the EDGE Benefits™

APPLICATION FOR INSURANCE - PART 1

SECTION 1 GENERAL INFORMATION

❍ NEW APPLICATION

❍ ADDING/CHANGING EXISTING POLICY - EXISTING POLICY # ____

❍ ADDING TO AN EXISTING MULTI-LIFE BILLING - COMPANY NAME: ____

APPLICANT NAME ____ First ____ Last ____

PREVIOUS NAME (if applicable) ____ First ____ Last ____

PLACE OF BIRTH ____ Country ____

DATE OF BIRTH ____ (YYYY/MM/DD) ____ AGE ____ ❍ MALE ❍ FEMALE OCCUPATION: ____

ADDRESS ____ Street ____ Suite/Apt. ____ City/Town ____ Prov. ____ Postal Code

PHONE ____ PERSONAL EMAIL ____ (In order to receive notifications about your policy)

EMPLOYER or COMPANY NAME ____

EMPLOYER or COMPANY ADDRESS ____ Street ____ Suite ____ City/Town ____ Prov. ____ Postal Code

EMPLOYER or COMPANY PHONE ____ WORK EMAIL: ____

SECTION 1A BENEFICIARY DESIGNATION: AD&D / FINAL EXPENSE/ CRITICAL ILLNESS

Where no beneficiary is indicated benefits will be payable to the estate of the insured. The beneficiary will be the Applicant in the event of death of a spouse and/or dependent child(ren), where Family coverage is selected (where applicable).

AD&D COVERAGE

APPLICANT BENEFICIARY ____ First ____ Last ____ RELATIONSHIP ____

PHONE: ____ ADDRESS: ____

TRUSTEE: for minor beneficiaries ____ RELATIONSHIP of trustee to beneficiary ____

PHONE: ____ ADDRESS: ____

FINAL EXPENSE COVERAGE ❍ Same as above, or;

APPLICANT BENEFICIARY ____ First ____ Last ____ RELATIONSHIP ____

PHONE: ____ ADDRESS: ____

TRUSTEE: for minor beneficiaries ____ RELATIONSHIP of trustee to beneficiary ____

PHONE: ____ ADDRESS: ____

CRITICAL ILLNESS COVERAGE ❍ Same as above, or;

APPLICANT BENEFICIARY ____ First ____ Last ____ RELATIONSHIP ____

PHONE: ____ ADDRESS: ____

TRUSTEE: for minor beneficiaries ____ RELATIONSHIP of trustee to beneficiary ____

PHONE: ____ ADDRESS: ____

Where Québec Law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable". I hereby make the above beneficiary designation: ❍ Revocable, I may change this designation at any time.

SECTION 1B ADVISOR INFORMATION PLEASE PRINT:

NAME First Mario Last Schwarzenberg EDGE ADVISOR CODE: 7382

ADDRESS 494 Street McNicoll Ave Suite/Apt. Ste 203 City/Town North York Ont. Prov. M2H 2E1 Postal Code

PHONE 416-499-6792 EMAIL msinsr@gmail.com Company/MGA: (if applicable)

Is your client replacing any other insurance with the coverage being applied for? ❍ YES ❍ NO

If "YES", you must provide this applicant with the applicable replacement disclosure form and submit a copy along with this application.

ADVISOR SIGNATURE ____

IS THIS A SPLIT COMMISSION? ❍ YES ❍ NO If "**YES**" Primary Advisor: ____ **%** Secondary Advisor: ____ **%**

SECONDARY ADVISOR NAME ____ First ____ Last ____ SECONDARY ADVISOR CODE ____ Company/MGA: (if applicable)

ADDITIONAL INFORMATION/ NOTES ____

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SECTION 2 — LOSS OF INCOME & BUSINESS OVERHEAD EXPENSE QUALIFYING QUESTIONS

MUST BE COMPLETED IF APPLYING FOR LOSS OF INCOME INJURY &/or BUSINESS OVERHEAD EXPENSE COVERAGE *Insured by Co-operators Life Insurance Company*

OCCUPATION*______________________ **OCCUPATIONAL RATING:** ❍ EXEC ❍ AA ❍ A ❍ B ❍ BB

**Please use the exact wording as stated in the Rate Guide. If the occupation is not listed, please go to our web site for more options.*

QUALIFYING QUESTIONS

1. **Have you ever had any injury(ies) or other condition which currently restricts your bodily movement or that limits you in performing any daily activities?** *If YES, coverage is NOT AVAILABLE* ❍ YES ❍ NO
2. **Are you currently working at least 20 hours per week and 35 weeks per year?** *If NO, coverage is NOT AVAILABLE* ❍ YES ❍ NO

If you have satisfied the qualifying questions above, continue

3. **Do you understand English and/or French?** *If NO, please submit the appropriate "statement of understanding" in your language*....... ❍ YES ❍ NO
4. **Are you covered by any workers' compensation plan?** *If No, only 24 hour coverage is available. If Yes, you can still purchase 24 hour coverage but benefits will be integrated. You may wish to consider non-occupational coverage*....... ❍ YES ❍ NO
5. **Are you covered by Employment Insurance?** *If Yes, 120 Day Elimination Period coverage is available*....... ❍ YES ❍ NO
6. **Do you work in any occupation other than the occupation noted above?**....... ❍ YES ❍ NO

If Yes; Occupation(s): ______________________ *percentage of time spent in this Occupation(s):* ___________

If this occupation is a different class than the primary occupation and more than 15% of time is spent, please use the lowest of the Occupational Classes for rating purposes.

