HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

DISABILITY, LIFE AND CRITICAL ILLNESS

Change application

For the advisor

1. Write legibly in blue or black ink.
2. Please attach a copy of your illustration for any increase of Prodige, Term Critical Illness coverage.
   - The application must be signed by the person to be insured and the policyowner if other than the person to be insured.
   - The application must be dated the day it is signed by the person to be insured, or the legal guardian for a minor.
   - Detach **page 7** of this application and leave it with the person to be insured.
3. Exchange right (HuGO)
   - Between the 1st and the 5th anniversary of the policy.
   - The application must be signed by the person to be insured and the policyowner if other than the person to be insured.
   - The application must be dated the day it is signed by the person to be insured, or the legal guardian for a minor.
   - Complete parts 1, 2, 4 and 5.
   - Detach **page 7** of this application and leave it with the person to be insured.
4. In the event that the documents necessary to make the change require a Statement of Good Health Form and a Teleunderwritting Interview, the Statement of Good Health Form is not required.

Part 1 - The Person to be Insured

Policy no.:

Last Name:

First Name: Sex: ☐ M ☐ F

Middle Name:

Phone number:

Date of Birth:
day / month / year

Occupation:

Part 2 - Type of Change Permitted at All Times

Change requested	Document to make the changes
☐ Decrease monthly benefit: From _____ to _____	None
☐ Increase elimination period: From _____ to _____	None
☐ Decrease benefit period: From _____ to _____	None
☐ Exchange right (HuGO) between the 1st and the 5th anniversary of the policy: ☐ The total insured amount ☐ Or part of the insured amount ☐ Amount to exchange: _____ Should the balance of the total amount remain in force? Yes ☐ No ☐	None
☐ Change status from smoker to non-smoker:	Declaration of insurability and tobacco use forms

Part 2 - Type of Change Permitted at All Times (...continued)

Change requested	Document to make the changes
☐ Transformation of Life Insurance:	None
☐ Transformation of Critical Illness	None
☐ Guarantee of benefit amount	Proof of income of the last 2 years Declaration of insurability form *
☐ Cancellation guarantee:	None

Indicate canceled coverages _____

* Humania Assurance reserves the right to request any requirement deemed necessary by underwriting regardless of age, amount or product.

Part 3 - Type of Change Permitted at the Anniversary Date

For Prodige, Term Critical Illness coverage.

Change requested	Document to make the change
☐ Increase face amount:	Teleunderwriting interview *

From _____ to _____

Indicate added coverages: _____

PART 4 - Identification of Financial Advisor

Complete name of service advisor/representative _____

Code ☐☐☐☐☐☐ % ☐☐☐ Telephone No. _____

Complete name of other advisor/representative _____

Code ☐☐☐☐☐☐ % ☐☐☐ Telephone No. _____

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 conflict of interest.

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/she was aware of the irrevocable nature of the designation so made by him/her.

Signature of Representative: _____

PART 5 - Authorizations and Signatures

I, the undersigned, as the Policyowner or the proposed 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 and its teleunderwriting agent, to obtain from any organization or person, any physician or practitioner, hospital, clinic or medically related facility, other insurance or reinsurance companies, the Medical Information Bureau, financial institutions, third party investigation agencies, any personal information, medical history on record on me and my health or my insurability 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 full particulars including prior medical history to Humania Assurance, its reinsurers or other insurance companies. I authorize Humania Assurance, or its reinsurers, to make a brief report of my personal health information to MIB. 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. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period.

A photographic copy of this signed consent shall be as valid as the original. The insurer can contest fraudulent declarations beyond the contestable period. **I acknowledge receiving the pre-notice form describing the procedures of the Medical Information Bureau, the Notice concerning Files and Personal Information and the notice regarding the advisor disclosure statement, and I confirm that I have understood the conditionnal 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 form 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 _____ Province ☐☐ Date _____
(city)

Signature of Representative _____ Signature of Policyowner _____

Signature of Parent or Guardian _____
(if other than the Policyowner/children 14 and over must also sign)

Part 6 - General Comments

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

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

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.

You 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, Saint-Hyacinthe (Quebec) J2S 2Z6.

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.

Notice – Medical Information Bureau

The information on your insurability will be kept confidential. However, Humania Assurance Inc., may submit a brief report to MIB Inc, formerly known as the Medical Information 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: 330, 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.

DETACH HERE

Humania Assurance Inc.

1555 Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6
Web site: www.humania.ca

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