	❑	❑	❑	❑

e) Insured ______ Height ______ ❑ in ❑ cm Weight ______ ❑ lbs ❑ kg Spouse ______ Height ______ ❑ in ❑ cm Weight ______ ❑ lbs ❑ kg

PART 9 – Medical information Complete only if at least one ● coverage is chosen

HAVE ANY OF THE PERSONS TO BE INSURED:

	Principal Insured Yes	Principal Insured No	Insured Spouse Yes	Insured Spouse No	Insured Children Yes	Insured Children No
1. Suffered an illness or had one of the following health problems in the past five years:						
a Chest pain, palpitations, high blood pressure, stroke (cerebrovascular accident, TIA), heart murmur, heart attack, elevated cholesterol or other heart or blood vessel disorder?	❑	❑	❑	❑	❑	❑
b) Asthma, chronic bronchitis, emphysema, bloody expectorations, tuberculosis, pneumonia or other respiratory disorder?	❑	❑	❑	❑	❑	❑
c) Colitis, ulcer, intestinal bleeding, hernia, gastritis or other disorders of the stomach, gallbladder, liver (hepatitis, cirrhosis), pancreas or intestines?	❑	❑	❑	❑	❑	❑
d) Sugar, albumen, blood or pus in the urine, kidney stones or other kidney, bladder, prostate or genital organ disorder?	❑	❑	❑	❑	❑	❑
e) Diabetes, thyroid or other endocrine disorder?	❑	❑	❑	❑	❑	❑
f) Rheumatism, arthritis, gout or muscle or bone disorders, including sciatica, spine, back and joints?	❑	❑	❑	❑	❑	❑
g) Epilepsy, convulsions, headaches, paralysis, fainting spells, anxiety, depression, chronic fatigue, fibromyalgia, multiple sclerosis, degenerative diseases, neurological problem, or other mental or nervous disorder?	❑	❑	❑	❑	❑	❑
h) Anaemia or other blood disease, cyst, tumour, cancer?	❑	❑	❑	❑	❑	❑
i) Hepatitis B, C, AIDS or positive HIV test?	❑	❑	❑	❑	❑	❑
2. Been aware of any symptoms or diseases for which a physician was not seen or no treatment was received?	❑	❑	❑	❑	❑	❑
3. Plan to consult a physician or other health professional or undergo an operation in the near future? If so, please specify: ______	❑	❑	❑	❑	❑	❑
4. In the last 5 years, consulted a physician or other health professionnal or been hospitalized or admitted to a health care facility? If so, please specify: ______	❑	❑	❑	❑	❑	❑
5. In the last twelve (12) months, have you used tobacco under any form including nicotine substitutes, nicotine products, marijuana or haschisch? If so, indicate the daily consumption and form of tobacco used. ______	❑	❑	❑	❑	❑	❑

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PART 10 – For any questions answered "yes" please provide details below, including the question number, the name of the person concerned and the name of the physician.

PART 11 – Occupational information

a) Occupation/Functions: ______________________ b) Are you presently working? Yes ❑ No ❑

c) In the last 12 months:
How many weeks have you worked?______ How many hours per week? ______What was your net work-related income before taxes?_______

PART 12 – Eligibility for Conditional Insurance

Conditional insurance coverage is in effect provided that the person to be insured has truthfully answered **no** to questions 1 to 4 below and that the age of the person to be insured is from 1 month to 60 years inclusive. If a question below is answered yes or not answered, no coverage takes effect under the Conditional Insurance Agreement.

