Critical Illness Insurance

Provided by: Specialty Life Insurance

Underwritten by: Chubb Life Insurance Company of Canada ("Chubb Life")

SLI-CIAP-1022

SLi | SPECIALTY LIFE INSURANCE

Critical Illness Insurance

Specialty Life Insurance - 8000 Jane Street, Tower A, Suite 101, Concord ON, L4K 5B8

Proposed Insured

Title ○ Mr. ○ Mrs. ○ Ms. ○ Miss. ○ Rev. ○ Dr.

First Name | Middle Initial | Last Name

Date of Birth (DD/MM/YYYY)

Age of Eligibility: 18 to 69 inclusively

Smoking Status ○ Smoker ○ Non-smoker

Defined as any use of a substance or product containing tobacco, nicotine, or smoking marijuana in the last 12 months.

Sex at Birth ○ Male ○ Female

Street Address | City | Province | Postal Code

Home Telephone | Work Telephone | Mobile Telephone

Email address | Occupation

○ I consent to Specialty Life Insurance and Chubb Life using this contact information to provide me with updates about my insurance coverage. I understand that I may withdraw my consent at any time.

○ I consent to Specialty Life Insurance and Chubb Life sending me information to the email address listed above to promote products and services offered by Chubb Life. I understand that I may withdraw my consent at any time.

Coverage Details

Minimum Coverage: *$5,000.00* **Maximum Coverage:** *$150,000.00*

For amounts higher than $50,000.00 in coverage, please complete the Simplified Issue Questionnaire on page 2.

$ Benefit amount being applied for | $ Premium amount ○ Monthly ○ Annually

Is this insurance policy intended to replace an existing in-force life insurance policy? ○ Yes ○ No

If Yes, please provide details in Special Instructions and attach the applicable Replacement/Comparison Disclosure forms, LIRD forms.

Payment Details

Specialty Life Inc. uses compliant encryption to protect the confidentiality of your personal and banking information.

Payment Method ○ Credit Card ○ PAD (preauthorized debit) Billing Frequency ○ Monthly ○ Annually

Transit Number | Financial Institution | Account number

Withdrawal date requested (1st - 28th)

Following the initial premiums withdrawal, all subsequent premiums will be withdrawn on the date identified above. If no date is selected, the withdrawal date will be the same as the effective date of the policy.

Withdrawals from my account may be for variable premium amounts, as these amounts may change in accordance with my insurance contract. I waive the right to pre-notification at least 10 days before my first PAD. I hereby authorize Specialty Life Inc. and the financial institution designated to make monthly (or annually if selected) automatic withdrawals from my bank account on or about the requested withdrawal date of each month for monthly insurance premiums (or annually if selected) due on or after the date of authorization. The financial institution designated by the payor(s) is authorized now or at any subsequent time to honour any requests made by Specialty Life Inc. to withdraw premium or fees which may include a redraw within 30 days should any withdrawal not clear the account. I waive the right to receive further notice of the amount and date of each automatic withdrawal from my account. I acknowledge that my financial institution may treat any withdrawal pursuant to this authorization as a personal withdrawal as defined by the Canadian Payments Association in Rule H-1. This authorization is to remain in effect until Specialty Life Inc. receives written notification from me of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address of Specialty Life Inc., Head Office. To obtain a sample cancellation form, or to obtain more information on your right to cancel a PAD agreement, contact your financial institution or visit cdnpay.ca. You have certain recourse rights if any PAD 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 PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit cdnpay.ca

Print name of Payor (as it appears on bank records) | Signature of Payor | Date signed (DD/MM/YYYY)

Special Instructions

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Simplified Issue Questionnaire

To be completed for amounts higher than $50,000.00 in coverage.

If you answer NO to all of the below questions, coverage up to $150,000 is available. If you answer YES to any question, coverage up to $150,000 is not available.

For all Simplified Issue Questions, "You" and "Your" refers to the Insured.

1. Have you ever sought advice or received any treatment for, or had any known indication of:

a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery? ○ Yes ○ No
b) Cancer, tumour or malignancy. ○ Yes ○ No
c) Advanced ophthalmic disease. ○ Yes ○ No
d) Multiple sclerosis or paralysis. ○ Yes ○ No
e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation. ○ Yes ○ No
f) AIDS, HIV, chronic or unexplained infections. ○ Yes ○ No

2. In the last 5 years, have you been diagnosed or had any known indication of a medical problem involving:

a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event. ○ Yes ○ No
b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome. ○ Yes ○ No
c) Hospitalized due to a medical problem with respect to severe respiratory disorder? ○ Yes ○ No
d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol? ○ Yes ○ No

3. Have you ever been declined for life insurance or offered coverage only at higher than standard rates? ○ Yes ○ No

4. Have you ever sought advice or received treatment for, or had any known indication of:

a) Advanced loss of hearing? ○ Yes ○ No
b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders? ○ Yes ○ No
c) Any psychiatric disorder, mental deterioration or loss of intellectual ability? ○ Yes ○ No
d) Gout, arthritis, scleroderma, muscular dystrophy, ataxia, systemic lupus erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis? ○ Yes ○ No
e) Amputation due to disease? ○ Yes ○ No