SECTION 3 — LOSS OF INCOME BENEFIT CALCULATOR

*For **Self Employed Individuals,** fill out the chart below to determine the best income option to use in Box A1.*

OPTION 1 - SELF-EMPLOYED - GROSS BUSINESS REVENUE

Gross Business Revenue Formula

Enter Gross Business Revenue	$
***LESS** Cost of Goods*	- $
***LESS** Employee Wages (Do not include wages to yourself or income splitting amounts)*	- $
*EDGE Gross Business Revenue (**Column 1** in Insurable Monthly Earnings chart)*	$
Divide by 2 for the Option 1 Total:	$

OPTION 2 - SELF-EMPLOYED - NET EARNED INCOME

Net Earned Income Formula

Enter Your Share of Profit before Tax (Net Earned Income)

Option 2 Total	$

*(**Column 2** in Insurable Monthly Earnings chart)*

Self Employed	*Enter the HIGHEST of OPTION 1 or 2 from the calculator above*	$ (A1)

OPTION 3 - EMPLOYEE/ CONTRACT PERSONNEL

EMPLOYEE/CONTRACT PERSONNEL INCOME

****Contract Personnel** means an individual who, during the term of the contract, provides services to only one person, partnership, association, body corporate or entity, including a partnership or an unincorporated association or organization (each entity, a "Person"), where (a) the Person provides the tools, materials or equipment for the individual to perform the services, and (b) the individual is remunerated on a per unit (pound, square foot, kilometre, etc.) or hourly basis.*

Employees/Contract Personnel	*Enter annual Employment Income/Earnings from Contract*	$ (A2)*

Qualifying Insurable Monthly Earnings (See Insurable Monthly Earnings Chart in LPP)	$ (B)
***LESS:** monthly amount of existing coverage remaining in force (provide details below)*	– $ (C)
Final Qualifying Insurable Monthly Earnings	$ (D)

EXISTING COVERAGE REMAINING IN FORCE

*If more space is required, please use the **"Additional Information/Notes" in Section 1B"***

Maximum Monthly Benefit Amount. (up to $5,000 for Classes A,B, and BB and up to $6,000 for Class AA and Exec).

Provide details of existing coverage remaining in force. Failure to disclose may result in cancellation of coverage, or a reduction in benefits provided under this policy.

Type: ________ (DI Injury, DI Illness, BOE etc.) ________ Amount__________ Company______________________ EP:_______ BP:_______

SECTION 4 — BUSINESS OVERHEAD EXPENSE COVERAGE *Insured by Co-operators Life Insurance Company*

MONTHLY PAYMENTS

Lease Payments	$	Insurance Payments	$
Property Rent	$	Utilities	$
Professional Accounting Fees	$	Miscellaneous	$

TOTAL EXPENSES

$ _______________

SECTION 5A — LOSS OF INCOME & BUSINESS OVERHEAD EXPENSE COVERAGE BEING APPLIED FOR

LOSS OF INCOME: *Loss of Income: Insured by Co-operators Life Insurance Company*

1st INJURY COVERAGE ❍ 24 Hour ❍ Non-Occupational **Benefit Period** ❍ 5 Year ❍ to age 70 **Elimination Period** ❍ 0 day ❍ 30 day ❍ 120 day

Monthly Benefit Amount ❍ $1,000 ❍ $1,500 ❍ $2,000 ❍ $2,500 ❍ $3,000 ❍ $3,500 ❍ $4,000 ❍ $4,500 ❍ $5,000 ❍ $5,500 ❍ $6,000 **AA & Exec ONLY** $ ________ *Monthly Premium*

2nd INJURY COVERAGE ❍ 24 Hour ❍ Non-Occupational **Benefit Period** ❍ 5 Year ❍ to age 70 **Elimination Period** ❍ 0 day ❍ 30 day ❍ 120 day

Monthly Benefit Amount ❍ $1,000 ❍ $1,500 ❍ $2,000 ❍ $2,500 ❍ $3,000 ❍ $3,500 ❍ $4,000 ❍ $4,500 ❍ $5,000 ❍ $5,500 ❍ $6,000 **AA & Exec ONLY** $ ________ *Monthly Premium*

ILLNESS COVERAGE: **Benefit Period** *(cannot be greater than Injury)* ❍ 5 Year ❍ to age 70 **Elimination Period** *(cannot be shorter than Injury)* ❍ 30 day ❍ 120 day

Monthly Benefit Amount ❍ $1,000 ❍ $1,500 ❍ $2,000 ❍ $2,500 ❍ $3,000 ❍ $3,500 ❍ $4,000 ❍ $4,500 ❍ $5,000 ❍ $5,500 ❍ $6,000 **AA & Exec ONLY** $ ________ *Monthly Premium* *do not collect illness premium*

(Illness Loss of Income must be purchased in conjunction with the Loss of Income Injury, and must be less than or equal to the Injury amount. Height & Weight, AND Gateway Questions must be satisfied.)