	Yes	No
1- Have you ever been treated for, consulted a doctor or other health practioner, or had indication of heart or blood vessel disease, suspected heart attack, chest pain, diabetes, cancer or tumor, transient ischemic attack, stroke, chronic kidney disease, disease of the liver or lungs, multiple sclerosis, paralysis, blindness, deafness, loss of speech, loss of limb, coma, serious burns, AIDS or HIV infection?	❑	❑
2- In the past 2 years, has any application for life or disability insurance been rated, declined or modified in any way?	❑	❑
3- In the past 90 days, have you been admitted in a hospital, clinic or other medical facility, or has an admittance been recommended for any reason other than pregnancy?	❑	❑
4- In the past 90 days, have you consulted a doctor or other health practioner, and been told to have a further examination, diagnostic test or surgery which has not been performed, or for which the results are not know?	❑	❑

If you answered no to questions 1 to 4, you are eligible for the conditional insurance as outlined in the Conditional Insurance Agreement.

PART 13 – Identification of the financial advisor

Complete name of service advisor/representative (please print)	Code %	Telephone No.
Complete name of other advisor/representative (please print)	Code %	Telephone No.

COMPENSATION ❑ Level ❑ Accelerated **If no choice is indicate, the accelerated commission shall be paid when this option is available.**

Confirmation of Advisor Disclosure

I hereby confirm that I have provided my client in writing with the necessary information, as outlined in the document entitled "Advisor Disclosure", namely: (a) the company(ies) I represent; (b) my compensation; (c) bonuses and conference incentives; and (d) any potential conflit of interest.

Signature of advisor/representative: ______________________________

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I certify that I have fully explained to the insured the nature and effect of making an irrevocable designation of beneficiary and such explanation was given to the insured not in the presence of the beneficiary and that the insured indicated that he was aware of the irrevocable nature of the designation so made by him.

Signature of advisor/representative: ______________________________

PART 14 – Authorizations and Signatures

I, the undersigned, as the Policyowner or the Insured, declare that the statements, answers and information provided in this application and in any documents which by agreement form part of this application, are complete and true. I understand that any misrepresentation or omission may result in the cancellation of any insurance coverage obtained through this application.

I authorize Humania Assurance Inc., its reinsurers, other insurers, to obtain from any organization or person, any physician or practitioner, hospital, clinic or medically related facility, other insurance or reinsurance companies, MIB Inc., financial institutions, third party investigation agencies, other provincial agencies providing medical care, any personal information, medical history or records on me for the purpose of underwriting my application and for administering any claim. I relieve these parties of their obligation of confidentiality and further authorize them to release the above mentioned information to Humania Assurance, its reinsurers or other insurance companies. I authorize Humania Assurance, its reinsurers, other insurance companies and third party investigation agencies hired by Humania Assurance to acquire personal information about me and to include this information in any other files which they currently hold respecting me or which may be opened in the future. I further authorize Humania Assurance to exchange information about me with its reinsurers and other insurance companies. I also authorize Humania Assurance to refer to any existing files, opened or closed, which they currently hold regarding me.

The present authorizations are valid only for the purposes of this contract, its modification or reinstatement also during the initial evaluation of risk and during the period of contestability. They also apply to any request for payment submitted during the aforementioned period of contestability. The Insurer will be able to dispute any fraudulent declaration beyond the contestable period.

A photographic copy of this signed consent shall be as valid as the original

I acknowledge receiving the pre-notice form describing the procedures of the MIB Inc., the Notice concerning Files and Personal Information and the notice regarding the advisor disclosure statement, and I recognize that I have understood the conditional insurance receipt.

No financial advisor or representative is authorized to modify this application form, the policy or the conditional insurance receipt.

Insurance is a contract based on trust. Failure to fully disclose facts material to this application can render the contract void.

Any policy issued on this application takes effect only upon acceptance of this application by the Insurer, without modification and then only if the first premium is paid in full and there has been no change in the insurability of the proposed insured subsequent to the completion of this application.

Signed at

Signature of Advisor/Representative

Signature of Policyowner

Signature of the person to be insured (If not also the Policyowner)

Signature of spouse to be insured

Date

Signature of Parent or Legal Guardian
(If other than the Policyowner)
(All insured children 14 and over must also sign this application)

PART 15 – General comments

Please provide any information which may assist in underwriting this application or any additional instructions.

