RESET

APP NO.

Face-to-Face
Life Insurance and Critical Illness Insurance

Application Form

BMO Insurance

Application for Life Insurance and Critical Illness Insurance – contents

Important Instructions for the Advisor

A – For faster issue

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

B – Medical questions

Section 12 – Medical Information

Section 12.1 is mandatory on all applications. If medical underwriting requires at least a tele-interview or paramedical, you may elect to NOT complete sections 12.2, 12.3 and 12.4. Do not remove this section.
Medical underwriting requirements are shown on all illustrations generated by The Wave illustration software.

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

C – Applying for temporary insurance

Section 16 and Section 21

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

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

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

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

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

Section 1 – Eligibility Questions – Completion is **mandatory**

1.1 – Understanding the Application Language

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

If "Yes" proceed to 1.2

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

If No, please do not proceed with this application.

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

1.2 – Understanding the Policy Language

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

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

1.3 – Declaration for Canadian Residency

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

If No, please do not proceed with this application.

Section 2 – This application is for:

◯ A new policy	◯ a replacement of BMO Insurance policy #
◯ an additional Proposed Insured with Application #	◯ an additional coverage to an existing LifeProvider, policy #

Section 3 – Information about the lives to be insured

3.1 – Proposed Insured 1

First Name	**Last Name**	**Middle Initial**	**Maiden Name** (if applicable)

What is your residency status? ◯ Canadian Citizen ◯ Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) ◯ Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY)

Date of Birth (DD/MMM/YYYY)	**Place of Birth** ◯ Canada (Province) ◯ U.S. (State) ◯ Other (Country)

Sex ◯ Male ◯ Female	**Smoking Class** ◯ Smoker ◯ Non-smoker	**Identification Details** ◯ Driver's Licence Number _____ ◯ Other (specify) _____	**Expiry Date** (DD/MMM/YYYY)

Home Address (Street, Apt.)	**Number of Years**	**Mobile Phone Number** (Preferred)

City	**Province**	**Postal Code**	**Home Phone Number** (Optional)

If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence	**Email Address –** By providing my email, I consent to receiving documents and information about this application electronically.

Occupation/Duties (If retired, also provide occupation/duties prior to retirement.)	**Years with Current Employer**

Employer's Name	**Type of Business**

Employer's Address (Street, Apt., R.R.)	**City**	**Province**	**Postal Code**

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

First Name	**Last Name**	**Middle Initial**	**Maiden Name** (if applicable)

Relationship to Proposed Insured 1

What is your residency status? ◯ Canadian Citizen ◯ Permanent Resident – Provide date of entry to Canada (DD/MMM/YYYY) ◯ Other (give details) – Provide date of entry to Canada (DD/MMM/YYYY)

Date of Birth (DD/MMM/YYYY)	**Place of Birth** ◯ Canada (Province) ◯ U.S. (State) ◯ Other (Country)

Sex ◯ Male ◯ Female	**Smoking Class** ◯ Smoker ◯ Non-smoker	**Identification Details** ◯ Driver's Licence Number _____ ◯ Other (specify) _____	**Expiry Date** (DD/MMM/YYYY)

Home Address (Street, Apt.)	**Number of Years**	**Mobile Phone Number** (Preferred)

City	**Province**	**Postal Code**	**Home Phone Number** (Optional)

If the address provided above is a P.O. Box, RR# or general delivery, provide physical location of residence	**Email Address –** By providing my email, I consent to receiving documents and information about this application electronically.

