

Face-to-Face Life Insurance and Critical Illness Insurance

Application Form





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Important Instructions for the Advisor

A – For faster issue

1. **Use this form only if you are completing it in person with the person(s) to be insured and the policy owner(s).**
2. Complete ALL questions on the application. Missed questions and/or incomplete answers will result in policy amendments and/or delay the issuance of coverage for your client.
3. PRINT all answers using black or dark blue ink.
4. DETACH the **Privacy and Personal Information – Section 20** and leave with the **Proposed Insured(s)**.
5. An ILLUSTRATION must accompany all applications for universal life insurance and the BMO Insurance Whole Life plan.
6. If PAYOR WAIVER OF PREMIUM is applied for, complete the relevant sections of Section 13.
7. Make sure that all CHANGES to the application are initialled by the person ANSWERING the questions.
8. If there is insufficient space in any section, use the COMMENTS sections. If you require additional space, please attach a separate page with the Proposed Insured(s) signature and current date.
9. Please ensure that all appropriate SIGNATURES have been affixed.
10. With the exception of Section 20 and Section 21, DO NOT remove any Section(s) from this form.

B – Medical questions

Section 12 – Medical Information

Section 12.1 is mandatory on all applications. If medical underwriting requires at least a tele-interview or paramedical, you may elect to NOT complete sections 12.2, 12.3 and 12.4. Do not remove this section.

Medical underwriting requirements are shown on all illustrations generated by The Wave illustration software.

*Medical underwriting requirements can be found in the **Underwriting Guidelines** (form 319E) within the Wave Illustration system and on the Advisor Support internet site at bmoinsurance.com/advisorsupport.*

C – Applying for temporary insurance

Section 16 and Section 21

All of the following conditions must be met before the **Temporary Insurance Agreement and Receipt – Section 21**, may be issued:

1. The Life Insured(s) must complete the questions in the **Application for Temporary Insurance – Section 16**.
2. The completed **Application for Temporary Insurance – Section 16** must be submitted with this Application.
3. The Proposed Life Insured(s) must NOT be over the age of 65.
4. The full premium or part of the premium as outlined in the **Temporary Insurance Agreement and Receipt – Section 21** is paid (post dated cheques are not acceptable).

ONLY COLLECT PREMIUM IF ALL OF THE ABOVE CONDITIONS ARE MET AND ALL QUESTIONS IN THE Application For Temporary Insurance – Section 16 ARE ANSWERED “NO”.



Throughout this application, we, us, our and the Company refer to BMO Life Assurance Company. I, you and your refer to the proposed life insured or the proposed owner.

We use the information in this application to determine whether or not you are eligible for the coverage and to establish the premium rates for the coverage you are applying for. If you misrepresent any facts or the information you provide is not current, correct and complete, we can cancel any policy we have issued on the basis of the information you provided.

Section 1 – Eligibility Questions – Completion is mandatory

1.1 – Understanding the Application Language

1. Do all of the proposed insureds and any policy owner understand the language (English or French) in which this Application for Insurance is written? ☐ Yes ☐ No

If “Yes” proceed to 1.2

2. If “No”, have the details of this Application been fully explained to you in your preferred language and are they completely understood? ☐ Yes ☐ No

If No, please do not proceed with this application.

If “Yes” in Section 11 or Section 14, please describe the steps that were taken to ensure all questions and authorizations in this Application for Insurance were understood.

1.2 – Understanding the Policy Language

1. Language for policy and future correspondence: ☐ English ☐ French

Your insurance policy will be issued in one of Canada’s official languages (English or French, as requested). It is your responsibility to take measures to fully understand the terms and conditions of the policy contract.

1.3 – Declaration for Canadian Residency

1. Are all of the proposed insureds and all of the proposed policy owners a resident of Canada for Canadian income tax purposes? ☐ Yes ☐ No

If No, please do not proceed with this application.

Section 2 – This application is for:

<input type="radio"/> A new policy	<input type="radio"/> a replacement of BMO Insurance policy #
<input type="radio"/> an additional Proposed Insured with Application #	<input type="radio"/> an additional coverage to an existing LifeProvider, policy #



Section 3 – Information about the lives to be insured

3.1 – Proposed Insured 1

First Name		Last Name		Middle Initial	Maiden Name (if applicable)
What is your residency status? <input type="radio"/> Canadian Citizen <input type="radio"/> Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) <input type="radio"/> Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY)					
Date of Birth (DD/MMM/YYYY)		Place of Birth		<input type="radio"/> U.S. (State) <input type="radio"/> Other (Country)	
<input type="radio"/> Canada (Province)					
Sex <input type="radio"/> Male <input type="radio"/> Female	Smoking Class <input type="radio"/> Smoker <input type="radio"/> Non-smoker	Identification Details <input type="radio"/> Driver's Licence Number _____ <input type="radio"/> Other (specify) _____			Expiry Date (DD/MMM/YYYY) _____
Home Address (Street, Apt.)			Number of Years	Mobile Phone Number (Preferred)	
City			Province	Postal Code	Home Phone Number (Optional)
If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence			Email Address – By providing my email, I consent to receiving documents and information about this application electronically.		
Occupation/Duties				Years with Current Employer	
Employer's Name			Type of Business		
Employer's Address (Street, Apt., R.R.)			City	Province	Postal Code

3.2 – Proposed Insured 2 – (To be completed if applying for joint plans or multi coverage)

First Name		Last Name		Middle Initial	Maiden Name (if applicable)
Relationship to Proposed Insured 1					
What is your residency status? <input type="radio"/> Canadian Citizen <input type="radio"/> Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) <input type="radio"/> Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY)					
Date of Birth (DD/MMM/YYYY)		Place of Birth		<input type="radio"/> U.S. (State) <input type="radio"/> Other (Country)	
<input type="radio"/> Canada (Province)					
Sex <input type="radio"/> Male <input type="radio"/> Female	Smoking Class <input type="radio"/> Smoker <input type="radio"/> Non-smoker	Identification Details <input type="radio"/> Driver's Licence Number _____ <input type="radio"/> Other (specify) _____			Expiry Date (DD/MMM/YYYY) _____
Home Address (Street, Apt.)			Number of Years	Mobile Phone Number (Preferred)	
City			Province	Postal Code	Home Phone Number (Optional)
If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence			Email Address – By providing my email, I consent to receiving documents and information about this application electronically.		
Occupation/Duties				Years with Current Employer	
Employer's Name			Type of Business		
Employer's Address (Street, Apt., R.R.)			City	Province	Postal Code



Section 4 – Information about the policy owner(s)

4.1 – Who will own this policy? (Select all that apply)

<input type="radio"/> A. Proposed Insured 1	<input type="radio"/> B. Proposed Insured 2	<input type="radio"/> C. Jointly owned by Proposed Insured 1 and Proposed Insured 2
If you have selected A, B or C, do not complete Section 4.2 and proceed to Section 4.3		
<input type="radio"/> D. Individual(s) other than Proposed Insured 1 or Proposed Insured 2 Proceed to Section 4.2		
<input type="radio"/> E. Corporation, Trust or other Entity Proceed to Section 4.5		

4.2 – Complete if Owner is an individual and not Proposed Insured 1 or Proposed Insured 2

For a sole proprietorship, the Owner will be the individual, or the individual carrying on business as the company

Proposed Owner 1

First Name	Last Name	Middle Initial	Maiden Name (if applicable)
Relationship to Proposed Insured	Date of Birth (DD/MMM/YYYY)	Place of Birth <input type="radio"/> U.S. (State) <input type="radio"/> Canada (Province) <input type="radio"/> Other (Country)	
Sex <input type="radio"/> Male <input type="radio"/> Female	If applying for Payor Waiver of Premium Smoking Class <input type="radio"/> Smoker <input type="radio"/> Non-smoker		
Name of sole proprietorship (if applicable)			
Home Address (Street, Apt.)		Number of Years	Mobile Phone Number (Preferred)
City	Province	Postal Code	Home Phone Number (Optional)
If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence		Email Address – By providing my email, I consent to receiving documents and information about this application electronically.	
Occupation/Duties			Years with Current Employer
Employer's Name		Type of Business	
Employer's Address (Street, Apt., R.R.)		City	Province Postal Code

Proposed Owner 2

First Name	Last Name	Middle Initial	Maiden Name (if applicable)
Relationship to Proposed Insured	Date of Birth (DD/MMM/YYYY)	Place of Birth <input type="radio"/> U.S. (State) <input type="radio"/> Canada (Province) <input type="radio"/> Other (Country)	
Sex <input type="radio"/> Male <input type="radio"/> Female	If applying for Payor Waiver of Premium Smoking Class <input type="radio"/> Smoker <input type="radio"/> Non-smoker		
Name of sole proprietorship (if applicable)			
Home Address (Street, Apt.)		Number of Years	Mobile Phone Number (Preferred)
City	Province	Postal Code	Home Phone Number (Optional)
If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence		Email Address – By providing my email, I consent to receiving documents and information about this application electronically.	
Occupation/Duties			Years with Current Employer
Employer's Name		Type of Business	
Employer's Address (Street, Apt., R.R.)		City	Province Postal Code



4.3 – Multiple owners

This section tells you what happens if one owner dies and other owners and the insured are still alive.