*If applying for Illness Coverage please complete the Application for Insurance **Part 2 - Section 5B, 5C, 5D and 13B***

BUSINESS OVERHEAD EXPENSE: *Insured by Co-operators Life Insurance Company*

INJURY COVERAGE

Monthly Benefit Amount ❍ $1,000 ❍ $1,500 ❍ $2,000 ❍ $2,500 ❍ $3,000 ❍ $3,500 ❍ $4,000 ❍ $4,500 ❍ $5,000 ❍ $5,500 ❍ $6,000 **AA & Exec ONLY** $ ________ *Monthly Premium*

ILLNESS COVERAGE

Monthly Benefit Amount ❍ $1,000 ❍ $1,500 ❍ $2,000 ❍ $2,500 ❍ $3,000 ❍ $3,500 ❍ $4,000 ❍ $4,500 ❍ $5,000 ❍ $5,500 ❍ $6,000 **AA & Exec ONLY** $ ________ *Monthly Premium* *do not collect illness premium*

(Illness BOE must be purchased in conjunction with Injury BOE, and must be less than or equal to the Injury BOE amount. Height & Weight, AND Gateway Questions must be satisfied.)

*If applying for Illness Coverage please complete the Application for Insurance **Part 2 - Section 5B, 5C, 5D, and 13B***

❍ Injury Now, Illness when approved and issued. (Illness premium will be automatically withdrawn, if/when approved – do not collect premium)

❍ Injury & Illness when illness is approved and issued – Trial Application (if selected do not collect premium)

SECTION 6

TRAVEL *Administered by Allianz Global Assistance* *Only available with Loss of Income - Injury coverage* ❍ **SINGLE** ❍ **FAMILY** $ ________ *Monthly Premium*

Travel Plus available exclusively through Quote on Demand/ Electronic Application.

SECTION 7 — ACCIDENTAL DEATH & DISMEMBERMENT *Insured by ACE INA Life Insurance*

Includes additional Accident Medical Reimbursement Benefits only if you are an EDGE Loss of Income Policyholder

OCCUPATION: ________________________ ❍ $50,000 ❍ $100,000 ❍ $200,000 ❍ $300,000 ❍ Single ❍ Family $ ________ *Monthly Premium*

DEPENDENT INFORMATION *Only required if Family coverage is selected. Dependent children are covered up to age 21, or 25 if enrolled as a student full-time. Please provide documentation.*

Name	Relationship to Applicant	Gender (M/ F)	Date of Birth (YYYY/MM/DD)

SECTION 8 — FRACTURE ACCIDENT BENEFIT *Insured by ACE INA Life Insurance*

❍ **PRIMARY PLAN** ❍ **BASE PLAN** $ ________ *Monthly Premium*

SECTION 9 — FINAL EXPENSE BENEFIT *Insured by ACE INA Life Insurance*

❍ $5,000 ❍ $10,000 ❍ $15,000 ❍ $20,000 ❍ $25,000 $ ________ *Monthly Premium*

SECTION 10A — CRITICAL ILLNESS COVERAGE *Insured by ACE INA Life Insurance*

TIER 1 ❍ $5,000 ❍ $10,000 ❍ $15,000 ❍ $20,000 ❍ $25,000 $ ________ *Monthly Premium*

TIER 2 *(Additional CI must be purchased in conjunction with Critical Illness Tier 1 and complete the Application for Insurance **Part 2 - 10B and 13B**)* ❍ $25,000 $ ________ *Monthly Premium*

TIER 3 *(Enhanced CI must be purchased in conjunction with CI Tier 1 and 2 and complete the Application for Insurance **Part 2 - 10B and 13B**)* ❍ $25,000 ❍ $50,000 $ ________ *Monthly Premium*

SECTION 11A — HEALTH & DENTAL *Provided by Green Shield Canada*

Coverage available from ages 18 to 64 who are covered by a provincial health plan. *If applying for H & D please complete the Application for Insurance **Part 2 - Question 11B and 13B***

❍ **HEALTH** (drugs not included for Quebec residents) ❍ **HEALTH & DENTAL** ❍ **RAMQ Top Up** (for Quebec residents only, includes medications)*

❍ **SINGLE** ❍ **COUPLE** ❍ **FAMILY**

❍ **BASE** ❍ **DELUXE** ❍ **PLATINUM** $ ________ *Monthly Premium*

If the applicant currently holds any other coverages offered through the EDGE, (Policy #:_____) or is applying for other EDGE coverages concurrently, you may use discounted premium rates in the Rate Guide.

