App. No._____

BMO® Insurance

Application for Life Insurance and Critical Illness Insurance

Important Instructions For The Advisor

A) FOR FASTER ISSUE

1. 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.
2. **Use this form only if you are completing it in person with the person(s) to be insured and the policy owner(s).**
3. PRINT all answers using black or dark blue ink.
4. DETACH the **Legal Information – Section 18** and leave with the Proposed Life Insured(s)
5. An ILLUSTRATION must accompany all applications for Universal Life
6. If PAYOR WAIVER OF PREMIUM is applied for, complete the relevant sections of Section 12.
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 Life Insured(s) signature and current date.
9. Please ensure that all appropriate SIGNATURES have been affixed.
10. With the exception of Section 17 and Section 18, DO NOT remove any Section(s) from this form.

B) MEDICAL QUESTIONS

Section 9 – Medical Information

If medical underwriting requires at least a paramedical, you may elect to NOT complete Section 9. 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 www.bmoinsurance.com/advisorsupport.*

C) APPLYING FOR TEMPORARY INSURANCE
Section 16 and Section 17

All of the following conditions must be met before the **Temporary Insurance Agreement and Receipt – Section 17**, may be issued:

1. The Proposed 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 17** 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".

D) PROCEEDS OF CRIME (MONEY LAUNDERING) AND TERRORIST FINANCING ACT
If this Application is for Universal Life insurance you must submit the following additional form(s) with this application.

Form Name	Form #	Requirement
Policy Owner Identification – Proceeds of Crime (Money Laundering) & Terrorist Financing	576E	Must be submitted with all applications for Universal Life
Politically Exposed Foreign Persons Questionnaire	420E	Must be submitted with all applications for Universal Life if a deposit of $100,000 or more will be made or has been illustrated.

Please be aware that these forms have an impact on the Underwriting Process, such that delays in submitting these required forms with the application can delay issuing coverage for your client.

BMO Insurance's illustration software, The Wave, will automatically print out the appropriate form(s) with every Universal Life illustration.

Section 1 - General Information

App. No. _____

**** This Application is for **** ☐ A new policy ☐ A replacement of a BMO Insurance policy # _____

☐ Additional coverage to a BMO Insurance Policy # _____

Section 1.1 - Proposed Life Insured

Legal Name (first, middle initial, last)			Maiden Name (if applicable)
What is your citizenship? ☐ Canadian Citizen ☐ Permanent Resident (give date of entry into Canada (dd/mmm/yyyy)) ☐ Other (provide details)			
Date of Birth (dd/mmm/yyyy) / /	Age	Place of Birth (Province/Country)	Are you a resident of Canada for Canadian income tax purposes? Yes ☐ No ☐
Male ☐ Female ☐ I request that the policy be issued in English ☐ French ☐		Smoking Class Smoker ☐ Non-smoker ☐	Social Insurance No. | | | — | | | | — | | |
Address (Street, Apt., R.R.)		No. of Years	Home telephone number ( )
City	Prov.	Postal Code	Preferred contact number ( )
Occupation/Duties			Years with current Employer
Employer Name			Type of Business
Address (Street, Apt., R.R.)			
City	Prov.	Postal Code	

Section 1.2 - Proposed Additional Life Insured

Legal Name (first, middle initial, last)			
Maiden Name (if applicable)			Relationship to Proposed Life Insured
What is your citizenship? ☐ Canadian Citizen ☐ Permanent Resident (give date of entry into Canada (dd/mmm/yyyy)) ☐ Other (provide details)			
Date of Birth (dd/mmm/yyyy) / /	Age	Place of Birth (Province/Country)	Are you a resident of Canada for Canadian income tax purposes? Yes ☐ No ☐
Male ☐ Female ☐ I request that the policy be issued in English ☐ French ☐		Smoking Class Smoker ☐ Non-smoker ☐	Social Insurance No. | | | — | | | | — | | |
Address (Street, Apt., R.R.)		No. of Years	Home telephone number ( )
City	Prov.	Postal Code	Preferred contact number ( )
Occupation/Duties			Years with current Employer
Employer Name			Type of Business
Address (Street, Apt., R.R.)			
City	Prov.	Postal Code	

Section 1.3 - Owner (Complete only if other than Proposed Life Insured)

- If Company owned, please provide the name of the Company and the name of the person to receive correspondence.
- For a sole proprietorship, the Owner will be the individual, or the individual carrying on business as the company.
- If this policy will be owned by more than one person, the policy will be set up as joint ownership with right of survivorship except in Quebec.