1.	<p>In all provinces, except Quebec – survivorship is the default. This means that on the death of an owner, the interests of the deceased owner will automatically pass to surviving owners.</p> <p><input type="radio"/> Check here to select no survivorship</p> <p>If you select “no survivorship”, the rights of the deceased owner will pass to that owner’s estate, or to the successor owner named in section 4.4.</p>
2.	<p>In the province of Quebec – no survivorship is the default. This means that on the death of an owner, the interests of the deceased owner will pass to his or her estate, or to the subrogated owner named in section 4.4.</p> <p><input type="radio"/> Check here for each owner to name the other owner as subrogated owner.</p> <p>This means that on the death of an owner, the interests of the deceased owner will automatically pass to surviving owners. <i>You do not need to complete Section 4.4.</i></p>

4.4 – Successor owner (Subrogated owner in Quebec)

Complete if ownership rights of a deceased owner will pass to the person named below. If no successor owner is named, the rights of the deceased owner will pass to that owner’s estate.

Owner 1	Successor Owner (first, middle, last)	Relationship to Owner
Owner 2	Successor Owner (first, middle, last)	Relationship to Owner

4.5 – Complete if Owner is a Corporation, Trust or other Entity

Legal Name			
Trade Name (if applicable)			
Relationship to Proposed Insured			
Business Address (Street, Apt., R.R.)	City	Province	Postal Code
Contact Name		Mobile Phone Number (Preferred)	
Email address - By providing my email, I consent to receiving documents and information about this application electronically.		Business Phone Number (Optional)	

4.6 – Mailing information

We will mail all correspondence to the Owner unless otherwise directed below:

Contact Name			
Address (Street, Apt., R.R.)	City	Province	Postal Code



Regulatory Verification of Identity and Tax Reporting

4.7 – Regulatory Verification of Identity and Tax Reporting

PCMLTFA – The Proceeds of Crime (Money Laundering) and Terrorist Financing Act is designed to help detect and deter money laundering and the financing of terrorist activities. BMO Insurance and its contracted independent advisors have accountabilities to comply with the Act and for risk management purposes require policy owner: Verification of identity, Third Party Determination, Politically Exposed Foreign Persons determination, Source of payment and Intended use of policy

FATCA – Foreign Account Tax Compliance Act - The automatic exchange of financial account information with the United States (U.S.) currently exists under the Foreign Account Tax Compliance Act (FATCA) which was implemented July 1, 2014. There is a requirement to identify, document and report on the tax jurisdiction of clients (policy owners) in the U.S.

CRS – Common Reporting Standard (CRS) – Expanding the foundation laid with FATCA by extending requirements to identify, document and report on the tax jurisdiction of clients (policy owners) in multiple countries (other than the U.S.). CRS legislation came into effect July 1, 2017.

Based on the Plan Name you select in Section 5.1, you are required to complete the following sections, and, in some cases, you are required to complete and submit additional forms with this application.

Complete 4.7.1, 4.7.2 if

- the policy owner(s) is an individual, and
- you are applying for universal life insurance or the BMO Insurance Whole Life plan with Additional Payment Option (APO) elected.

4.7.1 – PCMLTFA for individual (non-entity) owners – Verification of Identity

The Advisor must be physically present with the policy owner(s), and must view an original, valid and current Canadian or foreign equivalent government issued Photo ID.

NOTE: The Advisor must complete form 798E, Dual Process Verification of Identity, for any owner who is not physically present when this application is completed.

Photo identification - Proposed Owner 1

<input type="radio"/> Passport <input type="radio"/> Driver's Licence <input type="radio"/> Provincial ID Card <input type="radio"/> Other (specify)			
Country of Issue	Place of Issue	Document #	Expiry Date (DD/MMM/YYYY)
Are you an intermediary or "gatekeeper" such as a Lawyer, Accountant, Real Estate Broker or Certified Trust & Financial Advisor that holds accounts for clients?			
<input type="radio"/> Yes <input type="radio"/> No			

Photo identification - Proposed Owner 2

<input type="radio"/> Passport <input type="radio"/> Driver's Licence <input type="radio"/> Provincial ID Card <input type="radio"/> Other (specify)			
Country of Issue	Place of Issue	Document #	Expiry Date (DD/MMM/YYYY)
Are you an intermediary or "gatekeeper" such as a Lawyer, Accountant, Real Estate Broker or Certified Trust & Financial Advisor that holds accounts for clients?			
<input type="radio"/> Yes <input type="radio"/> No			

4.7.2 PCMLTFA for individual (non-entity) owners – Politically Exposed Foreign Persons determination

Additional form required and must be submitted:

If this application has an initial payment of \$100,000 or more and is for universal life insurance or the BMO Insurance Whole Life plan with the Additional Payment Option (APO) elected	Politically Exposed Foreign Persons Questionnaire, 420E
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Regulatory Verification of Identity and Tax Reporting (continued)

Complete 4.7.3 if

- the policy owner is an individual, and
- you are applying for universal life insurance or the BMO Insurance Whole Life plan.

4.7.3 – FATCA and CRS Self-certification for individual (non-entity) owners

Proposed Owner 1

Social Insurance Number (SIN)				-				-			
Are you a tax resident or a citizen of the United States of America? (FATCA)	<input type="radio"/> No <input type="radio"/> Yes – Provide TIN (Taxpayer Identification Number)										
Are you a tax resident of any country other than Canada or the United States of America? (CRS)	<input type="radio"/> No <input type="radio"/> Yes – Provide TIN (Taxpayer Identification Number)										
Country											

Proposed Owner 2

Social Insurance Number (SIN)				-				-			
Are you a tax resident or a citizen of the United States of America? (FATCA)	<input type="radio"/> No <input type="radio"/> Yes – Provide TIN (Taxpayer Identification Number)										
Are you a tax resident of any country other than Canada or the United States of America? (CRS)	<input type="radio"/> No <input type="radio"/> Yes – Provide TIN (Taxpayer Identification Number)										
Country											

Complete 4.7.4 if

- the policy owner is an entity (corporate, trust, etc.), and
- you are applying for universal life insurance or the BMO Insurance Whole Life plan.

4.7.4 – PCML and FATCA/CRS Self-certification for entity (corporate, trust, etc.,) owners

Additional form required and must be submitted:

If this application is for universal life insurance or the BMO Insurance Whole Life plan with the Additional Payment Option (APO) elected	Entity Verification, 715E
If this application is for the BMO Insurance Whole Life plan and you have NOT elected the Additional Payment Option (APO).	Declaration of Tax Residence for Entities, RC519E

Complete 4.7.5 if

- the policy owner(s) is an individual or an entity (corporate, trust, etc.), and
- you are applying for universal life insurance or the BMO Insurance Whole Life plan with Additional Payment Option (APO) elected.

4.7.5 – PCMLTFA - Third Party Determination

For the purpose of this section a “Third Party” is a person (Individual or company or organization) other than the proposed owner(s) of this contract that pays for the contract, have use of, or access to, the contract value. Example of a Third Party: Payor, Executor, Power of Attorney.

