Equitable Life of Canada®

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BASIC LIFE, AD&D, SHORT TERM DISABILITY AND LONG TERM DISABILITY APPLICATION

SECTION A

PLAN SPONSOR

This section to be completed by the Plan Sponsor or Group Plan Administrator/Insurer

Name of Policyholder

Name of Division/Subsidiary or Affiliate where the Plan Member works

Group Policy Number | Division Number | Class

Plan Member's Name (Please Print - First, Middle, Last) ☐ Male ☐ Female

Certificate Number | Occupation | Class

Date Employed Full time (MM/DD/YYYY)

Earnings: $ _____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other _____

If hourly earnings – standard hours worked per week: _____ Billing Sort Code (If applicable): _____

SECTION B

PLAN MEMBER

This section to be completed by the Plan Member

Plan Member's Date of Birth (MM/DD/YYYY)

Plan Member's address:

Street | City | Province | Postal Code

Preferred Language: ☐ English ☐ French

SECTION C

PLAN MEMBER

This section to be completed by the Plan Member

NOTE: If no beneficiary is appointed, the proceeds shall be paid as required by provincial law. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. The insured Plan Member can change the appointed beneficiary at any time.

Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Primary Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

SECTION C (Continued)

PLAN MEMBER

This section to be completed by the Plan Member

If the above Primary Beneficiary(ies) pre-deceases me, to:

Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share
Name of Contingent Beneficiary (first, middle, last)	☐ Male ☐ Female	Relationship to Plan Member:	% Share

NOTE: If both the Primary Beneficiary(ies) and Contingent Beneficiary(ies) are deceased, the proceeds will be paid as required by provincial law. If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note to this form with the beneficiary information.

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. I elect to make my spouse (married or civil union) designation: ❑ Revocable

If the beneficiary is under the age of majority at the time of my death, proceeds of the said policy shall be payable to the following:

Name of Trustee _____ ☐ Male ☐ Female
(Please Print - First, Middle, Last)

Relationship to Plan Member _____

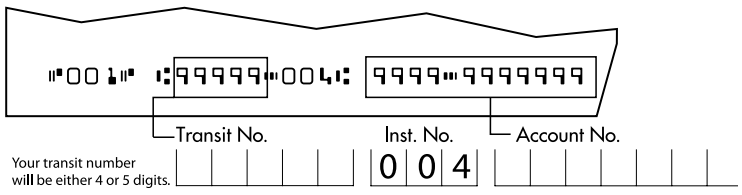
SECTION D

PLAN MEMBER

This section to be completed by the Plan Member

I authorize Equitable Life to deposit Group Claim payments directly into my bank account.

Bank's Name:	
Bank's Address:	
Bank's Phone Number:	Account Number:
Institution Code:	Bank Transit Number:



Please attach a VOID cheque or Stamped bank document to process your direct deposit.

SECTION E

PLAN MEMBER

This section to be completed by the Plan Member

Confirmation of Provincial Health Plan Coverage

I am covered for Provincial Health Plan: ☐ Yes ☐ No

If no, date your Provincial Health coverage will be in effect _____
(MM/DD/YYYY)

The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits there under, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales and distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize. If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I certify that all of the information given on this form is true, correct and complete. I authorize use of my Social Insurance Number (S.I.N.) for identification purposes and designate the beneficiary(ies) stated above.

Date: _____ Plan Members Signature: _____
(MM/DD/YYYY)

IMPORTANT NOTE:
Please keep a copy of this Application for your records. Please follow these instructions carefully.

Section A: To be completed by the Plan Sponsor. Please print.
Please note: information may be inserted by the insurer for data verification purposes.

Section B: To be completed by the Plan Member. Please print.

Section C: To be completed by the Plan Member. Please print.
Beneficiary Designations:

- Indicate the full name an relationship of the Beneficiary(ies) to you in the space(s) provided.
- You have the right to change the Beneficiary at any time; however, where Quebec law applies, the beneficiary designation for your spouse must be designated as revocable to reserve this right.
- If more than one Beneficiary is appointed, proceeds will be payable in equal shares, unless you indicate otherwise.
- If the appointed Beneficiary is under the age of majority, a Trustee of legal age must be appointed. If a Trustee is not appointed, proceeds will be paid as required by provincial law. The full name of the Trustee and relationship to you are required.

NOTE: You cannot appoint yourself as Beneficiary or Trustee.

Section D: To be completed by the Plan Member. Please print.
By providing your banking information and VOID cheque, you are authorizing Equitable Life Insurance company of Canada to deposit Group Claim Payments directly into your bank account.

Section E: To be completed by the Plan Member. Please print.
Please indicate here whether you are covered for the provincial health plan in your province of residence.
If not covered by the provincial health plan, please indicate the date on which you will be covered.