PART 16 – Pre-Authorized Debit Agreement (PDA)

THE PRE-AUTHORIZED DEBIT AGREEMENT (PDA)

The Payor named below authorizes Humania Assurance Inc. (Humania Assurance) to make scheduled pre-authorized debits (PDA) on the bank account with the financial institution named below, or any other financial institution that the Payor may later designate, for the purpose of paying the insurance premium in accordance with the premium schedule stipulated in the policy contract, including the initial premium.

THE ACCOUNT

- This Agreement must be signed by all persons whose signature is required to affect withdrawals on the account designated below.
- You must attach a sample cheque marked «VOID». The sample cheque you send to Humania Assurance will serve for all new debits that you may authorize on the account.
- If you wish to change the account on which the PDA is drawn, you must forward a sample cheque for the new account to Humania Assurance.

THE DEBIT

- You must be the designated Policyowner or the Payor of the policy contract and you must be the holder or the account on which the PAD is made.
- You must select a debit date between the 1st and the 28th of the month, inclusively. The debits will be made at this date each month for the duration stipulated in the policy contract.
- You can change the debits instructions provided the premium for the current month is paid or is due at least 10 days after the new date selected.
- The amount of the debit will vary in accordance with the premium as provided for in the policy contract.
- If the amount of the debit should vary, Humania Assurance is not required to provide notification.
- Unless otherwise indicated by you, this Agreement shall be valid for all renewals and conversions of your policy contract.

CANCELLING THIS AGREEMENT

- You can end this Agreement at any time for all policies included in it, by proving 10 days written notice.
- You may obtain further information on your right to cancel a PDA Agreement by visiting the Canadian Payments Association website at www.cdnpay.ca.

THE CONSEQUENCES OF NON-PAYMENT

- You are solely responsible for the consequences of a non-payment and any obligations that it may give rise to under the terms and conditions of the policy contract.
- You are in default of payment when a PDA is not honoured because of non-sufficient funds, closed account or other similar reasons.
- If your financial institution does not honour a debit because of non-sufficient funds, Humania Assurance will debit that amount again with the next monthly debit along with a fee of $25 for each debit not honoured. Humania Assurance may also terminate this Agreement and the annual premium would then be due for all policies covered by this Agreement.
- A notice of «Stop Payment» initiated by you without prior agreement with Humania Assurance for the payment of the premium, may result in the cancellation of all policies covered by this Agreement.

RIGHT TO REIMBURSEMENT

You have certain recourse rights if any debit does not comply with this Agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PDA Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

PART 16 – Pre-Authorized Debit Agreement (PDA) (...continued)

PERSONAL INFORMATION

In establishing your PDA, Humania Assurance will release and exchange with your financial institution only information that is legally required.

BANK ACCOUNT INFORMATION

These services are for ❑ Personnal ❑ Business Use

Name of bank or financial institution

Transit Number | Bank Number | Account Number

Address

City | Province | Postal Code

The financial institution named above is hereby authorized now or at any subsequent time to honour the requests for PDA or fees made by Humania Assurance on the above account, including a redraw within 30 days for any debit that was not honoured the first time it was presented. The Payor named above authorizes Humania Assurance to debit such amounts on another account, as the Payor may direct from time to time, upon oral or written instructions.

Signed at ______________________ this ____________ day of ______________________
(City/Province) (monthly/year)

First Name of Payor (Account Holder) | Name of Payor (Account Holder)

First Name of Second Payor (Account Holder) (if any) | Name of Second Payor (Account Holder) (if any)

Signature of Payor | Signature of Second Payor, if any

ATTACH A SAMPLE VOID CHEQUE HERE (if applicable)

SAMPLE
«VOID»
CHEQUE

PART 17 – Method of Payment

Verification of the individual paying the premiums is required if the premium to be paid to Humania Assurance Inc. is over $10,000. (Documents accepted : birth certificate, driver's licence, passport or citizenship certificate).