1	Is the policy owner(s) acting on behalf of or at the instruction of a Third Party <input type="radio"/> Yes <input type="radio"/> No		
2	Is someone other than the policy owner contributing funds to the policy, or now has or will in the future have use of the policy or access to its values <input type="radio"/> Yes <input type="radio"/> No		
3	If you answered “Yes” to either of the above questions, complete the following:		
	Is the Third Party an <input type="radio"/> Individual OR <input type="radio"/> Company, Trust or other Entity (If Company, Trust or other Entity, complete form 715E, Entity Verification)		
	Name of Third Party (individual, company, trust or other entity)	If individual, date of birth (DD/MMM/YYYY)	Relationship of Third Party to the Owner of this policy
	Type of Identification	Identification Number	Province of Issue Country of Issue
	Address of Third Party		
	Telephone Number	Principal Business and Occupation of Third party	
4	<input type="radio"/> I am unable to determine Third Party Ownership, however I have reasonable grounds to suspect there is a Third Party		



Section 5 – Plan Details

Please check one: ☐ Illustration attached ☐ No Illustration Completed *(You must submit a signed illustration with every application for universal life and the BMO Insurance Whole Life plan.)*

Please select a Policy Date: ☐ Current date OR
☐ Date to save age for:
☐ Proposed Insured 1
☐ Proposed Insured 2

5.1 – Single Life Options

Product Type	Proposed Insured 1	
	Plan Name	Face Amount
Universal Life	<input type="radio"/> Life Dimensions <input type="radio"/> Life Dimensions (Low Fees) <input type="radio"/> Wealth Dimensions	\$
Term Life	<input type="radio"/> Term 10 <input type="radio"/> Term 15 <input type="radio"/> Term 20 <input type="radio"/> Term 25 <input type="radio"/> Term 30	\$
Whole Life	<input type="radio"/> Term 100	\$
Whole Life	<input type="radio"/> Estate Protector <input type="radio"/> Wealth Accelerator <input type="radio"/> 10 Pay <input type="radio"/> 20 Pay <input type="radio"/> Pay to 100	\$
Critical Illness	<input type="radio"/> LB10 <input type="radio"/> LB20 <input type="radio"/> LB75 <input type="radio"/> LB100 <input type="radio"/> LB100 – 15 PAY	\$

5.2 – Joint Plans/Multi Coverage Options

Product Type	Plan Name	Coverage Type	Face Amount
Universal Life	<input type="radio"/> Life Dimensions <input type="radio"/> Life Dimensions (Low Fees) <input type="radio"/> Wealth Dimensions	<input type="radio"/> Joint First-to-Die <input type="radio"/> Joint Last-to-Die <input type="radio"/> Multi-Coverage	\$
Term Life	<input type="radio"/> Term 10 <input type="radio"/> Term 15 <input type="radio"/> Term 20 <input type="radio"/> Term 25 <input type="radio"/> Term 30	<input type="radio"/> Joint	\$
Whole Life	<input type="radio"/> Term 100	<input type="radio"/> Joint First-to-Die <input type="radio"/> Joint Last-to-Die <input type="radio"/> Multi-Coverage	\$
Whole Life	<input type="radio"/> Estate Protector <input type="radio"/> Wealth Accelerator <input type="radio"/> 10 Pay <input type="radio"/> 20 Pay <input type="radio"/> Pay to 100	<input type="radio"/> Joint Last-to-Die	\$

5.3 – Additional Benefits and Riders

Rider	Proposed Insured 1	Face Amount	Proposed Insured 2	Face Amount
Waiver of Premium Benefit	<input type="radio"/>		<input type="radio"/>	
Term Rider	<input type="radio"/> Term 10 <input type="radio"/> Term 15 <input type="radio"/> Term 20 <input type="radio"/> Term 25 <input type="radio"/> Term 30	\$	<input type="radio"/> Term 10 <input type="radio"/> Term 15 <input type="radio"/> Term 20 <input type="radio"/> Term 25 <input type="radio"/> Term 30	\$
Accidental Death Benefit	<input type="radio"/>	\$	<input type="radio"/>	\$
Children's Term Rider	<input type="radio"/>	\$	<input type="radio"/>	\$
Critical Illness Rider	<input type="radio"/> LB10 <input type="radio"/> LB20 <input type="radio"/> LB75 <input type="radio"/> LB100	\$	<input type="radio"/> LB10 <input type="radio"/> LB20 <input type="radio"/> LB75 <input type="radio"/> LB100	\$
Return of Premium Rider	<input type="radio"/> ROPS15 <input type="radio"/> ROPS20 <input type="radio"/> ROPS65 <input type="radio"/> ROPX <input type="radio"/> ROPD		<input type="radio"/> ROPS15 <input type="radio"/> ROPS20 <input type="radio"/> ROPS65 <input type="radio"/> ROPX <input type="radio"/> ROPD	
Other (specify)		\$		\$

5.4 – Request for Optional Policy

<input type="radio"/> Proposed Insured 1	<input type="radio"/> Required illustration attached	<input type="radio"/> Proposed Insured 2	<input type="radio"/> Required illustration attached
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Section 6 – Beneficiary Information

If you are applying for life insurance coverage

- Complete all applicable sections.

If you are applying for critical illness insurance coverage

- Proceeds from any critical illness living benefit, including Critical Illness Benefit, Early Discovery Benefit, Return of Premium on Surrender Benefit Rider, if applied for and the Return of Premium on Expiry Benefit Rider, if applied for, will be paid to the owner of the policy unless a beneficiary has been named or a direction to pay has been completed and is on file.
 - Beneficiaries may be designated in Section 6.1, 6.2 and 6.3 for applications signed and the policy issued in any of the following provinces: Alberta, British Columbia, Manitoba, Ontario or Quebec.
 - The Direction to Pay for Critical Illness Policies form 630E can be completed for applications signed and policies issued in any other province or territory in Canada.
- Proceeds from any critical illness death benefit, including Return of Premium on Death Benefit (ROPD) Rider will be paid to the Insured's estate unless a beneficiary has been designated in Section 6.3.

Revocable and irrevocable beneficiaries

There are two types of beneficiaries: revocable and irrevocable

- A beneficiary designation is considered revocable, unless you make it irrevocable. This will allow the policy owner to change their beneficiary designation at any time without the current beneficiary(ies) consent.
- If you name a beneficiary as irrevocable, your ability to deal with the policy is limited. For example, you cannot change the beneficiary without their consent, unless permitted by law. You may also need the irrevocable beneficiary's consent to deal with the policy, e.g., surrender, assign, and transfer ownership.
- In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless otherwise stated.
- A minor child or your estate cannot give consent to make any changes on the policy if they are designated as an irrevocable beneficiary.
- A minor irrevocable beneficiary cannot consent to change of beneficiary and a parent guardian may not sign on behalf of a minor child for this purpose.

Payment of benefits when the beneficiary is a minor

- Except where Quebec law applies, we will pay benefits to the trustee for the minor beneficiary, if you have named one. If no trustee is named, we will make the payment as the law requires.
- Where Quebec law applies, we will pay the parent(s) of the minor beneficiary or Tutor duly appointed in law.

Multiple and contingent beneficiaries

- You can name a beneficiary "primary" or "contingent" ("subrogated" in Quebec).
- If you name more than one beneficiary, indicate the share of each beneficiary; otherwise they will share the benefit equally.
- Benefits will first be paid to all living primary beneficiaries. If a primary beneficiary dies before you, their share of the benefits will be paid equally to the surviving primary beneficiaries unless you state otherwise, or the law provides otherwise.
- If all primary beneficiaries die before you, the benefits will be paid equally to the contingent beneficiary(ies) unless you state otherwise.
- If no beneficiary is alive when the benefits become payable, the benefits will be paid to the policy owner if other than the life insured, otherwise the policy owner's estate.
- If a beneficiary is disqualified from receiving the benefits for any reason, that beneficiary will be treated as if he/she died before you and the benefits will be dealt with in accordance with the law.

6.1 – Primary beneficiaries (share of benefits must add up to 100%)

If not completed, any beneficiary will be the proposed owner or the estate of the proposed owner

Legal Name (first, middle initial, last or Corporate/entity name)	Relationship to Proposed Insured 1 (in Quebec, relationship to the Proposed Owner)	Date of Birth for Minor Beneficiary (DD/MMM/YYYY)	Beneficiary designation	% share of benefits to be paid
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%

Legal Name (first, middle initial, last or Corporate/entity name)	Relationship to Proposed Insured 2 (in Quebec, relationship to the Proposed Owner)	Date of Birth for Minor Beneficiary (DD/MMM/YYYY)	Beneficiary designation	% share of benefits to be paid
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%



6.2 – Contingent beneficiaries

Legal Name (first, middle initial, last or Corporate/entity name)	Relationship to Proposed Insured 1 (in Quebec, relationship to the Proposed Owner)	Date of Birth for Minor Beneficiary (DD/MMM/YYYY)	Beneficiary designation	% share of benefits to be paid
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%

Legal Name (first, middle initial, last or Corporate/entity name)	Relationship to Proposed Insured 2 (in Quebec, relationship to the Proposed Owner)	Date of Birth for Minor Beneficiary (DD/MMM/YYYY)	Beneficiary designation	% share of benefits to be paid
			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	%

6.3 – Critical Illness Riders and Other Riders

	Legal Name (first, middle initial, last or Corporate/entity name)	Relationship to proposed life insured (in Quebec, relationship to the Proposed Owner)	% share of benefits to be paid
Critical Illness Rider			%
Critical Illness Return of Premium on Surrender Benefit Rider (ROPS)			%
Critical Illness Return of Premium on Expiry Benefit Rider (ROPX)			%
Critical Illness Return of Premium on Death Benefit Rider (ROPD)			%
Other, Please Specify			%

6.4 – Trustee for minor beneficiary designations

- Complete when a minor beneficiary has been named (Under the age of 18)
- In all provinces other than Quebec, if you designate minor children as beneficiaries, you should also name a trustee to receive funds on their behalf.
- In Quebec, any amount payable to a minor beneficiary during their minority will be paid to the parent(s) or a Tutor duly appointed in law.