Occupation/Duties (If retired, also provide occupation/duties prior to retirement.)	**Years with Current Employer**

Employer's Name	**Type of Business**

Employer's Address (Street, Apt., R.R.)	**City**	**Province**	**Postal Code**

Section 4 – Information about the policy owner(s)

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

◯ **A**. Proposed Insured 1	◯ **B**. Proposed Insured 2	◯ **C.** Jointly owned by Proposed Insured 1 and Proposed Insured 2
If you have selected A, B or C, do not complete Section 4.2 and proceed to Section 4.3		
◯ **D**. Individual(s) other than Proposed Insured 1 or Proposed Insured 2 **Proceed to Section 4.2**		
◯ **E**. Corporation, Trust or other Entity **Proceed to Section 4.5**		

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

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

Proposed Owner 1

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

Proposed Owner 2

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

4.3 – Multiple owners

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

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

4.4 – Successor owner *(Subrogated owner in Quebec)*

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

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

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

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

4.6 – Mailing information

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

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

Regulatory Verification of Identity and Tax Reporting

4.7 – Regulatory Verification of Identity and Tax Reporting

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

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

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

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

Complete 4.7.1, 4.7.2 if

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

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

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

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

Photo identification - Proposed Owner 1

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

Photo identification - Proposed Owner 2

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

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

Additional form required and must be submitted:

If this application has an initial payment of $100,000 or more and is for universal life insurance or the BMO Insurance Whole Life plan with the Additional Payment Option (APO) elected, complete:	**Politically Exposed Persons Questionnaire, 420E**

Regulatory Verification of Identity and Tax Reporting *(continued)*

Complete 4.7.3 if

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

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

Proposed Owner 1

Social Insurance Number (SIN)				–				–			

Are you a tax resident or a citizen of the United States of America? (FATCA)	◯ No	◯ Yes – Provide TIN (Taxpayer Identification Number)
Are you a tax resident of any country other than Canada or the United States of America? (CRS)	◯ No	◯ Yes – Provide TIN (Taxpayer Identification Number)
		Country

Proposed Owner 2

Social Insurance Number (SIN)				–				–			

Are you a tax resident or a citizen of the United States of America? (FATCA)	◯ No	◯ Yes – Provide TIN (Taxpayer Identification Number)
Are you a tax resident of any country other than Canada or the United States of America? (CRS)	◯ No	◯ Yes – Provide TIN (Taxpayer Identification Number)
		Country

Complete 4.7.4 if

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

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

Additional form required and must be submitted:

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

Complete 4.7.5 if

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

4.7.5 – PCMLTFA - Third Party Determination

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

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

Section 5 – Plan Details

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

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

5.1 – Single Life Options

Product Type	**Proposed Insured 1**	
	Plan Name	**Face Amount**
Universal Life	◯ Wealth Dimensions	$
Term Life	◯ Term 10 ◯ Term 15 ◯ Term 20 ◯ Term 25 ◯ Term 30	$
Whole Life	◯ Term 100	$
Whole Life	◯ **Estate Protector** ◯ **Wealth Accelerator** ◯ 10 Pay ◯ 20 Pay ◯ Pay to 100	$
Critical Illness	◯ LB10 ◯ LB20 ◯ LB75 ◯ LB100 ◯ LB100 – 15 PAY	$

5.2 – Joint Plans/Multi Coverage Options

Product Type	**Plan Name**	**Coverage Type**	**Face Amount**
Universal Life	◯ Wealth Dimensions	◯ **Joint First-to-Die** ◯ **Joint Last-to-Die** ◯ **Multi-Coverage**	$
Term Life	◯ Term 10 ◯ Term 15 ◯ Term 20 ◯ Term 25 ◯ Term 30	◯ **Joint** ◯ **Joint Last-to-Die** ◯ **Combined**	$
Whole Life	◯ Term 100	◯ **Joint First-to-Die** ◯ **Joint Last-to-Die** ◯ **Multi-Coverage**	$
Whole Life	◯ **Estate Protector** ◯ **Wealth Accelerator** ◯ 10 Pay ◯ 20 Pay ◯ Pay to 100	◯ **Joint Last-to-Die**	$