** You may qualify for RAMQ Top Up if you currently have RAMQ.*

Rates may be adjusted annually for the entire group once a year in October.

TOTAL MONTHLY PREMIUM: $________________

SECTION 12 PRE-AUTHORIZED DEBIT (PAD) *Please attach a cheque marked "VOID"*

I hereby request/authorize The Edge Benefits Inc. ("the Administrator") to debit my account, shown on the attached VOID cheque, pursuant to the Pre-Authorized Debit Agreement outlined on the attached product overview, for each month's premium payable to the Administrator and its successors or assigns. The Administrator's treatment of each payment shall be as if it were a cheque drawn on my account, and signed personally by me. **Under this premium payment method, the Administrator shall not be required to give notice of premiums due.** The expression "cheque" used in this request includes magnetic or computer produced paper tape that is or purports to be a direction to credit any amount to the Administrator and debits such amount to the account described. **If a pre-authorized cheque is returned due to non-sufficient funds, the Administrator is authorized to redeposit the cheque or add the appropriate amount to the next cheque. A $25.00 service fee will be applied to all NSF cheques. If you are applying for Health & Dental coverage, premium will be withdrawn on the 1st of each month. For all other products:**

Your PAD WITHDRAWAL DATE is the Effective Date of Coverage, or select a date ____________ (1st to 28th) *the withdrawal date selected must be within 15 days from the premium due date.*

If your application is submitted without a cheque representing the first month's premium, we will use this PAD information to withdraw the first premium upon receipt of your application.
If you submit a cheque, do not include premiums for Illness Coverages.

Name of Bank: ______________________________ Transit #:___________ Institution #:___________ Account #:____

Date (YYYY/MM/DD) ____________ Signature of Payor X (as it appears on bank records) ______________ Print name of Payor ____

Date (YYYY/MM/DD) ____________ Signature of Second Payor (if required for joint account) ______________ Print name of Second Payor ____

❍ Add to an existing monthly Multi-Life Billing and/or monthly Multi-Life Pre-Authorized Debit for: ______________ (name of company)

SECTION 13A AGREEMENT, DECLARATION & UNDERSTANDING SIGNATURE

I have reviewed this application for benefits, and it is to the best of my knowledge and belief true, complete and correctly recorded and together with any other forms signed by me in connection with this application form the basis for any policy issued. I understand that any coverage arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application. I hereby confirm that I understand, agree and consent as outlined herein.

1. I confirm that I live permanently in Canada and am a Canadian Citizen or a Permanent Resident (landed immigrant) of Canada, and I am not contemplating living permanently outside of Canada within the next 24 months. I understand that if I am not a Canadian Citizen or a Permanent Resident of Canada my coverage will not be valid. (If you are applying for Health & Dental coverage, Declaration #1 is not applicable). Please see the equivalent Declaration in the Supplemental Medical Application Section 13b.
2. I hereby consent to and authorize the disclosure of any records or information received or known by the insurers and/or The Edge Benefits Inc. to any insurance company which reinsures a group of policies which includes my policy number.
3. I understand that all benefits payable are subject to the general terms, conditions, definitions, exclusions and limitations outlined in The Policy Booklets for the applicable coverages.
4. I understand that The Edge Benefits Inc. and/or their Insurers will create and maintain a file for the purposes of the Application and any subsequent claim. Only the employees, mandatories or agents responsible for such purposes will have access to this file. I am entitled to consult the personal information contained in this file and where applicable have it rectified, by formulating a written request to The Edge Benefits and/or their Insurers.
5. EFFECTIVE DATE OF COVERAGE: I hereby understand that Coverage becomes effective on the later of, the date of this application, the date of the cheque for the first month's premium if submitted with this application, or the Effective Date specified on the Schedule of Benefits issued by The Edge Benefits Inc. Coverage will not become effective if the cheque submitted as payment, or pre-authorized debit from my account for the intial premium is not honoured on presentation. If Benefits are being added to a current policy, or age conservation applies, coverage will become effective when received and approved by the insurer, and premiums have been debited from my account. I authorize The Edge Benefits Inc. to debit my account for any additional benefits purchased.
6. If a third party or my employer (herein after referred to as "the Payor") is paying premiums on my behalf, I hereby authorize The Edge Benefits Inc. to receive and accept premium payments, pay any premium refunds, and send any premium or lapse notices to the Payor, and I understand and agree that for purposes set out herein, that the Payor shall be my agent, and the payment of premium refunds or the sending of notices referred to herein to the Payor, shall be deemed to be sufficient notice to me. In addition, I authorize the Payor to have access to my personal information, as supplied in the application form, for the purposes of forwarding it on my behalf to The Edge Benefits Inc. for determining coverage and for the administration of my policy. I also authorize the Payor to receive the policy contract from The Edge Benefits Inc. on my behalf, for delivery to me.
7. INCONTESTABILITY: The statements made in this application, in any subsequent application, or in any application for reinstatement, except for fraudulent misstatements and statements erroneous as to age or sex, shall be incontestable after the policy has been in effect for two years from the later of applicable effective date, or the effective date of an endorsement or amendment to the policy or from the effective date of the last reinstatement.
8. I declare that I am able to read and/or speak English or French and acknowledge having read this notice.