5. Do you currently:

a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift? ○ Yes ○ No
b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ○ Yes ○ No
c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation? ○ Yes ○ No

6. Does your height and weight fall outside the chart noted below? ○ Yes ○ No

Male Height & Weight Chart

Height	Min Weight.	Max Weight.	Height	Min Weight.	Max Weight.
4'8"	95	145	5'8"	132	207
4'9"	98	150	5'9"	137	213
4'10"	100	155	5'10"	141	219
4'11"	103	160	5'11"	145	225
5'0"	106	165	6'0"	150	233
5'1"	108	170	6'1"	155	241
5'2"	111	175	6'2"	160	249
5'3"	114	180	6'3"	165	257
5'4"	118	185	6'4"	170	265
5'5"	121	190	6'5"	175	272
5'6"	124	195	6'6"	180	279
5'7"	128	201	6'7"	185	285

Female Height & Weight Chart

Height	Min Weight.	Max Weight.	Height	Min Weight.	Max Weight.
4'8"	86	145	5'8"	119	207
4'9"	88	150	5'9"	123	213
4'10"	90	155	5'10"	127	219
4'11"	93	160	5'11"	131	225
5'0"	95	165	6'0"	135	233
5'1"	97	170	6'1"	140	241
5'2"	100	175	6'2"	144	249
5'3"	103	180	6'3"	149	257
5'4"	106	185	6'4"	153	265
5'5"	109	190	6'5"	158	272
5'6"	112	195	6'6"	162	279
5'7"	115	201	6'7"	167	285

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Advisor Disclosure

I declare that I am acting as a licensed advisor to sell this product underwritten by Chubb Life and offered by Specialty Life Insurance. It is my duty to disclose any potential conflict of interest to you should any exist. I am remunerated by commissions, either directly or indirectly, by Specialty Life Insurance. Should you require any information regarding my business practices or relationships, please feel free to contact me at:

Agent Phone Number/Email Address

Advisor Report

Is the Advisor related to the Insured? ○ Yes ○ No If Yes, please explain relation:

Commission split: (Please print names)

	Name	%	Code	Signature
Agent 1		%	Code:	Signature:
Agent 2		%	Code:	Signature:

Acceptance Agreements and Declarations

In undertaking this insurance agreement, you agree to and authorize the following:

I confirm that I read and understand English and/or French.

I declare that to the best of my knowledge the answers that I have provided in this application for insurance are true and accurate, and have been correctly recorded and, together with any other forms signed by me in connection with this application for insurance form the basis for any insurance policy being issued.

I understand that any insurance coverage arising from this application for insurance may not be valid if there are any incorrect answers or misrepresentations in the application.

I hereby designate the person or persons named as beneficiary(ies) to receive the proceeds of my insurance upon my death.

I understand that all benefits payable are subject to all the terms, conditions, exclusions and limitations outlined in the policy.

PRIVACY NOTICE: I understand that the information provided by me on this application for insurance and otherwise in respect of my application, is required by Chubb Life Insurance Company of Canada (the "insurer"), its reinsurers and authorized administrators to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions, limitations and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from, and exchange information with third parties. The Insurer will establish a file to which access will be restricted to authorized employees and agents of the insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that, in some instances, the employees, service providers, agents, reinsurers and any of their providers of Chubb Life may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the the date of signing of this application for insurance and understand that such consent will remain in place until such time as I may revoke it.

EFFECTIVE DATE OF COVERAGE: I understand that my insurance coverage becomes effective immediately once my policy is approved/issued and premiums are deducted either annually or on a monthly basis, and the application has been received by Specialty Life Insurance and is honored by me.

I understand that premiums will increase as I get older. I will enter a new premium rate level every 5 years starting at age 25. If I apply just before I am entering a new rate level, the rate that I pay will be guaranteed for the first year of coverage. It is also guaranteed that, if paid continuously and not subject to re-issue, and my rate would increase - it would always be lower than a newly issued policy on the life of an insured at the same age.

I understand that no insurance agent, person, or entity other than Chubb Life is authorized to modify, cancel or waive a question or provision of this applicattion, nor a provision of the contract or other document that is part of the contract. I understand that any notice to or knowledge of an insurance agent is not notice to or knowledge of Chubb Life unless stated in writing and made part of this application.

AUTHORIZATION OF PROPOSED INSURED: I authorize any physician, health care professional, hospital, clinic, or other medical or paramedical establishment, as well as any insurance company, the Medical Information Bureau, a credit agency, and any other organization, institution or person that holds records or information pertaining to me or my health status to exchange such records with Chubb Life or to its reinsurers for claims adjudication purposes. I authorize any coroner, police force, and any other agency that holds information regarding my death to communicate such information to Chubb Life and its reinsurers. I acknowledge that a reproduction of this authorization shall be as valid as the original.

Insured's Name

Signature of Insured

Signed at ____ in ____ on ____

City Province Date Signed (DD/MM/YYYY)