5.3 – Additional Benefits and Riders

Rider	Proposed Insured 1	Face Amount	Proposed Insured 2	Face Amount
Waiver of Premium Benefit	◯		◯	
Term Rider	◯ Term 10 ◯ Term 15 ◯ Term 20 ◯ Term 25 ◯ Term 30	$	◯ Term 10 ◯ Term 15 ◯ Term 20 ◯ Term 25 ◯ Term 30	$
Accidental Death Benefit	◯	$	◯	$
Children's Term Rider	◯	$	◯	$
Critical Illness Rider	◯ LB10 ◯ LB20 ◯ LB75 ◯ LB100	$	◯ LB10 ◯ LB20 ◯ LB75 ◯ LB100	$
Return of Premium Rider	◯ ROPS15 ◯ ROPS20 ◯ ROPS65 ◯ ROPX ◯ ROPD		◯ ROPS15 ◯ ROPS20 ◯ ROPS65 ◯ ROPX ◯ ROPD	
Other (specify)		$		$

5.4 – Request for Optional Policy

◯ Proposed Insured 1	◯ Required illustration attached	◯ Proposed Insured 2	◯ Required illustration attached

5.5 - Joint Last-to-Die Riders (Proposed Insured 1/Proposed Insured 2)

Rider	Plan Name	Face Amount
Term	◯ JLTD Term 10	$
	◯ JLTD Term 15	$
	◯ JLTD Term 20	$
	◯ JLTD Term 25	$
	◯ JLTD Term 30	$
Universal Life ART	◯ JLTD ART Rider	$

Section 6 – Beneficiary Information

If you are applying for life insurance coverage

- Complete all applicable sections.

If you are applying for critical illness insurance coverage

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

Revocable and irrevocable beneficiaries

There are two types of beneficiaries: revocable and irrevocable

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

Payment of benefits when the beneficiary is a minor

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

Multiple and contingent beneficiaries

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

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

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

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

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

6.2 – Contingent beneficiaries

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

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

6.3 – Beneficiaries for Critical Illness Riders and Other Riders

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

6.4 – Trustee for minor beneficiary designations

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

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

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

Section 7 – Purpose of Insurance and Source of Payment

Completion is **mandatory**.

7.1 – Purpose of Insurance

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

7.2 – Source of Payment (Select **all** that apply)

◯ 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 (specify)		

Section 8 – Financial Information

8.1 – Financial details (Completion is **mandatory**)

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

8.2 – To be completed if applying for business insurance

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

Section 9 – Insurance History

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

		Proposed Insured 1	**Proposed Insured 2**
1	Do you have in force or pending any of the following: Life Insurance, Critical Illness Insurance, Disability Insurance or Long Term Care Insurance? **(If "Yes" complete table below.)**	◯ Yes ◯ No	◯ Yes ◯ No
2a	Is this Insurance intended to replace or change any existing Life Insurance or Critical Illness Insurance with BMO Insurance or any other company? If "Yes" to 2a, and you are applying for Life Insurance, your advisor must provide you with a written analysis of the advantages and disadvantages of the proposed replacement. The Replacement Forms or Life Insurance Replacement Declaration (LIRD) must be submitted to Head Office with this application.	◯ Yes ◯ No	◯ Yes ◯ No
2b	If this insurance applied for will replace an existing BMO Insurance policy, does the owner of the existing policy instruct BMO Insurance to cancel such policy on settlement of the policy applied for herein? If "Yes" to 2b, include the policy number to be cancelled here, and submit a signed letter of direction or submit the completed Request to Cancel or Surrender Your Policy, form 747E.:	◯ Yes ◯ No	◯ Yes ◯ No
3	Has any Application or reinstatement 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)	◯ Yes ◯ No	◯ Yes ◯ No

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

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

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

Section 10 – Lifestyle Information

Completion is **mandatory**.