WITH RESPECT TO CRITICAL ILLNESS

9. I understand that a critical illness benefit will not be payable if I am diagnosed with an Insured Condition within the first 24 months immediately following the later of the effective date or the latest reinstatement date of critical illness insurance coverage, which results directly or indirectly from a Pre-existing Medical Condition. "Pre-existing Medical Condition" means any medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to the effective date of insurance, or latest reinstatement date.

I consent to the use of my personal information for the purposes outlined in the Privacy Statement located in the Lifestyle Protection Planner© or Product Overview.
I understand that my consent to the use of any information to offer me products and services is optional, and that if I wish to discontinue such use I may call or write to The Edge Benefits Inc. (or their insurers) at the telephone number or address shown on the Lifestyle Protection Planner© or Product Overview.

❍ I would like to receive additional information on other products and services ❍ I do not want to receive additional information

❍ I acknowledge having received, and have been advised to read the accompanying Lifestyle Protection Planner©, which contains some key exclusions and limitations applicable to the coverage and the Privacy Statement outlining certain privacy practices regarding collection, use and disclosure of my personal information. I have further been advised to review my Policy Booklet when issued for complete understanding of the terms, conditions, definitions, exclusions and limitations outlined in the policy.

Date ______________ Signed at ____________________________ Signature of Applicant X ____

It is the express wish of the parties that this application for insurance and any related documents be drawn up in English
Il est la volonté expresse des parties que cette demande d'assurance et tous les documents y afférents soient rédigés en anglais.

the EDGE Benefits™

APPLICATION FOR INSURANCE – PART 2

○ NEW APPLICATION ○ ADDING/CHANGING EXISTING POLICY - EXISTING POLICY #________________

IMPORTANT INFORMATION FOR THE ADVISOR

COMPLETE AND SUBMIT THIS APPLICATION PART 2 ONLY IF APPLYING FOR ONE OR MORE OF THE FOLLOWING:

LOSS OF INCOME – ILLNESS COVERAGE (refer to sections 5B, 5C, 5D, and 13B) ○ YES ○ NO

BUSINESS OVERHEAD EXPENSE – ILLNESS COVERAGE (refer to section 5B, 5C, 5D, and 13B) ○ YES ○ NO

Loss of Income Illness /Business Overhead Expense Illness – *Insured by Co-operators Life Insurance Company*

This coverage is based on the health and medical history of the applicant, and therefore the completion of these medical questions is required to enable the Insurers to determine if they should accept that risk.

Your role as Advisor in the field underwriting process is critical to ensure that the applicant provides the Insurer with full and complete medical and health history. Ask each question separately, ask additional questions as applicable, and record the information as accurately and precisely as possible.

This application must be submitted with a completed EDGE Disability Application Part 1 or Roadside Loss of Income, INJURY application unless submitted within 12 months of the Effective Date of the Injury only coverage and provided there is no change to the Proposed Insured's General, Qualifying and/or Financial Information.

The EDGE Illness products are for standard risks. If the applicant has applied for coverage with other Insurers that has been rated, or declined based on their health, they will probably be declined for the EDGE Illness product. Subsequently, when completing the illness medical questions if there are various medical conditions present (many "yes" answers) it may be prudent to avoid the resulting underwriting investigation and probable decline, by suggesting instead that they should consider our guaranteed to issue Critical Illness product, where they can purchase $25,000.

TIER 2 ADDITIONAL CRITICAL ILLNESS (refer to section 10B) ○ YES ○ NO

TIER 3 ENHANCED CRITICAL ILLNESS (refer to section 10B) ○ YES ○ NO

Critical Illness – *Insured by ACE INA Life Insurance*

This Tier 2 and Tier 3 coverage allows the applicant to purchase additional amounts up to $100,000 of CI in total, provided they are in good health.
Ask each question separately, to ensure the person qualifies for each Tier.

HEALTH & DENTAL COVERAGE (refer to section 11B and 13B) ○ YES ○ NO

Health & Dental – *Provided by Green Shield Canada*

This coverage is provided to cover unforeseen medical expenses. An application can be approved, approved with an exclusion(s), or declined, depending on the applicant's and/or family member(s) pre-existing medical condition(s).