Primary beneficiaries: I appoint	
Contingent beneficiaries: I appoint	
Return of premium on death benefit payee: I appoint	

as a trustee to receive any payments on behalf of any named minor beneficiary during their minority.

Section 7 – Purpose of Insurance and Source of Payment

Completion is mandatory.

7.1 – Purpose of Insurance

1. Purpose of Insurance	<input type="radio"/> Income Replacement <input type="radio"/> Key Person <input type="radio"/> Buy Sell <input type="radio"/> Personal <input type="radio"/> Other (specify)
2. Is there an existing or planned agreement that provides for anyone other than Proposed Insured 1, Proposed Insured 2 or Owner identified in Section 4, (Third Party) to obtain any legal interest, pay the premiums or have an ownership interest in any policy resulting from this application?	<input type="radio"/> Yes <input type="radio"/> No (If “Yes” provide details)

7.2 – Source of Payment (Select all that apply)

<input type="radio"/> Self-employment income	<input type="radio"/> Employment income	<input type="radio"/> Retirement Income/Pension Income	<input type="radio"/> Grants/Scholarships
<input type="radio"/> Insurance Claim Payments	<input type="radio"/> Corporate	<input type="radio"/> Investment Income/Savings	<input type="radio"/> Sale of Assets
<input type="radio"/> Trust/Inheritance	<input type="radio"/> Gift	<input type="radio"/> Loan	<input type="radio"/> Lottery Winnings
<input type="radio"/> Proceeds from a legal case or action	<input type="radio"/> Other (specify)		



Section 8 – Financial Information
8.1 – Financial details (Completion is mandatory)

Description	Proposed insured 1	Proposed insured 2	Owner (to be completed only if the Owner is not the Proposed Insured)
1. Total Assets	\$	\$	\$
2. Total Liabilities	\$	\$	\$
3. Net Worth	\$	\$	\$
4. Annual Earned Income	\$	\$	\$
5. Unearned Income	\$	\$	\$
Specify source of unearned income			
6. If not gainfully employed, what is the gross amount of the family income?	\$	\$	\$
7. If not gainfully employed, what is the amount of in force insurance on the working spouse?	\$	\$	\$

8.2 – To be completed if applying for business insurance

1. Full Legal Name of Business (including Company, Limited, Inc., etc.)			
2. Business Number		3. Type of Business <input type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Proprietorship	4. Nature of the Business
5. Fair Market Value \$	6. Net Profit After Taxes Last Year – \$	7. Net Profit After Taxes Year Before – \$	8. Percentage Ownership of Business %
9. Details of Business Insurance on other members of business		10. How was the amount of insurance determined?	

Section 9 – Insurance History

Please provide details for “Yes” answers in space provided, and if necessary in Comments Section.

		Proposed Insured 1	Proposed Insured 2
1	Do you have in force or pending any of the following: Life Insurance, Critical Illness Insurance, Disability Insurance or Long Term Care Insurance? (If “Yes” complete table below.)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2a	Is this Insurance intended to replace or change any existing Life Insurance or Critical Illness Insurance with BMO Insurance or any other company? If “Yes” to 2a, and you are applying for Life Insurance, your advisor must provide you with a written analysis of the advantages and disadvantages of the proposed replacement. The Replacement Forms or Life Insurance Replacement Declaration (LIRD) must be submitted to Head Office with this application.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2b	If this insurance applied for will replace an existing BMO Insurance policy, does the owner of the existing policy instruct BMO Insurance to cancel such policy on issuance of the policy applied for herein? If “Yes” to 2b, include the policy number to be cancelled here and submit a signed letter of direction or submit the completed Request to Cancel or Surrender Your Policy, form 747E.:	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3	Has any Application or re-instatement for Life, Critical Illness, Long Term Care or Disability Insurance ever been declined, rated, postponed, cancelled, rescinded or modified in any way? (If “Yes” provide details in Comments section)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

	Company	Type of Insurance Plan	Personal Amount	Business Amount	Yr. Issued (if in force) or Yr. submitted (if pending)
Proposed Insured 1			\$	\$	
			\$	\$	
			\$	\$	
Proposed Insured 2			\$	\$	
			\$	\$	
			\$	\$	

If the Proposed Insured is under the age of 16, the following table must be completed.

4	Indicate the total amount of in force life insurance on the parent(s)/legal guardian(s) and siblings of the minor child.	
	Parent/Legal Guardian \$	Parent/Legal Guardian \$
	Sibling \$	Sibling \$



Please provide details for "Yes" answers in space provided, and if necessary in the Comments Section below.

Section 11 – Comments



Section 12 – Medical Information

Section 12.1 is mandatory on all applications. If medical underwriting requires at least a tele-interview or paramedical, you may elect to NOT complete sections 12.2, 12.3 and 12.4.

12.1 – Physician

If you need more space use the Comments Section on page 11.

Details	Proposed Insured 1	Proposed Insured 2
1. Name of Personal Physician and any specialist consulted and/or referred to		
2. Physician's Address		
3. Physician's Phone Number		
4. Date of last consultation (DD/MMM/YYYY)		
5. Reason for last consultation		
6. Treatment or Medication prescribed		
7. Results		

12.2 – Height and weight

Details	Proposed Insured 1	Proposed Insured 2
1. Height	<input type="radio"/> cm <input type="radio"/> ft/in	<input type="radio"/> cm <input type="radio"/> ft/in
2. Weight	<input type="radio"/> kg <input type="radio"/> lbs	<input type="radio"/> kg <input type="radio"/> lbs
a) In the past year	<input type="radio"/> Same <input type="radio"/> Gain <input type="radio"/> Loss	<input type="radio"/> Same <input type="radio"/> Gain <input type="radio"/> Loss
b) How much weight change?	<input type="radio"/> kg <input type="radio"/> lbs	<input type="radio"/> kg <input type="radio"/> lbs
c) Reason for change		
3. If the proposed insured is less than 6 months old, weight at birth	<input type="radio"/> kg <input type="radio"/> lbs	<input type="radio"/> kg <input type="radio"/> lbs

12.3 – Medical history

If additional space is required, please attach a separate page with the proposed insured's signature and current date.
Please circle the applicable disorder if any. Please provide details for "Yes" answers in space provided below.

		Proposed Insured 1	Proposed Insured 2
1	Are you now under medical observation or are you receiving or been recommended to receive any type of medication, treatment or therapy, or have you ever been advised to have, any pending test, investigation, hospitalization or surgery, which was not completed?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2	Have you ever had or been told you had, or are you aware of any symptoms or complaints or had any known indication of, disease or disorder of, or received treatment or advice for:		
	a) Elevated cholesterol, high blood pressure, chest pain, heart murmur, palpitations, rheumatic fever, phlebitis, varicose veins or other disorders of the heart and blood vessels, abnormal ECG, Angina, cerebrovascular disease (CVA), coronary bypass surgery, transient ischemic attack (TIA), stroke, peripheral vascular disorder, any cardiac procedure, heart attack?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	b) Epilepsy, fainting, dizziness, convulsions, optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Paralysis, Cerebral Palsy, Down's Syndrome or any other neurological disease?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	c) Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	d) Chronic Kidney Disease, Diabetes, Cancer, tumour or other growth?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	e) Arthritis, neuritis, sciatica, fibromyalgia, lupus or other disorder of the back, muscles, bones or joints?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	f) Anemia, gout, lymph glands, allergies, skin disorders, thyroid, unusual bleeding or other endocrine disorders?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	g) Ulcer, hernia, colitis, gallstones, jaundice, hepatitis (including hepatitis carrier), Crohn's disease or other disorders of the stomach, liver, pancreas, or intestines?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	h) Kidneys, bladder, genitals, including sugar, blood, pus or protein in urine, kidney stones, prostate, venereal disease, reproductive disorders, any disease or disorders of the breasts - including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	i) Asthma, bronchitis, emphysema, pleurisy, pneumonia, tuberculosis, sleep apnea, shortness of breath, chronic cough or other disorders of the nose, throat or lungs?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	j) Anxiety, stress, "burnout", depression, fatigue, chronic fatigue, suicide ideation or an emotional, behavioral, mental or nervous disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	k) The eyes, ears or throat including loss of speech?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3	Have you ever had or been recommended to have a Computer Tomography Scan (CT Scan) including a coronary calcium scan or Magnetic Resonance Imaging (MRI) and/or any other diagnostic testing not mentioned above?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No



12.3 – Medical history (*continued*)

If additional space is required, please attach a separate page with the proposed insured's signature and current date.
Please circle the applicable disorder if any. Please provide details for "Yes" answers in space provided below.