Legal Name (first, middle initial, last and/or company name)			
Maiden Name (if applicable)			Relationship to Proposed Life Insured
Date of Birth (dd/mmm/yyyy) / /	Age	Place of Birth (Province/Country)	Are you a resident of Canada for Canadian income tax purposes? Yes ☐ No ☐
Male ☐ Female ☐ I request that the policy be issued in English ☐ French ☐		Smoking Class Smoker ☐ Non-smoker ☐	Social Insurance No. | | | — | | | | — | | |
Address (Street, Apt., R.R.)		No. of Years	Home telephone number ( )
City	Prov.	Postal Code	Preferred contact number ( )
Occupation/Duties			Years with current Employer
Employer Name			Type of Business
Address (Street, Apt., R.R.)			
City	Prov.	Postal Code	

Section 2 - Verification of Identity

Complete on all applications excluding Universal Life applications. For Universal Life applications complete Policy Owner Identification - Proceeds of Crime (Money Laundering) & Terrorist Financing - 576E

For EACH Life Insured, select one (1) appropriate form of valid government issued identification to verify the identity of the individual paying the premium. Photo ID – e.g., Passport, Driver's Licence, Provincial Health Card (except in Manitoba, Ontario and PEI)

Proposed Life Insured	Type of Document (Photo ID)	Document #	Place of Issue	Expiry Date (dd/mmm/yyyy)
Owner (if different from the proposed Life Insured)	Type of Document (Photo ID)	Document #	Place of Issue	Expiry Date (dd/mmm/yyyy)
Proposed Additional Life Insured	Type of Document (Photo ID)	Document #	Place of Issue	Expiry Date (dd/mmm/yyyy)

Section 3 - Plan Details

Please check one: ☐ Illustration attached ☐ No Illustration Completed *(You must submit an illustration with every application for Universal Life.)*

Please select a Policy Date: ☐ Date to save age for: ☐ Proposed Life Insured ☐ Proposed Additional Life Insured ☐ Current date

Section 3.1 - Single Life Options

Complete this section if you want one (1) individual insurance policy or two (2) individual insurance policies.

Product Type	**Proposed Life Insured**		**Proposed Additional Life Insured**	
	Plan Name	**Face Amount**	**Plan Name**	**Face Amount**
☐ Universal Life				
☐ Term Life				
☐ Traditional Whole Life				
☐ Critical Illness				

Section 3.2 - Joint Plans/Multi Coverage Options

Complete this section if you want one insurance policy that covers two or more individuals and that provides payment of the proceeds as directed in Section 5, Beneficiary Information.

Product Type	**Plan Name**	**Coverage Type**	**Face Amount**
☐ Universal Life		☐ Joint First-to-Die ☐ Joint Last-to-Die ☐ Multi-Coverage	
☐ Term Life		Joint First-to-Die	
☐ Pure Term 100		☐ Joint First-to-Die ☐ Joint Last-to-Die	

Section 3.3 - Additional Benefits and Riders

Rider	**Proposed Life Insured**	**Face Amount**	**Proposed Additional Life Insured**	**Face Amount**
Waiver of Premium Benefit	☐		☐	
Term Rider	☐		☐	
Accidental Death Benefit	☐		☐	
Children's Term Rider	☐		☐	
Critical Illness Rider	☐		☐	
Other, Please Specify				

Section 3.4 - Request for Optional Policy

☐ Proposed Life Insured	☐ Required illustration(s) attached
☐ Proposed Additional Life Insured	☐ Required illustration(s) attached

Section 4 - Payment Information

Section 4.1 - Frequency of Payment

All payments must be in Canadian funds drawn on a Canadian financial institution and be payable to BMO Life Assurance Company.

Premium Mode: (select one only)

☐ Annually by cheque $

☐ Semi-Annually by cheque $

☐ Monthly by Pre-Authorized Cheque (PAC) $

☐ **Monthly PAC including initial premium withdrawal** $

- **If selected, Temporary Insurance Agreement (TIA) does not apply.**
- **Upon approval and receipt of all outstanding settlement requirements of this application, BMO Insurance will commence withdrawals beginning with the initial premium for this policy plus any outstanding premiums due as a result of a Special Policy Date selection in Section 3.**

Monthly PAC Details

Withdrawal Day (choose from the 1st to the 28th)

Please note that for all Universal Life policies, the issue day and the withdrawal day must be the same. If we are unable to provide you with your requested withdrawal day, you will be notified accordingly.

Section 4.2 - Authorization for Pre-Authorized Cheque (PAC)

I would like to set up my PAC Agreement in the following manner:

☐ Create new PAC Agreement using either: ☐ The Account information on the first cheque provided with this application; or
☐ The Account information shown on VOID cheque attached or a bank Letter of Direction (a line of credit account cannot be used)

☐ Add to existing PAC Agreement – BMO Insurance Policy #:

I authorize BMO Life Assurance Company (BMO Insurance) to at any time begin deductions as per my instructions for monthly recurring premiums as payment for the insurance coverage applied for in this Application.