	Please provide details for "Yes" answers in space provided, and if necessary in the Comments Section below.	**Proposed Insured 1**	**Proposed Insured 2**
1	Have you used any form of tobacco, nicotine products or nicotine substitutes (including e-cigarettes or vaping)		
	a) in the past 12 months?	◯ Yes ◯ No	◯ Yes ◯ No
	b) in the past 24 months?	◯ Yes ◯ No	◯ Yes ◯ No
	c) in the past 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
2	Do you drink alcoholic beverages? (If "Yes", indicate type and frequency)	◯ Yes ◯ No	◯ Yes ◯ No
3	Have you received treatment or been advised to seek treatment or medical advice due to the use of drugs or alcohol? (If "Yes", complete the appropriate Drug Usage or Alcohol Usage Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
4	In the last 10 years, have you used any habit forming drugs including, but not limited to cocaine, ecstasy, LSD, methamphetamine, mushrooms, or any other narcotics? (If "Yes", complete the Drug Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
5	In the last 5 years, have you used cannabis? (If "Yes", complete the Cannabis Usage Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
6	Have you within the past 2 years flown as a pilot, student pilot, crew member or intend to do so in the next 12 months. (If "Yes", complete the Aviation Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
7	Have you within the past 2 years participated in motor vehicle or power boat racing, scuba diving, skydiving, hang gliding, ultra-light flying, air ballooning, rock climbing, mountaineering, heli-skiing, back country skiing or any similar sports or avocations or do you intend to do so in the next 12 months? (If "Yes", complete the appropriate Avocation Questionnaire.)	◯ Yes ◯ No	◯ Yes ◯ No
8	Do you have any plans to travel, reside, or work outside of Canada or the United States in the next 12 months? (If "Yes", provide details in the Comments Section including dates, countries/cities travelling to including length of time in each location and the purpose of each trip.)	◯ Yes ◯ No	◯ Yes ◯ No
9	Have you had:		
	a) three or more motor vehicle moving violations in the past 3 years?	◯ Yes ◯ No	◯ Yes ◯ No
	b) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 5 years?	◯ Yes ◯ No	◯ Yes ◯ No
	c) a license suspension, DUI (Driving Under the Influence) or reckless driving conviction in the past 10 years?	◯ Yes ◯ No	◯ Yes ◯ No
	If you answered "Yes" to a, b, or c please provide your Driver's Licence number:		
10	In the last 10 years, have you been arrested, charged or convicted of any criminal offense? (If "Yes", provide details in the Comments Section.)	◯ Yes ◯ No	◯ Yes ◯ No
11	In the last 5 years, have you declared or are you contemplating personal or corporate bankruptcy? (If "Yes", provide details in the Comments Section including date of discharge and current status.)	◯ Yes ◯ No	◯ Yes ◯ No

Section 11 – Comments

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

Section 11 – Comments *(continued)*

Section 12 – Medical Information

Section 12.1 is mandatory on all applications.

12.1 – Physician (Mandatory)

If you need more space use the Comments Section on page 12.

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

If medical underwriting requires at least a tele-interview or paramedical, you may elect NOT to complete sections 12.2, 12.3, and 12.4.