		Proposed Insured 1	Proposed Insured 2	
4	a) Have you had any symptoms of or treatment for any medical condition that resulted in hospitalization (other than normal childbirth) within the past 2 years?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	b) Have you been absent from work for more than 7 days within the last 6 months because of sickness or injury? (If Yes, state reason and duration)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	c) Have you been absent from work for more than a two week period due to disability within the past two years? (If Yes, state reason and duration)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
5	Do you drink alcoholic beverages? (If Yes, indicate type and frequency)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
6	Have you received treatment or been advised to seek treatment or medical advice due to the use of drugs or alcohol? (If Yes, complete the appropriate Drug Usage or Alcohol Usage Questionnaire.)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
7	In the last 10 years, have you used any habit forming drugs including, but not limited to cannabis, cocaine, ecstasy, LSD, methamphetamine, mushrooms, or any other narcotics? (If Yes, complete the Drug Questionnaire.)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
8	Other than as already disclosed, within the past five years, have you:			
	a) Consulted a Physician, Chiropractor, Therapist or Health Care Worker?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	b) Been a patient in a hospital, clinic or other medical facility?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	c) Had, or been advised to have, any hospitalization or pending test or investigation or surgery which was not completed?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	d) Had an electrocardiogram, x-ray, blood test or other diagnostic test?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	e) Had any mental or physical diseases or disorders not listed above?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	f) Been aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
9	Provide details below for MEDICAL HISTORY question(s) (1-8) to which you answered "Yes".			
	Question no.	Name of Proposed Insured	Name of Physician (if Different from Section 12.1)	Details (Including relevant dates, treatments, symptoms, referrals and results)

12.4 – Family history

		Proposed Insured 1	Proposed Insured 2					
1	Have your parents, brothers or sisters had cancer, high blood pressure, heart or kidney disease, polycystic kidney disease, diabetes, mental or nervous disorder (including Alzheimer's Disease), stroke, multiple sclerosis, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Parkinson's Disease or any other hereditary disorders?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No					
2	If you answered 'Yes' to question 1, provide details below of FAMILY HISTORY for all parents, brothers and sisters. If diagnosis or cause of death was cancer or cancer related, please specify the type(s) of cancer.							
	Proposed Insured 1	Proposed Insured 2	Relationship to Proposed Insured	Disease or disorder, if any	Age if Living	Age at Onset	Cause of Death	Age at Death
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						



Section 13 – Children’s Term Rider and Payor Waiver of Premium

☐ Children’s Term Rider*

☐ Payor Waiver of Premium on ☐ Proposed Owner 1 OR ☐ Proposed Owner 2

*To be completed on behalf of all children applying for Term Insurance, who are between 15 days and up to and including 17 years old.
The Beneficiary of this rider is the Owner unless stated otherwise.
Complete a separate Section 13 if both Children’s Term Rider and Payor Waiver of Premium are applied for.

Proposed Life Insured

First and Last Name	Relationship to Life Insured	Date of Birth (DD/MMM/YYYY)	Height	Weight
			<input type="radio"/> cm <input type="radio"/> ft/in	<input type="radio"/> kg <input type="radio"/> lbs
			<input type="radio"/> cm <input type="radio"/> ft/in	<input type="radio"/> kg <input type="radio"/> lbs
			<input type="radio"/> cm <input type="radio"/> ft/in	<input type="radio"/> kg <input type="radio"/> lbs
			<input type="radio"/> cm <input type="radio"/> ft/in	<input type="radio"/> kg <input type="radio"/> lbs

1	Has anyone proposed for coverage above, within the past five years: a) Consulted a physician for any reason; had an electrocardiogram or other diagnostic tests; been in a clinic, hospital or medical facility for observation or treatment? b) Been advised to have any diagnostic test, hospitalization or surgery which was not done?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
2	Has anyone proposed for coverage above ever had or had indication of: a) Cancer, stroke, heart attack or heart disease? b) Diabetes, glandular or thyroid disorder, enlarged lymph nodes, epilepsy, or any mental, nervous or neurological disorder? c) Chest pain, angina, high blood pressure, heart murmur or other circulatory or blood disorders? d) Kidney, urinary or reproductive disorder, or sexually transmitted disease? e) Liver or gastrointestinal disorder, hepatitis or hepatitis carrier state? f) Asthma, emphysema, or other respiratory disorder? g) Loss of vision, amputation, deformity, arthritis or other musculo-skeletal disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
3	Has anyone proposed for coverage above ever had or been told they have: Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	<input type="radio"/> Yes <input type="radio"/> No
4	Is anyone proposed for coverage above presently taking any medication?	<input type="radio"/> Yes <input type="radio"/> No
5	Has anyone proposed for coverage above: a) Ever had any Application or re-instatement for Life, Critical Illness, Long Term Care or Disability Insurance declined, rated, postponed, cancelled, rescinded or modified in any way? b) Within the past two years flown or taken instruction as a pilot or engaged in any kind of racing, scuba or sky diving, hang gliding or other hazardous activities or intend to do so? c) Within the past five years used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol use? d) Ever had their driver’s licence restricted, suspended, revoked or had three or more moving violations within the past three years? If yes, provide drivers licence # e) Intend to reside or travel outside of Canada for more than four consecutive weeks?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

Give full details for all “Yes” answers to questions 1 to 5. Give dates, treatment, duration of illness, and names and addresses of all attending physicians and medical facilities.

Question No.	First and Last Name	Details



Section 14 – General Comments

Lined area for general comments.



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Section 15 – Payments & Authorizations

15.1 – Method of payment

- BMO Life Assurance Company (Company, We) does **not** accept cash
- All payments must be in Canadian funds drawn on a Canadian financial institution and be payable to BMO Life Assurance Company.
- If a method of payment is not selected, We will proceed on a payment on delivery basis and an Annual Billing basis thereafter.
- Payments will not be taken from the payor's account until the policy is in effect unless an initial payment option has been selected.

Initial Payment of \$ _____ will be submitted:

- ☐ With the application (TIA is available); OR
- ☐ When the policy has been accepted and delivery requirements received by us (TIA is NOT available with this option)

Initial payment will be paid by (select one):

- ☐ Pre-authorized Debit (PAD) **Complete Section 15.2, Pre-Authorized Debit (PAD) Set Up and Authorization**
- ☐ Cheque
- ☐ Credit Card - First ANNUAL Payment only **Complete Section 15.3, Credit Card Authorization**

Subsequent payments paid by (select one):

- ☐ Monthly Pre-Authorized Debit (PAD) **Complete Section 15.2, Pre-Authorized Debit (PAD) Set Up and Authorization**
- ☐ Annual Billing

15.2 – Pre-Authorized Debit (PAD) set up and Authorization

- ☐ Add to existing PAD Agreement for BMO Insurance Policy # _____
- ☐ Create a new PAD Agreement using:
- ☐ The Account information on the first cheque provided with this application
- ☐ The Account information shown on a bank Letter of Direction. (A line of credit account cannot be used)
- ☐ the VOID cheque attached (cheque must have accountholder name preprinted)

When should PAD withdrawals begin?

- ☐ Match Policy Date
- ☐ Preferred Withdrawal Day* (choose from the 1st to the 28th)
*Not available for Universal Life policies

If a pre-authorized payment is returned due to non-sufficient funds (NSF), BMO Life Assurance Company is authorized to retry the payment within ten (10) business days. The payor is responsible for any NSF charges incurred by their financial institution.

All payors must agree to all of the following terms in order to use the PAD payment option.

- BMO Life Assurance Company (Company) may make deductions, at any time, for regular recurring payments and/or one-time payments from time to time, from the bank account indicated in this application for insurance;
- For the purpose of this agreement, all pre-authorized debits will be treated as Personal under the Canadian Payments Association rules (this means having 90 calendar days from the date any payment is processed to claim reimbursement for any unauthorized payment);
- The withdrawal amount is considered to be variable under the Canadian Payment Association rules;
- Any notices to be sent under this agreement may be sent to the proposed owner/owner's most recent address that the Company has on record at the time the notice is sent;
- The Company may charge a fee and may cancel the PAD for any withdrawal that is not honoured;
- This authorization may be cancelled at any time upon the Company's receipt of written notice by the payor;
- Any cancellation of this pre-authorized withdrawal will not affect the agreement between them and the Company whatsoever with respect to any insurance coverage so long as payment is provided by an alternate acceptable method.
- All persons whose signatures are required to sign on this account have signed below, including any required joint account holder.
- **To waive the requirement that BMO Life Assurance Company notify them of:**
 - This authorization before the first payment is processed,
 - Any subsequent payments, and
 - Any changes to the amount or date of the payment initiated by them or the Company.