Name of payor: ______________________________

Name of document: __________________________ Document number: _________________

In the case of a corporation or an entity that is not a corporation or is acting on behalf a third party, you must attach the applicable form: http://www.humania.ca / Customer Service / Forms / Individual Insurance / Administration / Determination of Persons.

If the amount of payment is $100,000 or more, you must attach the form concerning politically exposed foreign persons (PEFP): http://www.humania.ca / Customer Service / Forms / Individual Insurance / Administration / Determination of Persons.

Monthly pre-authorized debit

❑ Monthly pre-authorized debit **(Complete the Pre-Authorized debit Agreement Part 16.)**

Date of withdrawals (1st to 28th): _________________________

Amount paid with application: $ ______________________________
(Cash Payments or Postal Money orders are not accepted)

Annual payment by cheque

❑ Annual payment by cheque

Amount paid with application: $ ______________________________

PART 17 – Credit Card payment mode

❑ Credit Card payment mode **(Annual or first monthly premium only)**

Authorized debit amount: $ ______________________________

❑ Visa ❑ Master Card

Name of card holder: ____

All payments by credit card will be processed upon receipt of the application at the Head Office of Humania Assurance Inc.

Nº : ______________________________

Credit card number: ____ Expiry: ________________________________

PART 18 – Authorization to release information

No.: ____________________

I authorize any health professional, any public or private health care or social services institution, any insurance company, MIB Inc., financial institutions, personal information agencies or security and investigation agencies, risk and claims data agencies, crime prevention and detection agencies, market intermediaries, or any other person given as a reference, as well as any public or private organisation holding personal information on me, including medical information, to provide and exchange this information with Humania Assurance, its reinsurers and other insurers for the assessment of the risk or the investigation related to any claims examination.

In the event of death, the policyholder, subrogate policyholder, beneficiary, heir or estate liquidator is expressly authorised to supply to Humania Assurance all the information and authorisations required for claims examination and justification purposes.

This authorization is valid for the purposes of the present contract, its amendment, extention or reinstatement.

A photocopy of this agreement has the same value as the original.

Name of proposed Insured

Date of birth

Date

Signature of proposed Insureds
(Children 14 and over must also sign)

PART 18 – Authorization to release information

No.: ____________________

I authorize any health professional, any public or private health care or social services institution, any insurance company, MIB Inc., financial institutions, personal information agencies or security and investigation agencies, risk and claims data agencies, crime prevention and detection agencies, market intermediaries, or any other person given as a reference, as well as any public or private organisation holding personal information on me, including medical information, to provide and exchange this information with Humania Assurance, its reinsurers and other insurers for the assessment of the risk or the investigation related to any claims examination.

In the event of death, the policyholder, subrogate policyholder, beneficiary, heir or estate liquidator is expressly authorised to supply to Humania Assurance all the information and authorisations required for claims examination and justification purposes.

This authorization is valid for the purposes of the present contract, its amendment, extention or reinstatement.

A photocopy of this agreement has the same value as the original.

Name of proposed Insured

Date of birth

Date

Signature of proposed Insureds
(Children 14 and over must also sign)

HUMANIA
ASSURANCE MD®

HUMANIA
ASSURANCE MD®

TO BE DETACHED AND GIVEN TO THE PERSON TO BE INSURED

Right of cancellation

At the Policyowner's request, the policy could be cancelled by submitting a written request and returning the policy to the Insurer within 10 days of its receipt. Any premium paid under the policy will then be refunded to the Policyowner.

Advisor disclosure statement

The transaction represented by this application is between the Policyowner and Humania Assurance Inc. The financial advisor or representative soliciting this insurance application is an independent contractor and will receive compensation from Humania Assurance when the insurance becomes effective. The advisor may also be eligible to receive additional compensation under the form of a bonus, participation at conventions or other incentives. The applicant is not obligated to transact any other business with Humania Assurance as a condition of this application.