12.2 – Height and weight

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

12.3 – Medical history

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

		Proposed Insured 1	Proposed Insured 2
1	Are you now under medical observation or are you receiving or been recommended to receive any type of medication, treatment or therapy, or have you ever been advised to have, any pending test, investigation, hospitalization or surgery, which was not completed?	◯ Yes ◯ No	◯ Yes ◯ No
2	Have you ever had or been told you had, or are you aware of any symptoms or complaints or had any known indication of, disease or disorder of, or received treatment or advice for:		
	a) High cholesterol, high blood pressure, heart attack, coronary bypass surgery, coronary artery disease, abnormal ECG, angina, chest pain, heart murmur, irregular pulse, cardiomyopathy, stroke, transient ischemic attack (TIA), cerebral vascular disease, aneurysm, peripheral vascular disease, or any other disease, disorder or procedure of the heart or blood vessels?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Epilepsy, seizure disorder, fainting, dizziness, loss of balance, sensation or speech; severe headaches, amyotrophic lateral sclerosis (ALS) or other motor neuron disease, Multiple Sclerosis (MS), optic neuritis, Parkinson's disease, Alzheimer's disease, dementia, paralysis, cerebral palsy, Down syndrome, or any other disorder of the brain or nervous system?	◯ Yes ◯ No	◯ Yes ◯ No
	c) Acquired Immunodeficiency Syndrome (AIDS), positive HIV test, systemic lupus (SLE), scleroderma; or do you currently have any other autoimmune or connective tissue disorder(s) that require ongoing medication, treatment, or follow up?	◯ Yes ◯ No	◯ Yes ◯ No
	d) Diabetes, impaired glucose tolerance, gestational diabetes, chronic kidney disease, hypothyroidism, hyperthyroidism; or do you currently have any other disorder(s) of the glands or endocrine system that require ongoing medication, treatment or follow-up?	◯ Yes ◯ No	◯ Yes ◯ No
	e) Cancer, leukemia, tumour, polyp(s), cyst(s), melanoma, dysplastic nevus or other atypical skin lesions/disorder, abnormalities of the lymph nodes, breast lump(s), abnormal mammogram, or any other abnormal lumps, growths, or malignancy?	◯ Yes ◯ No	◯ Yes ◯ No
	f) Arthritis, chronic pain, fibromyalgia, muscular dystrophy, osteoporosis; or do you currently have any other disorder(s) of the spine, muscles, bones or joints?	◯ Yes ◯ No	◯ Yes ◯ No
	g) Anemia, low iron, gout, hemochromatosis, hemophilia or any other platelet or blood clotting disorders; or do you currently have any other disorder(s) of the blood that require ongoing medication, treatment or follow-up?	◯ Yes ◯ No	◯ Yes ◯ No
	h) Ulcerative colitis, Crohn's disease, gastrointestinal bleeding, diverticulitis, hernia, peptic or gastric ulcer, hepatitis B or C including hepatitis carrier state, liver transplant, cirrhosis, fatty liver disease, jaundice, gallstones, pancreatitis; or do you currently have any other disorder(s) of the stomach, esophagus, liver, pancreas, gallbladder or intestines?	◯ Yes ◯ No	◯ Yes ◯ No
	i) Kidney disease, polycystic kidney disease, kidney stone(s), kidney transplant recipient, nephritis, blood or protein in the urine, abnormal pap smear, elevated PSA (prostate specific antigen), prostatitis or other prostate disorder; or do you currently have any other disorder(s) of the kidneys, bladder, prostate, ovaries, uterus or reproductive organs?	◯ Yes ◯ No	◯ Yes ◯ No
	j) Asthma, chronic obstructive pulmonary disease (COPD) or emphysema, bronchitis, pneumonia, sarcoidosis, tuberculosis, cystic fibrosis, pulmonary fibrosis, sleep apnea, chronic cough, shortness of breath; or do you currently have any other disorder(s) of the lungs or respiratory system?	◯ Yes ◯ No	◯ Yes ◯ No
	k) Anxiety, depression, bipolar disorder, chronic fatigue syndrome, post-traumatic stress disorder (PTSD), schizophrenia, any other psychological, behavioral, or eating disorder, or have you ever contemplated or attempted suicide?	◯ Yes ◯ No	◯ Yes ◯ No
	l) Blindness, loss of vision which cannot be fixed with corrective lenses or laser treatment; deafness, impaired hearing; or do you currently have any other disorder(s) of the eyes or ears that require ongoing medication, treatment or follow up?	◯ Yes ◯ No	◯ Yes ◯ No