15.2 – Pre-Authorized Debit (PAD) set up and Authorization (continued)

• Payors have certain recourse rights in the event that a debit does not comply with this agreement. Payors have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. Payors may obtain a sample cancellation form or more information on rights to cancel this Authorization by contacting their financial institution or by visiting www.cdnpay.ca

Contact us at any time:
BMO Life Assurance Company
60 Yonge Street
Toronto, ON M5E 1H5
1-877-742-5244 Fax 416-596-0348

Date (DD/MMM/YYYY)	Signature(s) (for a joint account, all depositors must sign) X
Date (DD/MMM/YYYY)	X

15.3 – Credit Card Authorization
(FOR FIRST ANNUAL PAYMENT ONLY, UP TO A MAXIMUM OF \$50,000)

Name as it appears on the card:		
<input type="radio"/> Mastercard <input type="radio"/> VISA	Card Number	Expiry Date (MM/YY)
I authorize BMO Life Assurance Company (BMO Insurance) to charge \$ _____ to the above account in respect to this Application for Insurance.		

Upon receipt of this form, BMO Insurance will request necessary authorization from the issuer of your credit card. If necessary authorization is obtained from the issuer, your account will be debited accordingly. Payment to BMO Insurance by the issuer pursuant to the above will constitute and represent “an amount paid” and, as such, is governed by the provisions of this Application.

Date (DD/MMM/YYYY)	Cardholder’s Signature X	Cardholder’s Name (please print)
--------------------	-----------------------------	----------------------------------

Section 16 – Application for Temporary Insurance

In this section, “you” and “your” mean the proposed insured.
Each proposed insured who is applying for temporary life or temporary critical illness insurance must complete this section.

If you are applying for:
Temporary life insurance – complete questions 1 and 2 (a) to (e).
Temporary critical illness insurance – complete questions 1, 2 and 3.

Age eligibility for temporary insurance
Temporary life insurance - the proposed insured must be between the ages of 15 days to 65 years.
Temporary critical illness insurance – the proposed insured must be between the ages of 30 days to 65 years.

		Proposed Insured 1	Proposed Insured 2
1	Are you over the age of 65?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2	Have you		
	a) Ever been treated for or had any indication, signs or symptoms of Alzheimer’s, Parkinson’s, Huntington’s Chorea, heart or circulatory disease, heart attack, chest pain, abnormal ECG, elevated blood pressure, loss of speech, severe burns, diabetes, cancer or tumours, stroke, transient ischemic attacks (TIA), chronic kidney, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, AIDS or HIV infections?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	b) Been unable to perform regular activities for more than 7 consecutive days within the last 6 months because of a sickness or injury or currently under any treatment?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	c) Within the past 2 months, other than pregnancy or childbirth, been admitted to a hospital or other medical facility or been advised to do so?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	d) Been advised to have any tests, investigation or surgery not yet done?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	e) Been advised that you are not eligible for life insurance or been offered such insurance with extra premium or modified in any way?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3	Have you been advised that you are not eligible for health or critical illness insurance or been offered such insurance with extra premium or modified in anyway?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

If any of the above questions are answered “Yes” for Proposed Insured 1 and/or Proposed Insured 2, **DO NOT** accept payment or detach the receipt. Payment remitted in an invalid TIA will be returned. The Temporary Insurance will only be provided if all of the above questions are answered “No” and will only be valid and enforceable if such answers are true.

Payment must be dated the same day as the Application for Temporary Insurance.
Amount paid with Application \$ _____



Section 17 – Notice, Representations, Acknowledgements, Authorizations & Signatures

- 17.1 – IMPORTANT NOTICE:** The information contained in this application and other information BMO Insurance may collect in connection with the application is required by BMO Insurance for insurance purposes, including activities, such as: considering and processing the application and administering any policy if issued and investigating coverage and claims (the “Insurance Purposes”). Further information about the Insurance Purposes and BMO Insurance’s privacy practices are set out in the notice on *Privacy and Personal Information and MIB Inc. Notice* provided at the time of Application.
- 17.2 – REPRESENTATIONS AND ACKNOWLEDGEMENTS:** “I” (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below represent and confirm that:
- 1. I have read and understood all of the questions in this application form and if temporary insurance is applied for, the term application includes the Application for Temporary Insurance, and in any supplemental questionnaires, submitted to BMO Life Assurance Company (BMO Insurance) as part of this application for life insurance (the “Application”) and that I intend to submit the Application for insurance.
 - 2. I have reviewed all of my answers and statements recorded in the Application and the answers provided are true and complete and were provided by me to my advisor (or some other authorized person acting on behalf of my advisor) for the Insurance Purposes. In addition, I understand that any statements that I make during a telephone conversation or visit with a medical professional or other representative are also part of my Application and will also be used for the Insurance Purposes.
 - 3. I understand that the information and answers provided in the Application will be relied upon by BMO Insurance in assessing the Application, and issuing any policy. I was present when the answers to the questions related to me were collected and I provided the answers.
 - 4. BMO Insurance may void any policy it issues based on the Application if any of the information or answers provided in the Application is incomplete or incorrect.
 - 5. I will notify BMO Insurance immediately if any of the answers or information provided in the Application is discovered to be untrue, or changes in the period before approval of, the issuance of, and delivery of, the policy applied for. I will notify BMO Insurance if there is a change in my residency status for tax purposes if this is an application for a universal life policy or the BMO Insurance Whole Life plan.
 - 6. I have received sufficient and satisfactory information concerning the product(s) I am applying for before signing this Application, and I understand that the life insurance advisor may be paid on a commission basis.
 - 7. I also understand that there are variables (e.g., type and performance of investments, cost of insurance, policy loans, payments and withdrawals, etc.) that can affect the performance of a universal life insurance policy or the BMO Insurance Whole Life plan policy and that changes in these variables can affect the policy’s non-guaranteed benefits and values, and I further understand that benefits and values set out in a universal life illustration and the BMO Insurance Whole Life plan illustration are not guaranteed and are based on assumptions that are likely to change.
 - 8. I (being the proposed owner) will be deemed to have accepted the terms of the policy and any endorsements, additions and amendments attached to it, issued based on this Application if I do not return the policy to BMO Insurance within 10 days of delivery.
- 17.3 – AUTHORIZATIONS AND SIGNATURES:** “I” (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below indicate that:
- 1. I consent to the collection, use and disclosure of my personal information by BMO Insurance for the Insurance Purposes. I understand that BMO Insurance may share my personal information with companies that provide services on its behalf. In some cases, these other companies may be located outside of Canada (such as the United States)
 - 2. I consent to BMO Insurance obtaining a credit bureau report, conducting a criminal records check and obtaining information relating to my driving history, as required, for the Insurance Purposes
 - 3. I authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, and insurance company, advisor or broker or its affiliate, the MIB Inc., and any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide and exchange all such information and records with BMO Insurance or its reinsurers.
 - 4. I consent to the testing of specimens(s) provided by me, which may include AIDS Virus (HIV) antibody/antigen testing, unless I expressly revoke this consent.
 - 5. I consent to BMO Insurance releasing the results of any tests, reports and personal information gathered about me to its reinsurers and other authorized insurers, to my personal physician, and to the MIB Inc.
 - 6. I understand that if the proposed life insured is not the only proposed life insured or is different than a proposed policy owner(s), that the personal information (including health information) of the proposed life insured will be shared with any additional proposed life insured or policy owner and I consent to this.
 - 7. I have read, understood and agree to the collection, use and disclosure of my personal information as set out in the *Privacy and Personal Information and MIB Inc. Notice* provided to me at the time of Application.
 - 8. Acceptance of any policy issued on the Application constitutes approval of the provisions of the policy and ratification of any additions or endorsements or amendments.

By signing below I understand and agree to the statements in the section above and consent to the collection, use and disclosure of my personal information as described.

Province Signed	Date (DD/MMM/YYYY)	Signature
		Proposed Owner (indicate title of signing officers if applicable) X
		Proposed Owner (indicate title of signing officers if applicable) X
		Proposed Insured (if other than proposed owner or if under 16 (18 in Quebec) signature of parent or guardian) X
		Proposed Insured (if other than proposed owner) X
		Payor (if Payor Waiver of Premium is applied for) X

An electronic copy of this authorization is as valid as the original.



Section 18 – Authorization to disclose information to your advisor (optional)

In this section, “you” and “your” mean the proposed insured. “We”, “us”, “our” and “Company” refer to BMO Life Assurance Company.