IMPORTANT NOTE TO ADVISOR:

Understand your role in completing the application is to act as a field underwriter for the insurers. It is your fiduciary responsibility to **ensure responses to ALL questions are answered fully and completely.**

ADDITIONAL INFORMATION:____

____

____

____

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____

ADVISOR NAME:____________________ ADVISOR SIGNATURE:____________________

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SUPPLEMENTARY ILLNESS MEDICAL QUESTIONNAIRE

To be completed in addition to the Application for Insurance -Part 1 if applying for **LOSS OF INCOME/BUSINESS OVERHEAD ILLNESS COVERAGE** *in Section 5A*

SECTION 5B — ILLNESS GATEWAY MEDICAL QUESTIONS *Insured by Co-operators Life Insurance Company*

COMPLETE THIS SECTION ONLY IF APPLYING FOR LOSS OF INCOME ILLNESS OR BOE ILLNESS COVERAGE

1 What is your current Height:________________ ❍feet/inches ❍cm   Weight:________________ ❍lbs ❍kg
Check against the Height & Weight Qualifying Chart on page 8 of the Lifestyle Protection Planner. If outside the limits, Illness Coverage is NOT available.

2 Have you ever had any consultation, advice or treatment for:

a) Heart attack, stroke, disease/disorder of the blood vessels of the heart or brain .... ❍YES ❍NO
b) Parkinson's disease, multiple sclerosis, lupus, cerebral palsy, Lou Gehrig's disease (amyotrophic lateral sclerosis-ALS), emphysema.......... ❍YES ❍NO
c) Huntington's Chorea, muscular dystrophy, cystic fibrosis, Alzheimer's disease, brain or nervous system disease/disorder .... ❍YES ❍NO
d) AIDS, HIV positive or any subtypes, any disease or disorder of the immune system, paralysis, schizophrenia .... ❍YES ❍NO
e) alcoholic pancreatitis, liver cirrhosis, polycystic kidney disease .... ❍YES ❍NO
f) **Within the last 5 years,** have you had any consultation, advice or treatment for any type of cancer (other than basal cell or squamous cell carcinoma)?.......... ❍YES ❍NO

Provided the answers to 1, 2a-2f are acceptable, proceed with Section 5c.

If the answer is YES to any of the illness questions above, Illness Coverage is NOT available, however you may purchase up to $25,000 of Critical Illness coverage (Tier 1) coverage. (refer to Section 10A in the Application for Insurance).

SECTION 5C — ILLNESS MEDICAL QUESTIONS *Insured by Co-operators Life Insurance Company*

DOCTOR'S NAME: ______ First ______ Last ______ DATE LAST CONSULTED: ______ (YYYY/MM/DD) ______

ADDRESS: ______ Street ______ Suite/Apt. ______ City/Town ______ Prov. ______ Postal Code ______

PHONE: ________________________ FAX: ________________________

Provide details of last consultation including: Reason________________________

Outcome/Results/Diagnosis________________________

Treatment given or medication prescribed ________________________

(if you do not have a family physician, please indicate the information above for the last clinic or hospital visited)

ANSWER YES or NO: For any ***"yes"*** answer to the following questions, circle any specific condition and provide details in Section 5D.

Have you ever had any known indication or symptom of, seen a doctor for, or been treated for:

1. Heart, circulatory problem, TIA (transient ischemic attack), high blood pressure, elevated cholesterol, angina, varicose veins, chest pain, palpitations, heart murmur, rheumatic fever or other heart disorder?.......... ❍YES ❍NO
2. Cancer, leukemia, tumor, abnormal growth or cyst, or unusual skin lesion?.......... ❍YES ❍NO
3. Diabetes, sugar in the urine, elevated sugar in the blood, disorder of the thyroid, pituitary or other glands?.......... ❍YES ❍NO
4. Asthma, bronchitis, tuberculosis, persistent or chronic cough, shortness of breath or any disorder of the lungs or respiratory system?.......... ❍YES ❍NO
5. Dizziness, seizures, fainting, chronic headaches, migraines, epilepsy, loss of consciousness, sleep apnea or, other sleep disorder?.......... ❍YES ❍NO
6. Any disease or disorder of the reproductive organs, breast, or prostate?.......... ❍YES ❍NO
7. Protein or blood in the urine, kidney stone, or other disorder of the bladder or kidneys?.......... ❍YES ❍NO
8. Hepatitis B or C, anemia, hemophilia or any other disorder or abnormality of the blood?.......... ❍YES ❍NO
9. Internal bleeding, jaundice, colitis, crohn's, ulcer, hernia, chronic diarrhea or other disease, condition or disorder of the stomach, intestines, liver, gall bladder or pancreas?.......... ❍YES ❍NO
10. Amputation, deformities, numbness, tingling of the limbs, arthritis, osteoporosis, or connective tissue disease?.......... ❍YES ❍NO
11. Any disease, disorder or impairment of the eyes or ears?.......... ❍YES ❍NO
12. Any disease or disorder of the back, neck, or spinal discomfort including pain, sprain, strain, sciatica or disc disease?.......... ❍YES ❍NO
13. Any disease or disorder of the knees, ankles, feet, hips, wrists, hands, elbows, shoulders or any other joints? If YES, please indicate specific joint.......... ❍YES ❍NO
14. Have your parents or siblings ever had polycystic kidney disease, Huntington's chorea, dystonia or other hereditary disease?.......... ❍YES ❍NO
*15. **Within the past 5 years,** have you been advised about or treated for use or abuse of alcohol or drugs (prescription or non-prescription), or have you been convicted of any criminal offense or are charges currently pending against you?*.......... ❍YES ❍NO
*16. **Within the past 5 years,** have you had any undiagnosed or untreated condition for which tests or examination are as yet to be completed or are ongoing?*.......... ❍YES ❍NO
*17. **Within the past 5 years,** have you had any illness or injury that resulted in missing more than 10 consecutive days of work?*.......... ❍YES ❍NO
18. Are you presently under investigation, observation or treatment therapy, counselling or taking medication?.......... ❍YES ❍NO
*19. Do you use any form of tobacco or nicotine product? If "YES", what type?*________________________.......... ❍YES ❍NO