12.3 – Medical history *(continued)*

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

		Proposed Insured 1	Proposed Insured 2
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), biopsy and/or any other diagnostic testing not mentioned above?	◯ Yes ◯ No	◯ Yes ◯ No
4	a) Within the past 12 months, have you been hospitalized for more than 24 hours for a condition which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Other than for a medical condition already disclosed, in the past 24 months have you been absent from work or school for more than 2 consecutive weeks due to sickness or disability? (If Yes, state reason and duration in the Medical History section below.)	◯ Yes ◯ No	◯ Yes ◯ No
5	Other than as already disclosed, within the past five years, have you:		
	a) Consulted a doctor or healthcare provider for any medical conditions which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	b) Been a patient in a hospital, clinic or other medical facility?	◯ Yes ◯ No	◯ Yes ◯ No
	c) Had, or are you currently awaiting, or have you been advised to have any type of surgery or medical procedure which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	Had, or are you currently awaiting, or have you been advised to have any type of medical test or diagnostic investigation which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	Had, or are you currently awaiting, or have you been advised to see a specialist for any reason which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	d) Had an electrocardiogram, x-ray, blood test, urinalysis, ultrasound, colonoscopy or any other non-routine medical test which you have not yet mentioned?	◯ Yes ◯ No	◯ Yes ◯ No
	e) Had any mental or physical diseases or disorders not listed above?	◯ Yes ◯ No	◯ Yes ◯ No
	f) Been aware of any symptoms or complaints for which you are waiting to see a doctor?	◯ Yes ◯ No	◯ Yes ◯ No

6 Provide details below for **MEDICAL HISTORY** question(s) to which you answered "Yes".

Question no.	Name of Proposed Insured	Name of Physician (if Different from Section 12.1)	Details (Including relevant dates, treatments, symptoms, referrals and results)

12.4 – Family history

		Proposed Insured 1	Proposed Insured 2
1	Have your parents, brothers or sisters had cancer, high blood pressure, heart or kidney disease, polycystic kidney disease, diabetes, mental or nervous disorder (including Alzheimer's Disease), stroke, multiple sclerosis, motor neuron disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Parkinsons' Disease or any other hereditary disorders?	◯ Yes ◯ No	◯ Yes ◯ No

2 If you answered 'Yes' to question 1, provide details below of **FAMILY HISTORY** for all parents, brothers and sisters. If diagnosis or cause of death was cancer or cancer related, please specify the type(s) of cancer.

Proposed Insured 1	Proposed Insured 2	Relationship to Proposed Insured	Disease or disorder, if any	Age if Living	Age at Onset	Cause of Death	Age at Death
◯	◯						
◯	◯						
◯	◯						
◯	◯						
◯	◯						
◯	◯						

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

◯ Children's Term Rider*	◯ Payor Waiver of Premium on ◯ Proposed Owner 1 OR ◯ Proposed Owner 2 OR ◯ Other

*To be completed on behalf of all children applying for Term Insurance, who are between 15 days and up to and including 17 years old.
The Beneficiary of this rider is the Owner unless stated otherwise.

Complete a separate Section 13 if both Children's Term Rider and Payor Waiver of Premium are applied for.

Proposed Life Insured

First and Last Name	**Relationship to Life Insured**	**Date of Birth** (DD/MMM/YYYY)	**Height**	**Weight**
			◯ cm ◯ ft/in	◯ kg ◯ lbs
			◯ cm ◯ ft/in	◯ kg ◯ lbs
			◯ cm ◯ ft/in	◯ kg ◯ lbs
			◯ cm ◯ ft/in	◯ kg ◯ lbs

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

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

Question No.	**First and Last Name**	**Details**

This page intentionally blank

Section 14 – General Comments

Section 14 – General Comments *(continued)*

Section 15 – Payments & Authorizations

15.1 – Method of payment

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

Initial Payment of $ _____ will be submitted:	
◯	With the application **(TIA is available); OR**
◯	When the policy has been accepted and delivery requirements received by us **(TIA is NOT available with this option)**

Initial payment will be paid by (select one):	
◯	Annual Pre-authorized Debit (PAD) **Complete Section 15.2, Pre-Authorized Debit (PAD) Set Up and Authorization**
◯	Monthly Pre-Authorized Debit (PAD) **Complete Section 15.2, Pre-Authorized Debit (PAD) Set Up and Authorization**
◯	Cheque
◯	Credit Card - First ANNUAL Payment only **Complete Section 15.3, Credit Card Authorization**
◯	Online Payment[1] – Annual Premium **(TIA is NOT available with this Option)**

[1] Sign into your financial institution's online banking site or app where you normally pay bills. Add our company as a payee.
Payee Name: BMO LIFE ASSURANCE COMPANY. Account Number : 811 (Plus your nine digit BMO Insurance policy number).
Note: the 811 is mandatory and needs to be included before your policy number. You will need to enter a separate account number for each BMO policy that you are paying.