1. I agree that, for the purpose of this agreement, all pre-authorized debits from my account will be treated as Personal.
2. I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of withdrawal.
3. This authorization may be cancelled at any time upon BMO Insurance's receipt of written notice by me.
4. Any cancellation of this pre-authorized withdrawal will not affect the agreement between me and BMO Insurance whatsoever with respect to any insurance coverage so long as payment is provided by an alternate acceptable method.
5. I certify that all persons whose signatures are required to sign on this account have signed below, including any required joint account holder.
6. I understand and agree that if a pre-authorized payment is returned due to non-sufficient funds, BMO Insurance is authorized to retry the payment within ten (10) business days.
7. I am aware that certain recourse rights exist in the event that a debit does not comply with this agreement. I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAC agreement. I may obtain a sample cancellation form or more information on my right to cancel this Authorization by contacting BMO Insurance or by visiting www.cdnpay.ca

Date Signed

Signature(s) (for a joint account, all depositors must sign) X

X

Section 4.3 - Credit Card Authorizations

PLEASE PRINT - CREDIT CARD AUTHORIZATION (FOR FIRST ANNUAL PAYMENT ONLY, UP TO A MAXIMUM OF $50,000)

Proposed Life Insured's Name(s)

☐ Master Card ☐ Visa Card Number

Expiry date (mm/yyyy)

I authorize BMO Life Assurance Company (BMO Insurance) to charge $ to the above account in respect of 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 your Application.

Date Signature X Cardholder's Name (please print)

Section 5 - Beneficiary Information

If you are applying for life insurance coverage
- Complete sections 5.1, 5.2 and 5.3 (as needed)

If you are applying for critical illness insurance coverage
- All proceeds from any Critical Illness base plan will be paid to the owner of the policy unless a beneficiary has been designated or a direction to pay has been completed.
- For applications signed and the policy issued in any of the following provinces: Alberta, British Columbia, Manitoba or Quebec, beneficiaries may be designated in Section 5.1.
- For applications signed and Critical Illness policies issued in any other province or territory in Canada, the Direction to Pay for Critical Illness Policies form (630E) can be completed.
- All proceeds from any Critical Illness Return of Premium on Surrender (ROPS) Rider will be paid to the owner of the policy unless a beneficiary has been designated or a direction to pay has been completed.
- All proceeds from any Critical Illness Return of Premium on Death (ROPD) Rider will be paid to the owner of the policy, or the owner's estate, unless a beneficiary has been designated or a direction to pay has been completed.
- For applications signed and the policy issued in any of the following provinces: Alberta, British Columbia, Manitoba or Quebec, beneficiaries for the ROPS or ROPD may be designated in Section 5.3.
- For applications signed and Critical Illness policies issued in any other province or territory in Canada, the Direction to Pay for Critical Illness Policies form (630E) can be completed for the ROPS (section C) and ROPD (section D).

IMPORTANT INFORMATION

Primary/Contingent Beneficiaries
- The beneficiary is the Primary Beneficiary as indicated in the chart below.
- A Contingent Beneficiary (Subrogated Beneficiary in Quebec) becomes the beneficiary in the event that all of the Primary Beneficiaries named have died before the death of the Proposed Life Insured or have been disentitled.
- A Contingent Beneficiary (Subrogated Beneficiary in Quebec) is always revocable.

Irrevocable/Revocable Beneficiaries
- In all provinces except Quebec, Primary Beneficiaries are revocable unless otherwise stated.
- In Quebec, if a married or civil union spouse is named beneficiary the designation is irrevocable unless otherwise stated.
- A minor should not be named as an irrevocable beneficiary.
- A minor irrevocable beneficiary cannot consent to change of beneficiary and a parent or guardian may not sign on behalf of a minor child for this purpose.

Minors
- Outside Quebec you should name a Trustee to receive the benefits while the beneficiary is still a minor.
- In Quebec, the benefits will be paid to the Tutor(s) unless you have appointed an Administrator or have established a formal Trust.

All beneficiary percentages must total 100%

Section 5.1 - Proposed Life Insured

		Legal Name (first, middle initial, last)	Relationship to Proposed Life Insured (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	Percentage Share (%)
Primary Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Contingent (Subrogated in Quebec) Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Primary Beneficiary for Joint Last to Die Special Death Benefit Rider, if different from above	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Contingent (Subrogated in Quebec) Beneficiary for Joint Last to Die Special Death Benefit Rider, if different from above	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					

Section 5 - Beneficiary Information (continued)

Section 5.2 - Proposed Additional Life Insured

		Legal Name (first, middle initial, last)	Relationship to Proposed Additional Life Insured (in Quebec, relationship to Owner)	Date of Birth for Minor Beneficiary (dd/mmm/yyyy)	Trustee name /Administrator	Percentage Share (%)
Primary Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Contingent (Subrogated in Quebec) Beneficiary	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Primary Beneficiary for Joint Last to Die Special Death Benefit Rider, if different from above	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					
Contingent (Subrogated in Quebec) Beneficiary for Joint Last to Die Special Death Benefit Rider, if different from above	☐ Revocable ☐ Irrevocable					
	☐ Revocable ☐ Irrevocable					

Section 5.3 - Optional Benefits and Riders

A beneficiary on any rider is as stated above unless otherwise indicated in the chart below.