Purpose of this authorization

By signing this form, you give us permission to discuss your personal (including medical) information listed below, with your advisor or designated consultant who may use it to discuss insurance options with you.

Advisor’s full name (Please print)	Advisor’s code number
Advisor’s designated consultant (if applicable)	

We do not need this authorization to review and make a decision about your application.

The Authorization you provide when you sign this form

By signing below, you authorize the Company to disclose your personal information that was collected in the scope of this application.

The information that we may disclose with your advisor or designated consultant can include:

1. Medical testing and laboratory results*;
2. Confidential personal information about illness, including mental illness, other medical conditions, use of medications, drug or alcohol use and rehabilitation;
3. Other information about your health discovered as we assess your application but that you may not know about when you apply;
4. Employment history and personal finances;
5. Any record of your criminal activity; and
6. Other facts about your life and how they affect our decision to insure you.

*We reserve the right to not disclose all sensitive medical/financial information should we see fit. We may choose not to disclose information about you that we have obtained from a physician or medical facility where that information was not disclosed to us as part of the application process.

Your agreement and signature

By signing this authorization, you agree:

1. You have read and understood the terms of this authorization;
2. You are authorizing us to disclose information, set out in this authorization, to your advisor or designated consultant;
3. Even though you have signed this form, we have the right to withhold highly sensitive personal information from your advisor or designated consultant;
4. You may cancel this authorization at any time by sending us a letter in writing to BMO Insurance, 60 Yonge Street, Toronto, ON M5E 1H5; and
5. You understand that this authorization is valid until 30 days after the later of the date we;
 - a. issue a policy as applied for or amend an existing insurance policy, or
 - b. notify you that your application has been declined.

Province Signed	Date (DD/MMM/YYYY)	Signature
		Proposed Insured 1 X
		Proposed Insured 2 X
		Parent or Guardian and Relationship (if Proposed Insured is under 16 [18 in Quebec]) X

An electronic copy of this authorization is as valid as the original.



Section 19 – Authorization to Share Information

Authorization to Share information - PLEASE COMPLETE ON ALL APPLICATIONS - Do not detach

You and *your* refer to the person(s) to be insured and the parent or guardian (tutor, in Quebec) of children to be insured who are under age 18. *us* and *our* refer to BMO Life Assurance Company (BMO Insurance). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, public or private health or social services establishments, clinics and other medically related facilities, insurance companies, MIB, Inc., your advisor or its affiliate and any other organization, institution, association or person that has information, records or knowledge of you or your health or of your children or their health (if applicable), to share or exchange information with us or our reinsurers. You also authorize us, or our reinsurers, to make a brief report of your personal information to MIB, Inc. Note: A parent or legal guardian signing on behalf of a minor must indicate relationship.

Province Signed	Date (DD/MMM/YYYY)	Signature	Print Name
		Proposed Insured 1 X	
		Proposed Insured 2 X	
		Parent or Guardian and Relationship (if Proposed Insured is under 16 [18 in Quebec]) X	

An electronic copy of this authorization shall be as valid as the original.

Section 20 – Privacy and Personal Information and MIB Inc. Notice

Please detach and give to Proposed Insured(s)

In this Privacy and Personal Information Authorization, “you” and “your” mean either the policy owner, proposed life insured, or payor of the policy either individually or collectively. “we”, “us” and “our” refer to BMO Life Assurance Company.

We are committed to respecting and protecting the privacy and confidentiality of your personal information. Please see our Privacy Code at www.bmoinsurance.com for more details.

When we receive your Application (which includes the application for insurance and any supplemental forms), we will establish and maintain a confidential file which will contain your personal information including any health information and your Application and any related contracts for insurance.

We collect your personal information and maintain this file in order to:

- (1) determine your eligibility for our products and services;
- (2) support and streamline the underwriting process;
- (3) confirm your identity and the accuracy of the information that you have provided to us;
- (4) issue, service, and administer your contract of insurance, even after your contract has ended;
- (5) assess any claim for benefits under your contract;
- (6) comply with legal and regulatory requirements.

If you are the owner of a permanent life or universal life policy, then we will collect your social insurance number for income tax reporting purposes. As part of our underwriting process, we may request a consumer report or conduct a personal investigation in connection with this Application.

Access to your file, and your personal information, is limited to:

- (1) BMO Insurance employees;
- (2) your insurance advisor and the managing general agent that your advisor is associated or connected to;
- (3) our reinsurers;
- (4) our third party service providers related to the administration, processing and servicing of your contract;
- (5) those other third parties that you authorize or those authorized by law;
- (6) where necessary, your named beneficiary(ies) in the event of a claim.

You may access your file and request corrections to your personal information by sending a written request to Privacy Officer, BMO Insurance, 60 Yonge St, Toronto, ON M5E 1H5.

MIB Inc. Notice:

Except as required by law, information regarding your insurability will be treated as confidential. BMO Insurance or its reinsurers may however, make a brief report to the MIB Inc., a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If a person named in this Application applies to another MIB Inc. Member company for life or health insurance, or a claim for benefits is submitted to such a company, MIB Inc. will, upon request, supply that insurance company with the information in its file.

BMO Insurance or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.



BMO Life Assurance Company

60 Yonge Street
Toronto, Ontario
Canada M5E 1H5

Tel 416-596-3900
Fax 416-596-4143
Toll Free 1-877-742-5244
bmoinsurance.com



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Section 21 – Temporary Insurance Agreement and Receipt

Please detach and leave with Owner only if Temporary Insurance has been applied for.

Important: No Temporary Insurance coverage shall take effect except as stated in the Temporary Insurance Agreement.

Received from	The amount of \$
Person(s) to be insured ("Insured") [list all persons to be insured under this Agreement]	

This Receipt is issued on the condition that any cheque or other order for the payment of money is honoured upon first presentation for payment.

Banking information provided and Pre-Authorized Debit (PAD) Authorization signed to take initial payment by Pre-Authorized Debit (PAD) ☐ Yes ☐ No

ALL CHEQUES MUST BE MADE PAYABLE TO BMO LIFE ASSURANCE COMPANY. DO NOT MAKE THE CHEQUE PAYABLE TO THE ADVISOR OR LEAVE THE PAYEE BLANK. NO PERSON IS AUTHORIZED TO CHANGE OR WAIVE ANY CONDITIONS IN THIS AGREEMENT.

Signed at	Date (DD/MMM/YYYY)
Signature of Advisor X	Date (DD/MMM/YYYY)

Temporary life insurance agreement

In this temporary life insurance Agreement ("*Agreement*"), "*we*", "*us*", "*our*", "*the Company*" mean BMO Life Assurance Company. "*You*" and "*your*" mean the proposed owner. "*Insured*" means a person listed in Section 3 of this application to be insured under this Agreement. "*Application*" means the application for life or critical illness insurance that you are applying for.

What is the temporary life Insurance Agreement?

This Agreement sets out the terms and conditions under which we agree to provide temporary life insurance coverage while we process your Application. This means that if the Insured dies, we will pay the benefit provided by this Agreement, subject to the terms and conditions set out below.

When does temporary life insurance comes into effect?

Temporary life insurance under this Agreement comes into effect on the date you and the Insured(s) sign Section 17 of this Application, provided that all the following conditions are met:

1. on the date the Application is signed, the age of the Insured is from 15 days and 65 years inclusive;
2. payment of at least 1/12th of the annual premium paid for by cheque or PAD authorization for the policy and any riders has been made with the Application. Payment is deemed made if it is honoured when we first present it; and
3. the temporary insurance questions in Section 16 have been truthfully answered "no".

If any of the conditions are not met, temporary life insurance does not take effect.

When does temporary life insurance end?

Temporary life insurance under this Agreement ends on the earliest of:

1. the date insurance as applied for comes into effect;
2. the date we present a counteroffer to your advisor;
3. the date we decline this Application. In this case, we will mail you a notice of decline to the address given on the Application along with refund of any amount you have paid us;
4. the date you request the cancellation of the Application; and
5. 90 days after this Application was signed.

What are the terms and conditions for the payment of temporary life insurance benefit?

Conditions for payment – Provided all terms and conditions under this Agreement are met, we will pay the temporary life insurance benefit if the Insured dies while this Agreement is in force. In the case of joint coverage, payment of the temporary life insurance benefit is also contingent on the type of plan applied for in this application (joint-first-to-die or joint-last-to-die).

Amount we will pay – The total amount we will pay under this Agreement is the lesser of:

1. the amount of life insurance applied for in this application, excluding any accidental death benefit, and
2. the maximum amount of \$1,000,000.