Please provide details of any "YES" answers on following page.

I declare I have asked the applicant each of the above questions, and disclosed all provided information within. (Advisor initials) ______________

SECTION 5D

ILLNESS - *Details for any previously answered **"yes"** medical questions*

IMPORTANT: If you are providing details regarding a history of elevated blood pressure, high cholesterol, or diabetes, please provide the most recent readings and dates completed. If more space is required, complete the Additional Information section.

Question No.:______ Please provide details including diagnosis________________________ Date______(YYYY/MM/DD)______

Type of treatment (including medication) ________________________ and results/outcome ________________________

DATE fully recovered with no residuals or limitations:______(YYYY/MM/DD)______ Dr. Information: ______First______Last______

Street______ Suite/Apt.______ City/Town______ Prov.______ Postal Code______

COMMENTS: ____

Question No.:______ Please provide details including diagnosis________________________ Date______(YYYY/MM/DD)______

Type of treatment (including medication) ________________________ and results/outcome ________________________

DATE fully recovered with no residuals or limitations:______(YYYY/MM/DD)______ Dr. Information: ______First______Last______

Street______ Suite/Apt.______ City/Town______ Prov.______ Postal Code______

COMMENTS: ____

Question No.:______ Please provide details including diagnosis________________________ Date______(YYYY/MM/DD)______

Type of treatment (including medication) ________________________ and results/outcome ________________________

DATE fully recovered with no residuals or limitations:______(YYYY/MM/DD)______ Dr. Information: ______First______Last______

Street______ Suite/Apt.______ City/Town______ Prov.______ Postal Code______

COMMENTS: ____

(If not applying for Tier 2 or Tier 3 CI or H&D, skip to Section 13B on the reverse side of this page for Declarations and Signature)

SECTION 10B

TIER 2 & 3 ADDITIONAL AND ENHANCED CRITICAL ILLNESS

TIER 2 – ADDITIONAL CRITICAL ILLNESS

You must first apply for Critical Illness Tier 1 by completing the Application for Insurance Part 1 - Section 10A in order to be eligible to apply for Tier 2 ADDITIONAL Critical Illness.

1) What is your current Height:________________ ❍ feet/inches ❍ cm Weight:________________ ❍ lbs ❍ kg Check against the Height & Weight Qualifying Chart on page 8 of the Lifestyle Protection Planner. If outside the limits, Tier 2 ADDITIONAL Critical Illness Coverage is NOT available.

2) **Have you ever had any consultation, advice or treatment for:**

a) Heart attack, stroke, disease/disorder of the blood vessels of the heart or brain .... ❍ YES ❍ NO

b) Parkinson's disease, multiple sclerosis, lupus, cerebral palsy, Lou Gehrig's disease (amyotrophic lateral sclerosis-ALS), emphysema .... ❍ YES ❍ NO

c) Huntington's Chorea, muscular dystrophy, cystic fibrosis, Alzheimer's disease, brain or nervous system disorder/disease .... ❍ YES ❍ NO

d) AIDS, HIV positive or any subtypes, any disease or disorder of the immune system, paralysis, schizophrenia .... ❍ YES ❍ NO

e) alcoholic pancreatitis, liver cirrhosis, emphysema, polycystic kidney disease .... ❍ YES ❍ NO

f) Have you ever had consultation, advice, or treatment for cancer, tumor, malignancy, disease/disorder of the kidney, lung, bone marrow, severe valvular heart disease, advanced ophthalmis disease, advanced hearing loss .... ❍ YES ❍ NO

g) Have you ever been declined or offered coverage at a higher than standard rate for Life Insurance? .... ❍ YES ❍ NO

If question 1 is acceptable, and 2 a-g are answered NO, you qualify for Tier 2 ADDITIONAL Critical Illness (complete the Application for Insurance Part 1), and are eligible to continue to apply for Tier 3 ENHANCED Critical Illness (below).