	Legal Name (first, middle initial, last)	Relationship to Proposed Life Insured (in Quebec, relationship to Owner)	Percentage Share (%)
Term Riders			
Accidental Death Benefit			
Children's Term Rider			
Critical Illness Return of Premium on Surrender (ROPS) Rider			
Critical Illness Return of Premium on Death (ROPD) Rider			
Other, Please Specify			

Section 6 - Insurance History

Please complete questions 1, 2 and 3.
Please provide details for "Yes" answers in space provided, and if necessary in Comments Section below.

	Proposed Life Insured		Proposed Additional Life Insured	
	Yes	No	Yes	No
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.)	☐	☐	☐	☐
2a. Is this Insurance intended to replace or change any existing Life or Critical Illness Insurance with BMO Insurance or any other Company? If Yes, answer 2b.	☐	☐	☐	☐
2b. If this insurance applied for will replace an existing BMO Insurance policy, does the owner instruct BMO Insurance to cancel such policy on issuance of the policy applied for herein?	☐	☐	☐	☐
If Yes to 2a, **to Life Insurance application**, 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.				
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 below.)	☐	☐	☐	☐

	Company	Type of Insurance Plan	Personal Amount	Business Amount	Yr. Issued (if in-force) or Yr. submitted (if Pending)
Proposed Life Insured					
Proposed Additional Life Insured					

Section 7 - Comments

Comments (If additional space is required, please attach a separate page with the Proposed Life Insured's signature and current date.)

Section 8 - Personal Information

Please provide details for "Yes" answers in space provided, and if necessary Comments Section below. For Quebec and British Columbia residents, include an MVR Authorization if required due to Underwriting Requirements.

	Proposed Life Insured		Proposed Additional Life Insured	
	Yes	No	Yes	No
1. Have you used any form of tobacco, marijuana, hash, nicotine products or nicotine substitutes:				
a) in the past 12 months?	☐	☐	☐	☐
b) in the past 24 months?	☐	☐	☐	☐
c) in the past 5 years?	☐	☐	☐	☐
2. Have you within the past 5 years flown as a pilot, student pilot, crew member or intend to do so? (If Yes, complete the Aviation Questionnaire.)	☐	☐	☐	☐
3. Have you within the past 5 years participated in motor vehicle or motor boat racing, scuba or skin diving, skydiving, hang gliding, ultra light flying, hot air ballooning, rock climbing, mountaineering, heli-skiing, back country skiing or any other similar sports or avocations or intend to do so? (If Yes, complete the appropriate Avocation Questionnaire.)	☐	☐	☐	☐
4. Have you traveled, resided, or worked outside North America in the past 12 months or have any plans to do so in the next 12 months? (If Yes, provide details in Comments Section including length of time outside of North America, dates and purpose of trips.)	☐	☐	☐	☐
5. Have you had:				
a) more than two moving violations in the past 3 years? (If Yes, give details including dates and type of violation.)	☐	☐	☐	☐
b) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 5 years?	☐	☐	☐	☐
c) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 10 years?	☐	☐	☐	☐
If you answered Yes to a, b, or c please provide your Driver's License number.				
6. Have you ever been charged or convicted of any criminal offense? (If Yes, provide details.)	☐	☐	☐	☐
7. Have you ever declared personal or corporate bankruptcy? (If Yes, when was it discharged)	☐	☐	☐	☐

dd/mmm/yyyy

Comments (If additional space is required, please attach a separate page with the Proposed Life Insured's signature and current date.)

Section 9 - Medical Information

Section 9.1 - Physician

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.

If you need more space use the Comments Section on page 7.

	Proposed Life Insured	Proposed Additional Life Insured
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		

Section 9.2 - Height and Weight

	Proposed Life Insured	Proposed Additional Life Insured
1. Height	☐ cm ☐ ft/in	☐ cm ☐ ft/in
2. Weight	☐ kg ☐ lbs	☐ kg ☐ lbs
a) In past year	☐ Same ☐ Gain ☐ Loss	☐ Same ☐ Gain ☐ Loss
b) Reason for change		
c) How much weight change		

3. If insured is less than 6 months old, weight at birth ☐ kg ☐ lbs

Section 9.3 - Medical History

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.