For purposes of this section, the maximum amount is determined as follows:

- a. If more than one Insured is covered under this Agreement, the maximum amount of \$1,000,000 is for all Insureds;
- b. If an Insured is covered under more than one temporary life insurance agreement with us, the maximum amount of \$1,000,000 is for all temporary life insurance agreements.

For purposes of this section, temporary life insurance agreements include this temporary life insurance agreement, and any accidental death coverage in effect while your application is being underwritten.

Person we will pay – We will pay the person you have named to receive the death benefit in the Application.

Exclusions and limitations – We will not pay a benefit under this Agreement if:

1. any information has been misrepresented on or omitted from this Application;
2. the Insured commits suicide, while sane or insane. In this case, we will refund the premium; or
3. the Insured dies before reaching the age of 15 days.



Section 21 – Temporary Insurance Agreement and Receipt (*continued*)

Temporary critical illness insurance agreement

In this temporary critical illness insurance agreement ("*Agreement*"), "*we*", "*us*", "*our*", "*the Company*" mean BMO Life Assurance Company. "*You*" and "*your*" mean the proposed owner. "*Insured*" means the person listed in Section 3 to be insured under this Agreement. "*Application*" means the application for life or critical illness insurance that you are applying for.

In addition, the following definitions describe terms used in this Agreement:

- "*covered condition*" means a condition as defined in the Covered Conditions section of the policy or rider provisions;
- "*Diagnosis*" means the written opinion of a specialist, supported by clinical, radiological, histological and laboratory evidence that the Insured meet the definition of a covered condition in the policy or rider provisions;
- "*Specialist*" is a medical practitioner licensed in Canada or the United States and who has been trained in the specific area of medicine relevant to the covered condition for which benefit is being claimed, and who has been certified by a specialty examining board. If a Specialist is not available and if we approve, a covered condition may be diagnosed by a qualified medical practitioner practising in Canada or the United States of America. The Specialist cannot be the Insured, the proposed owner, a relative of or business associate of either the proposed owner or the Insured;
- "*Policy and rider provisions*" means the contractual documents relating to the critical illness you have applied for. You may request a copy from your advisor.

What is the temporary critical illness insurance agreement?

This Agreement sets out the terms and conditions under which we agree to provide temporary critical illness coverage while we process your Application. This means that if the Insured suffers a covered critical illness, we will pay the benefit provided by this Agreement, subject to the terms and conditions set out below.

When does temporary critical illness insurance comes into effect?

Temporary critical illness insurance under this Agreement will come into effect on the date you and the Insured(s) sign Section 17 of this Application, provided that all the following conditions are met:

1. the age of the Insured is from 30 days and 65 years inclusive on the date the Application is signed;
2. payment of at least 1/12th of the annual premium paid for by cheque or PAD authorization for the policy and any riders has been made to the Company with the Application. Payment is deemed made if it is honoured when we first present it; and
3. the temporary insurance questions in Section 16 have been truthfully answered "no".

If any of the conditions are not met, temporary critical illness insurance does not take effect.

When does temporary critical illness insurance end?

Temporary critical illness insurance under this Agreement ends on the earliest of:

1. the date insurance as applied for comes into effect;
2. the date we present a counteroffer to your advisor;
3. the date we decline this Application. In this case, we will mail you a notice of decline to the address given on the Application along with refund of any amount you have paid us;
4. the date you request the cancellation of the Application; and
5. 90 days after this Application was signed.

What are the terms and conditions for the payment of temporary critical illness insurance benefit?

Conditions for payment – Provided all the terms and conditions under this Agreement are met, we will pay the temporary critical illness insurance benefit on the occurrence of a covered condition if:

1. the diagnosis of the covered condition is made while this Agreement is in force;
2. all the requirements for the covered condition as set out in the policy or rider provisions you are applying for are satisfied;
3. the Insured satisfies the survival period of 30 days as defined in the policy or rider provisions; and
4. the covered condition is not specifically excluded in this Agreement.

Amount we will pay – The total amount we will pay under this Agreement is the lesser of:

1. the amount of critical illness insurance applied for in this application, excluding any accidental death benefit; and
2. the maximum amount of \$500,000 for all Insureds together.

For purposes of this section, the maximum amount is determined as follows:

- a. If more than one Insured is covered under this Agreement, the maximum amount of \$500,000 is for all Insureds;
- b. If an Insured is covered under more than one temporary critical illness insurance agreement with us, the maximum amount of \$500,000 is for all temporary critical illness insurance agreements.

Person we will pay – We will pay the owner unless a beneficiary has been named to receive the critical illness benefit in the Application.

Exclusions and limitations – We will not pay a benefit under this Agreement:

1. if any information has been misrepresented on or omitted from this Application;
2. for a diagnosis of cancer as the term is defined in the policy or rider provisions;
3. if the Insured dies before completing the survival period of 30 days as the term is defined in the policy or rider provisions; or
4. if the Insured suffers from a covered condition that results directly or indirectly from:
 - i. intentionally causing self-inflicted injury, or attempting suicide, while sane or insane;
 - ii. committing or attempting to commit a criminal offence;
 - iii. using any drug, poisonous substance, intoxicant (including alcohol) or narcotic other than as prescribed by a licensed physician and in accordance with instructions given;
 - iv. operating a motor vehicle while the concentration of alcohol in one hundred (100) millilitres of blood exceeds eighty (80) milligrams.



Section 22 – Advisor Report

22.1 – General information

1	How long have you known the Proposed Life Insured(s)? Relationship to the Proposed Life Insured(s)? <input type="radio"/> Know well <input type="radio"/> Know slightly <input type="radio"/> Just met If related: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Child/Dependent <input type="radio"/> Sibling <input type="radio"/> Other _____
2	Who solicited this Application? <input type="radio"/> Advisor <input type="radio"/> Proposed Life Insured <input type="radio"/> Owner
3	Did you personally meet with the person(s) to be insured and the policy owner(s)? <input type="radio"/> Yes <input type="radio"/> No If No, do not submit this application. You must use the SmartApp
4	Underwriting requirements ordered: <input type="radio"/> Urine-HIV <input type="radio"/> Tele-Interview Vitals <input type="radio"/> Para-Medical <input type="radio"/> Resting E.C.G. <input type="radio"/> Doctor's Medical <input type="radio"/> Stress E.C.G. <input type="radio"/> Blood Profile <input type="radio"/> APS <input type="radio"/> Inspection Report <input type="radio"/> MVR <input type="radio"/> Other _____ APS (if ordered, name of Physician) Dr. _____ MVR for Quebec and British Columbia residents: Include a MVR Authorization if required due to Age & Amount Requirements. Name of Paramedical facility or Medical Examiner _____

22.2 – Advisor declaration

The foregoing answers are correct to the best of my knowledge. By signing here, I confirm that:

- I am the soliciting Advisor and I am duly licensed to write this Application in the jurisdiction where the transaction occurred, and
- I confirm that:
 - as part of the sales process, I met with Proposed Insured 1, Proposed Insured 2 (if applicable) and the Owners;
 - the application has been reviewed with each proposed owner, proposed insured and PAD payor;
 - all information in this application is, to the best of my knowledge, complete and true and has all the facts material to the insurance applied for.
- I have seen the original valid government issued document presented by Proposed Insured 1, Proposed Insured 2 (if applicable) and the Owners, for identification purposes (unless form 798E, Dual Process Verification of Identity, has been completed..
- I used reasonable efforts to determine if the policy owner(s) is/are acting on behalf of a third party, and
- I have provided an Advisor Disclosure Statement to the Owner, advising:
 - about the company(ies) that I currently represent;
 - that I receive compensation (such as commissions) for the sale of life and health insurance products;
 - that I may receive additional compensation in the form of bonuses, conference programs or other incentives; or
 - of any conflicts of interest I may have with respect to this transaction.
- I saw every person sign this application.

Soliciting Advisor's Name (please print)	Soliciting Advisor's Signature X	Date (DD/MMM/YYYY)
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22.3 – Advisor information

1	Full Name (please print) (Servicing Advisor)	Advisor Code No.	Percentage Split	Print Name of MGA and MGA code# here
2	Full Name (please print)	Advisor Code No.	Percentage Split	
3	Full Name (please print)	Advisor Code No.	Percentage Split	

22.4 – Licensed administrative assistant's declaration

To be completed if a licensed administrative assistant helped to complete this application.

I, the licensed administrative assistant confirm that:

- I have reviewed with each proposed owner, proposed insured and PAD payor, all information in this application and, to the best of my knowledge, this information is complete and true, and has all the facts material to the insurance applied for, and
- I saw every person sign this application.

Licensed administrative assistant's full name (please print)	Licensed administrative assistant's signature X	Licensed administrative assistant's licence number	Date (DD/MMM/YYYY)
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APP NO.



BMO Life Assurance Company
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