TIER 3 –ENHANCED CRITICAL ILLNESS

You must first qualify and purchase Tier 1 and Tier 2 Critical Illness in order to be eligible to apply for Tier 3 ENHANCED Critical Illness.

1) **Have you ever had any known indication or symptom of, seen a doctor for, or been treated for:**

a) Heart, circulatory problem, TIA (transient ischemic attack), high blood pressure, elevated cholesterol, angina, varicose veins, chest pain, palpitations, heart murmur, rheumatic fever or other heart disorder?.......... ❍ YES ❍ NO

b) Cancer, leukemia, tumor, abnormal growth or cyst, or unusual skin lesion?.......... ❍ YES ❍ NO

c) Diabetes, sugar in the urine, elevated sugar in the blood, disorder of the thyroid, pituitary or other glands?.......... ❍ YES ❍ NO

d) Asthma, bronchitis, tuberculosis, persistent or chronic cough, shortness of breath or any disorder of the lungs or respiratory system?.......... ❍ YES ❍ NO

e) Any disease or disorder of the reproductive organs, breast, or prostate?.......... ❍ YES ❍ NO

f) Internal bleeding, jaundice, colitis, crohn's, ulcer, hernia, chronic diarrhea or other disease, condition or disorder of thestomach, intestines, liver, gall bladder or pancreas?.... ❍ YES ❍ NO

g) Amputation, deformities, numbness, tingling of the limbs, arthritis, osteoporosis, or connective tissue disease?.......... ❍ YES ❍ NO

If you answered "yes" to any of the above, Tier 3 ENHANCED Critical Illness is not available. If you have satisfied all the questions above, you may qualify for a maximum total of $100,000 Critical Illness coverage in force with EDGE.

SECTION 11B HEALTH & DENTAL MEDICATIONS *Provided by Green Shield Canada*

(Please Print Clearly) Complete this section if applying for Health & Dental coverage.
Please list all medications you, your spouse/partner or any listed dependent children have taken in the last 3 months, including those for which refills are currently authorized or any medications expected to be used in the near future. Note: Prescription drugs include oral medications, injectables, creams, drops or serum.

	Patient Name	Medication	Dosage	Frequency	Monthly Cost	Nature of illness/injury or condition
EXAMPLE:	John Smith	Adalat xl	30 mg 1 tab	2 X/day	$50.00	Hypertension

How long is medication expected to be taken? (indicate for each medication) ______ *If more space is required, please use the Additional Information notes section*

DEPENDENT INFORMATION

Only required if: *Couple or Family coverage is selected for Health & Dental*
Dependent children are covered up to age 21, or 25 if enrolled as a student full-time. Please provide documentation.

Name	Relationship to Applicant	Gender (M/ F)	Date of Birth (YYYY/MM/DD)

SECTION 13B AGREEMENT, DECLARATION & UNDERSTANDING SIGNATURE

With respect to Illness Coverage:

1. I hereby authorize any physician, healthcare professional, hospital, clinic, or any other medically related facility, any provincial or federal tax authority, MIB, Inc ("MIB") or any other organization, institution or Company that has records or knowledge of me to provide such information to Co-operators Life Insurance Company, The Edge Benefits Inc., or any other party providing or administering benefits under this plan, for the assessment of this application for insurance. I also authorize Co-operators Life Insurance Company or its reinsurer(s) to make a brief report of my personal health information to "MIB". A facsimile, photocopy, scan or other electronically imaged copy of this authorization is as valid as the original and this authorization shall continue to be in effect so long as I maintain insurance with Co-operators Life Insurance Company.
2. I authorize The Edge Benefits Inc. to debit my account for any additional benefits purchased upon approval and understand that coverage will take effect when approved by the Insurer and the premiums have been debited on the next scheduled Pre-Authorized Debit (PAD) date, on file with the administrator.

With respect to Health & Dental Coverage:

3. I hereby authorize any licensed physician or other medical practitioner, medical or medically related facility, that has any records or knowledge of me or my health, or that of my spouse/partner or any listed dependents, to exchange any such information as is needed to administer benefit claims and/or confirm the accuracy of the information with The Edge Benefits Inc. and Green Shield Canada. A photographic copy of this authorization shall be as valid as the original.
4. I declare that I, my spouse/partner and all listed dependents are residents of Canada who are covered by a provincial government health plan.
5. I understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and or listed dependents could result in denial of a claim and the cancellation or modification of the coverage.
6. I am authorized to release information concerning my spouse/partner and my dependent child(ren) for the purposes of determining their eligibility for benefits.
7. I hereby understand that the coverage applied for shall be effective on the 1st of the month following notification of approval.I understand that it is my obligation to inform The Edge Benefits Inc. of a change in my health or that of my listed dependents due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.
8. Green Shield Canada reserves the right to perform a claim audit from time to time, to verify the accuracy of the medical information provided.

NAME of Applicant ______ First ______ Last ______

Date (YYYY/MM/DD) ______ Signed at ______ X Signature of Applicant ______