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

	Proposed Life Insured		Proposed Additional Life Insured	
	Yes	No	Yes	No
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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 and any other neurological disease?	☐	☐	☐	☐
c) Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or any other immunological disorder?	☐	☐	☐	☐
d) Chronic Kidney Disease, Diabetes, Cancer, tumour or other growth?	☐	☐	☐	☐
e) Arthritis, neuritis, sciatica, fibromyalgia, lupus or other disorder of the back, muscles, bones or joints?	☐	☐	☐	☐
f) Anemia, gout, lymph glands, allergies, skin disorders, thyroid, unusual bleeding or other endocrine disorders?	☐	☐	☐	☐
g) Ulcer, hernia, colitis, gallstones, jaundice, hepatitis (including hepatitis carrier), Crohn's disease or other disorders of the stomach, liver, pancreas, or intestines?	☐	☐	☐	☐
h) Kidneys, bladder, genitals, including sugar, blood, pus or protein in urine, kidney stones, prostate, venereal disease, or reproductive disorders? Any disease or disorders of the breasts - including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	☐	☐	☐	☐
i) Asthma, bronchitis, emphysema, pleurisy, pneumonia, tuberculosis, sleep apnea, shortness of breath, chronic cough or other disorders of the nose, throat or lungs?	☐	☐	☐	☐
j) Anxiety, stress, "burnout", depression, fatigue, chronic fatigue, suicide ideation or an emotional, behavioral, mental or nervous disorder?	☐	☐	☐	☐
k) The eyes, ears or throat including loss of speech?	☐	☐	☐	☐
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?	☐	☐	☐	☐

Section 9.3 - Medical History (Continued)

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.

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

	Proposed Life Insured		Proposed Additional Life Insured	
	Yes	No	Yes	No
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?	☐	☐	☐	☐
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)	☐	☐	☐	☐
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)	☐	☐	☐	☐
5. Do you drink alcoholic beverages? (If Yes, indicate type and frequency)	☐	☐	☐	☐
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 or Alcohol Questionnaire.)	☐	☐	☐	☐
7. Have you used any habit forming drugs (including but not limited to marijuana, LSD, cocaine, barbiturates, hash, excitants, hallucinogens or other narcotics) except as prescribed by a Physician? (If Yes, complete the Drug Questionnaire.)	☐	☐	☐	☐
8. Other than as already disclosed, within the past five years, have you:				
a) Consulted a Physician, Chiropractor, Therapist or Health Care Worker?	☐	☐	☐	☐
b) Been a patient in a hospital, clinic or other medical facility?	☐	☐	☐	☐
c) Had, or been advised to have, any hospitalization or pending test or investigation or surgery which was not completed?	☐	☐	☐	☐
d) Had an electrocardiogram, x-ray, blood test or other diagnostic test?	☐	☐	☐	☐
e) Had any mental or physical diseases or disorders not listed above?	☐	☐	☐	☐
f) Been aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐	☐	☐	☐

9. Provide details below for **MEDICAL HISTORY** question(s) (1-8) to which you answered "Yes".

Question No.	Name of Life Insured	Name of Physician if Different from Section 9.1	Details (Including relevant dates, treatments, symptoms, referrals and results)

Section 9.4 - Family History

In the event that medical underwriting requires at least a paramedical, you may elect to NOT complete this section.

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), Parkinsons' Disease or any other hereditary disorders?	☐	☐	☐	☐

2. 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 Life Insured	Additional Life Insured	Relationship to Life Insured	Disease or disorder, if any	Age if Living	Age at Onset	Cause of Death	Age at Death
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Section 10 - Purpose of Insurance and Source of Payment

Section 10.1 - Purpose of Insurance - Completion is mandatory on all applications.

1. Purpose of Insurance: ☐ Personal ☐ Key Person ☐ Buy Sell

☐ Stock Redemption ☐ Other

2. Is there an existing or planned agreement that provides for anyone other than the Proposed Life Insured or Owner identified in Sections 1.1, 1.2, or 1.3 to obtain any legal interest in any policy resulting from this application? ☐ Yes ☐ No

If Yes, provide details.

Section 10.2 - Source of Payment – Completion is mandatory on all applications (Select all that apply)

1. Source of Payment

☐ Self-employment income ☐ Employment income ☐ Retirement Income/Pension Income ☐ Grants/Scholarships

☐ Insurance Claim Payments ☐ Corporate ☐ Investment Income/Savings ☐ Sale of Assets

☐ Trust/Inheritance ☐ Gift ☐ Loan ☐ Lottery Winnings

☐ Proceeds from a legal case or action ☐ Other

Section 11 - Financial Information

Section 11.1 - Completion is mandatory on all applications.

	Proposed Life Insured	Proposed Additional Life Insured	Owner (to be completed only if the Owner is not the Proposed Life 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 inforce insurance on the working spouse?	$	$	$

Section 11.2 - 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 ☐ Corporation ☐ Partnership ☐ Proprietorship

4. Nature of the Business

5. Fair Market Value $

6. Net Profit After Taxes Last Year $ Year Before $

7. Percentage Ownership of the Business %

8. Details of Business Insurance on other members of business

9. How was the amount of insurance determined?

Section 11.3 - To be completed if the Proposed Life Insured is under the age of 16.

1. Is the Proposed Life Insured under the age of 16? ☐ Yes ☐ No

(If Yes, indicate the amount of In Force Life and or Critical Illness Insurance on the parents and other siblings)

Section 12 - Children's Term Rider and Payor Waiver of Premium

☐ Children's Term Rider * ☐ Payor Waiver of Premium

*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 12 if both Children's Term Rider and Payor Waiver of Premium is applied for.