MIB Inc. prenotice

The information on your insurability will be kept confidential. However, Humania Assurance Inc., may submit a brief report to MIB Inc, formerly know as the Medical Informaton Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply for life, critical illness or health insurance to another MIB Inc. member company, or if a claim for benefits is submitted to a member company, MIB Inc. will supply, on request, such company with the information in its file. Upon receipt of a request from you, MIB Inc. will arrange a disclosure of any information it may have in your file. If you question the accuracy of information in the MIB Inc. file, you may contact MIB Inc. and seek a correction.

MIB Inc. address is: 300, University Avenue, Toronto (Ontario) M5G 1R7 / Telephone No.: 416 597-0590.

Humania Assurance Inc., may also release information in this file to other insurance companies to which you may apply for life, critical illness or health insurance, or from which you may have claimed benefits.

Conditional insurance agreement

Humania Assurance Inc., agrees to insure the person to be insured for P.A.G.E. from the date this application is completed if the person to be insured qualifies for conditional insurance under the elibibility questions in PART I of the application, and if the person to be insured meets all of the following conditions:

1- All required medical exams have been completed.
2- **The person to be insured has truthfully answered no to all of the elibibility questions in part 12 of the application.**
3- The person to be insured must be insurable without a rating, restrictions, exlcusions, limitations or modification.
4- The age of the person to be insured is between 1 month and less than 60 years old.

There is no fraud or material misrepresentation in this Agreement or non-disclosure in the application forms or the telephone interview questionnaire that would affect our decision to provide insurance or the terms on which we provide it.

The maximum amount payable for life insurance under this Conditional Agreement is limited to the lesser of the amount of life insurance applied for or $25,000.

The maximum amount payable for disability insurance under this Conditional Agreement and any other pending agreements with Humania Assurance is limited to the lesser of the amount of disability insurance applied for or $2,500 and for life insurance $100,000.

There is no coverage under this Agreement if disability or death results from suicide or attempted suicide whether sane or insane, drug or alcohol use or abuse, or while operating a motor vehicle with a blood alcohol level above the legal limit.

The conditional insurance outlined in this Agreement will end on the earliest of the date we mail you a notice informing you that your application for insurance has been declined, or 90 days from the date of your application for insurance.

Humania Assurance may terminate this agreement at any time by notice mailed to the Policyowner at the address indicated on the application form.

NO FINANCIAL ADVISOR OR REPRESENTATIVE IS AUTHORIZED TO MODIFY THIS AGREEMENT.

Notice concerning files and personal information

In order to ensure the confidentiality of the personal information held concerning you, Humania Assurance Inc., will establish a file in which the information concerning your application for insurance and information concerning any insurance claim will be held. Access to this file will be restricted to Humania Assurance employees, reinsurers or mandatories who will be responsible for underwritting, administration, investigation and claims, or any other person designated or authorized by you. Your file will be kept at the Company's head office. Your are entitled to examine the personal information contained in this file and, if required, to have the information corrected by submitting a written request to the address below:

Access to Information Officer, Humania Assurance, 1555, Girouard Street West, Postal Box 10000, Saint-Hyacinthe (Quebec) J2S 7C8

Please be informed that, in the regular process of examining your application, Humania Assurance may request an investigation report to gather information based on personal interviews with your acquaintances. The investigation may cover your reputation, lifestyle and finances. A representative of the company retained to prepare these reports may also visit or telephone you.

Humania Assurance Inc.
1555, Girouard Street West, P.O. Box 10000, Saint-Hyacinthe (Quebec) J2S 7C8
Saint-Hyacinthe: 450 773-6051 / Montreal: 514 866-6051 or 1 888 400-6051
www.humania.ca

PART 19 – Deposit receipt

A deposit does not confer any insurance coverage by virtue of the Conditional Insurance Agreement if any of its conditions are not respected.

No.: ______________________

Received the sum of $____/100 (__________)

As deposit only for an application for P.A.G.E. submitted to Humania Assurance Inc.,
for the Insured ____

and dated on ______________________________ 20__________

Signed at ______________________ on ______________________________ 20_____

____
Signature of advisor/representative