Proposed Life Insured

First and Last Name	Relationship to Proposed Life Insured	Date of Birth (dd/mmm/yyyy)	Height	Weight
			☐ cm ☐ ft/in	☐ kg ☐ lbs
			☐ cm ☐ ft/in	☐ kg ☐ lbs
			☐ cm ☐ ft/in	☐ kg ☐ lbs
			☐ cm ☐ ft/in	☐ kg ☐ lbs

	Yes	No
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?	☐	☐
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?	☐	☐
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?	☐	☐
4. Is anyone proposed for coverage above presently taking any medication?	☐	☐
5. Has anyone proposed for coverage above:		
a) Ever had a request for life or disability insurance declined, postponed, rated, or restricted 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, 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?	☐	☐

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 13 - Representations, Acknowledgements, Authorizations and Signatures

Section 13.1 - Representations, Acknowledgements and Signatures

I, we the undersigned, consent to the issue of a policy based on this Application for insurance (Application) and confirm that the declaration made below is complete and true: and I, we

1. Confirm that the statements and answers in this Application, and in any documents which by Agreement form part of this Application, are complete and true and correctly recorded.
2. Agree that such statements and answers shall form part of any policy, if issued. I, we understand that any false, incomplete or misleading statement or answer on my/our part shall render any policy issued by BMO Life Assurance Company (BMO Insurance) voidable.
3. Agree that the insurance applied for shall take effect, notwithstanding coverage issued under the Temporary Insurance Agreement, only if and when:
   a) this Application is approved by BMO Insurance subject to any amendments, and
   b) the premium is paid, in full, on delivery of the policy, and
   c) answers and statements in this Application continue to be complete and true at the time of acceptance of the Policy.
4. Agree that acceptance of any policy issued on this Application constitutes approval of the provisions of the policy and ratification of any additions or endorsements or amendments.
5. Authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, any insurance company, advisor or broker, or its affiliate, the Medical Information Bureau, any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide to and exchange with BMO Insurance or its reinsurers all such information and records.
6. Authorize BMO Insurance or any personal information agents, third party investigation agencies or organizations hired by BMO Insurance to acquire information about me for the appraisal of the risk or the evaluation of a claim. I acknowledge receipt of the Medical Information Bureau-Notice and the BMO Insurance Privacy and Confidentiality Notice.
7. Authorize BMO Insurance to exchange the personal information obtained during my Application, or claim made under the policy issued on this Application with BMO Insurance's advisors, brokers or its affiliates and reinsurers. I, we further authorize BMO Insurance and its reinsurers to include this personal information in any other files, which they currently hold respecting me, or which may be opened in the future. I, we also authorize BMO Insurance and its reinsurers to refer to any existing files, opened or closed which they currently hold regarding me, us.
8. Authorize BMO Insurance to record and refer to my Social Insurance Number for record keeping, underwriting and claims paying process.
9. Consent to the testing of specimen(s) provided by me, which may include AIDS Virus (HIV) antibody/antigen testing. I, we consent to BMO Insurance releasing the results of any tests, reports and personal information gathered about me to its reinsurers, if involved in the appraisal of risk or the evaluation of claims, to my Personal Physician, to the Medical Information Bureau and other authorized insurers, and to inquire of them for the appraisal of the risk or the evaluation of a claim.
10. Agree that in addition to this Application, a supplementary medical and lifestyle questionnaire(s) could be completed either directly with the advisor, or in a telephone conversation with a medical professional, or during a visit with a medical professional. I, we agree that any such information will be used to consider the Application. I, we agree as well to review this information upon receipt of the policy and to advise BMO Insurance immediately if there is any inaccurate or false information.
11. Declare that the person or firm advising me on the purchase of this product has provided me with written materials advising: about the company(s) they currently represent; that they receive compensation (such as commissions) for the sale of life and health insurance products; that they may receive additional compensation in the form of bonuses, conference programs or other incentives; of any conflicts of interest they may have with respect to this transaction.

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

Policy Language

Do you understand the language in which this Application for Insurance is written? ☐ Yes ☐ No

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, please describe the steps that were taken to ensure you understood the questions and authorizations in this Application for insurance. The insurance policy you applied for will only 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.

Section 13.1 - Representations, Acknowledgements and Signatures (continued)

I, we the undersigned confirm that I, we have read and understood the foregoing Representations, Acknowledgements and Authorizations.

Signatures

Signed at _____ this _____ day of _____ , 20 _____

Proposed Life Insured or Consenting Parent or Guardian (Child age 16 or older, age 18 or older in Quebec, must sign application)	X
Additional Proposed Life Insured	X
Owner (If other than Proposed Life Insured(s)	X
If company owned, 2 Signatures and Titles or 1 Signature and Corporate seal)	X
Payor(s) (if other than the Proposed Life Insured(s) or if Owner Waiver elected)	X
Witness	X
Name of witness (if not advisor)	

Section 13.2 - Comments

Section 13.3 - Authorization - PLEASE COMPLETE ON ALL APPLICATIONS - *Do not detach*

(Valid in Alberta for a period of twelve (12) months and not more than twenty-four (24) months)

I, we hereby authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, any insurance company, advisor or broker, or its affiliate, the Medical Information Bureau, any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide to and exchange with BMO Life Assurance Company or its reinsurers all such information and records. This same complete authorization is made concerning any member of my family proposed for coverage. Note: Parent or legal guardian signing on behalf of a minor must indicate relationship. (A photographic copy of this authorization shall be as valid as the original.)

Date (dd/mmm/yyyy)	Witness	Name of witness (if not advisor)	Proposed Insured
/ /	X		X
/ /	X		X
/ /	X		X

Proposed Additional Life Insured

Proposed Life Insured, Parent or Legal Guardian and relationship (if Proposed Life Insured is a minor)

Section 14 - Advisor Report

Section 14.1 - General Information

1. How long have you known the Proposed Life Insured(s)? _____

Relationship to the Proposed Life Insured(s)? ☐ Know well ☐ Know slightly ☐ Just Met

If related: ☐ Spouse ☐ Parent ☐ Child/Dependent ☐ Sibling ☐ Other _____

2. Who solicited this Application? ☐ Advisor ☐ Proposed Life Insured ☐ Owner

3. Did you personally meet with the person(s) to be insured and the policy owner(s)? ☐ Yes ☐ No

4. Underwriting requirements ordered:

☐ Urine-HIV ☐ Para-Medical ☐ Resting E.C.G. ☐ Saliva-HIV

☐ Doctor's Medical ☐ Stress E.C.G. ☐ Blood Profile ☐ APS

☐ Inspection Report ☐ Other _____

APS (if ordered, name of Physician) Dr. _____

Name of Paramedical facility or Medical Examiner _____

Section 14.2 - Advisor Certification

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. I confirm that I have seen the original valid government issued document presented by the Proposed Life Insured and Proposed Additional Life Insured, if applicable, for identification purposes. I also confirm that 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.**

Soliciting Advisor's Name (please print)	Soliciting Advisor's Signature	Date (dd/mmm/yyyy)

Section 14.3 - Advisor Information

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

BMO Insurance

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
www.bmoinsurance.com

Section 15 - General Comments

Outline any information which may help in the underwriting of the risk and processing of this Application for Insurance. (ie. special instructions - issues)

Section 16 - Application for Temporary Insurance

The following questions are to be answered by all Proposed Life Insured(s) and Proposed Additional Life Insured(s).

If applying for life insurance only, complete question 1 and questions 2 a) through e).

If applying for critical illness insurance, complete questions 1, 2 and 3.

	Proposed Life Insured		Proposed Additional Life Insured	
	Yes	No	Yes	No
1. Are you over the age of 65?	☐	☐	☐	☐
2. Have any Proposed Life Insured(s) or Proposed Additional Life Insured(s)				
a) Ever been treated for or had any indication 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, symptoms of or treatment for cancer or tumour, AIDS or HIV infections?	☐	☐	☐	☐
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?	☐	☐	☐	☐
c) Within the past 2 months have you (other than pregnancy or childbirth) been admitted to a hospital or other medical facility or been advised to do so?	☐	☐	☐	☐
d) Been advised to have any tests, investigation or surgery not yet done?	☐	☐	☐	☐
e) Been advised that you are not eligible for life insurance or been offered such insurance with extra premium or modified in any way?	☐	☐	☐	☐
3. Have any Proposed Life Insured(s) or Proposed Additional Life Insured(s) been advised that you are not eligible for health or critical illness insurance or been offered such insurance with extra premium or modified in any way?	☐	☐	☐	☐

If any of the above questions are answered "Yes" for any Proposed Life Insured and/or Proposed Additional Life Insured, **DO NOT** accept premium monies or detach the receipt. Premium 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.

Amount paid with Application $ _____

In addition to the acknowledgements on the Representations, Acknowledgements, Authorizations and Signatures Section, we specifically acknowledge that we have read and received the Temporary Insurance Agreement and Receipt.

Dated at _____ this _____ day of _____ year _____

X _____	_____	X _____
Witness	Name of witness (if not advisor)	Proposed Life Insured, Parent of Legal Guardian (if Proposed Life Insured is a minor)
X _____	_____	X _____
Witness	Name of witness (if not advisor)	Proposed Additional Life Insured
X _____	_____	X _____
Witness	Name of witness (if not advisor)	Policyowner (if other than Proposed Life Insured)

Section 17 - Temporary Insurance Agreement and Receipt

Please detach and give to 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 $ _____

for Life and or Critical Illness Insurance on the life of _____ (Proposed Life Insured)

with an application dated (dd/mmm/yyyy) / /

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.

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)

X _____ / /

(Signature of Advisor) — Date (dd/mmm/yyyy)

This temporary insurance is to provide limited coverage (temporary insurance amount) as described below while your Application is being processed. Coverage under this temporary insurance does not guarantee approval of your Application. Any change in insurability while your Application is being processed may also affect whether or not your Application is approved.

In the event of death of a life to be insured while this temporary insurance is in force, who qualifies for temporary insurance coverage, BMO Life Assurance Company (BMO Insurance) will pay the temporary insurance amount. Payment will be made in accordance with the beneficiary designation(s) in the Application and, in cases of joint lives to be insured, the plan for which application has been made.

Where an amount equal to at least one twelfth of the annual premium for the policy(ies) applied for has been paid, BMO Life Assurance Company (BMO Insurance) agrees to provide Temporary Life and Critical Illness Insurance to the Proposed Life Insured(s) subject to the conditions, terms, limitations and other provisions set forth below:

Conditions for Termination:

1. Termination date is the 90th day after the date this application is signed.
2. This Agreement terminates automatically when the policy(ies) applied for become(s) effective, a counteroffer is tendered to your representative, or on the termination date, which ever comes first.
3. BMO Insurance may terminate this Agreement at any time prior to the above indicated termination date. Notice will be mailed to the Owner with a refund of any money paid, to the mailing address designated on this Application. The termination date is the day following the mailing of the notice by BMO Insurance.

No representative of BMO Insurance is authorized to modify this Agreement.

Effective date:

Temporary coverage under this Agreement is effective when this Application has been fully completed and signed and an amount equal to at least one twelfth of the annual premium has been paid on the same date.

Temporary Life Insurance Coverage:

1. The maximum amount of insurance on the Proposed Life Insured(s) under this and any other Temporary Insurance Agreement with BMO Insurance is limited to the lesser of:
   a) The amount of insurance applied for, or
   b) $1,000,000 on each life for Life Insurance Application (regardless of the amount of money submitted with this Application), or
   c) $500,000 on each life for Critical Illness;
2. No insurance is provided for any accidental death benefit rider, waiver of premium benefit, Children's Term Rider and Payor Waiver of premium.
3. If any Proposed Life Insured dies by his or her own intentional act, whether sane or insane, BMO Insurance's only liability is to refund any payment received.

Limitations: No insurance will be in effect under this Agreement unless:

1. The Proposed Life Insured is at least 15 days of age for life insurance and 30 days of age for critical illness insurance and is not over 65 years of age on the date of this agreement.
2. Any cheque or draft given for premium is payable to BMO Life Assurance Company and is honoured upon first presentation for payment.
3. No Critical Illness Benefit will be paid under this Agreement for any diagnosis of cancer.
4. No Critical Illness Benefit will be paid under this Agreement if death occurs within thirty days of the diagnosis of a defined critical illness.
5. Our standard Critical Illness policy provisions and exclusions shall govern the Critical Illness Insurance provided under this Receipt.

Section 18 - Legal Information *Please detach and give to Proposed Life Insured(s)*

MEDICAL INFORMATION BUREAU-NOTICE

Information regarding your insurability will be treated as confidential. BMO Life Assurance Company (BMO Insurance) or its Reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

BMO Insurance or its Reinsurer(s) may also release information to other life or health insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7, telephone (416) 597-0590, www.mib.com. BMO Insurance or its reinsurer(s) may also release information in its files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

DISCLOSURE STATEMENT

The transaction represented by this Application is between the applicant and BMO Life Assurance Company (BMO Insurance). The Advisor soliciting this insurance Application is an independent contractor and the person or firm advising you on the purchase of this product has provided you with written materials advising: about the company(s) they currently represent; that they receive compensation (such as commissions) for the sale of life and health insurance products; that they may receive additional compensation in the form of bonuses, conference programs or other incentives; of any conflicts of interest they may have with respect to this transaction. The applicant is not obligated to transact any other business with BMO Insurance as a condition of the Application.

BMO Insurance PRIVACY AND CONFIDENTIALITY NOTICE

BMO Life Assurance Company (BMO Insurance) has requested personal information in respect of your Application for insurance. BMO Insurance will use this information and information in its existing files to assess risk, process your application, administer any policy, if issued and to investigate claims. BMO Insurance will also use and collect additional information from third parties to evaluate and investigate claims. BMO Insurance will keep your information in a file in its offices and will not disclose the information in that file except to those BMO Insurance employees, agents, its affiliates, administrators or reinsurers who need access to assess risk and investigate claims. From time to time, BMO Insurance may wish to offer you upgrades to your coverage and additional products and services. You may ask us not to make these offers to you by writing to our Privacy Officer at the address below. You may also request, upon presentation of proper identification and proof of entitlement, to review and if appropriate, correct, your personal information in our possession by writing to:

Privacy Officer, BMO Life Assurance Company
60 Yonge Street, Toronto, Ontario, Canada M5E 1H5

App. No._____

BMO Insurance

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
www.bmoinsurance.com