Subsequent payments paid by (select one):	
◯	Monthly Pre-Authorized Debit (PAD) **Complete Section 15.2, Pre-Authorized Debit (PAD) Set Up and Authorization**
◯	Annual Billing

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

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

When should PAD withdrawals begin?

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

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

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

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

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

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

Contact us at any time:
BMO Life Assurance Company
9-250 Yonge Street
Toronto, ON M5B 2L7
1-877-742-5244 Fax 416-596-0348

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

15.3 – Credit Card Authorization

(FOR FIRST ANNUAL PAYMENT ONLY, UP TO A MAXIMUM OF $100,000)

Name as it appears on the card:		
◯ Mastercard ◯ VISA	**Card Number**	**Expiry Date** (MM/YY)
I authorize BMO Life Assurance Company (BMO Insurance) to charge $ _____ to the above account in respect to this Application for Insurance.		

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

Date (DD/MMM/YYYY)	**Cardholder's Signature** X	**Cardholder's Name** (please print)

Section 16 – Application for Temporary Insurance

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

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

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

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

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

Payment must be dated the same day as the Application for Temporary Insurance.

Amount paid with Application $ _____

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

17.1 – IMPORTANT NOTICE: The information contained in this application and other information BMO Insurance may collect in connection with the application is required by BMO Insurance for insurance purposes, including activities, such as: considering and processing the application and administering any policy if issued and investigating coverage and claims (the "Insurance Purposes"). Further information about the Insurance Purposes and BMO Insurance's privacy practices are set out in the notice on *Privacy and Personal Information and MIB, LLC Notice* provided at the time of Application.

17.2 – REPRESENTATIONS AND ACKNOWLEDGEMENTS: "I" (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below represent and confirm that:

1. I have read and understood all of the questions in this application form and if temporary insurance is applied for, the term application includes the Application for Temporary Insurance, and in any supplemental questionnaires, submitted to BMO Life Assurance Company (BMO Insurance) as part of this application for life insurance (the "Application") and that I intend to submit the Application for insurance.
2. I have reviewed all of my answers and statements recorded in the Application and the answers provided are true and complete and were provided by me to my advisor (or some other authorized person acting on behalf of my advisor) for the Insurance Purposes. In addition, I understand that any statements that I make during a telephone conversation or visit with a medical professional or other representative are also part of my Application and will also be used for the Insurance Purposes.
3. I understand that the information and answers provided in the Application will be relied upon by BMO Insurance in assessing the Application, and issuing any policy. I was present when the answers to the questions related to me were collected and I provided the answers.
4. BMO Insurance may void any policy it issues based on the Application if any of the information or answers provided in the Application is incomplete or incorrect.
5. I will notify BMO Insurance immediately if any of the answers or information provided in the Application is discovered to be untrue, or changes in the period before approval of, the issuance of, and delivery of, the policy applied for. I will notify BMO Insurance if there is a change in my residency status for tax purposes if this is an application for a universal life policy or the BMO Insurance Whole Life plan.
6. I have received sufficient and satisfactory information concerning the product(s) I am applying for before signing this Application, and I understand that the life insurance advisor may be paid on a commission basis.
7. I also understand that there are variables (e.g., type and performance of investments, cost of insurance, policy loans, payments and withdrawals, etc.) that can affect the performance of a universal life insurance policy or the BMO Insurance Whole Life plan policy and that changes in these variables can affect the policy's non-guaranteed benefits and values, and I further understand that benefits and values set out in a universal life illustration and the BMO Insurance Whole Life plan illustration are not guaranteed and are based on assumptions that are likely to change.
8. I (being the proposed owner) will be deemed to have accepted the terms of the policy and any endorsements, additions and amendments attached to it, issued based on this Application if I do not return the policy to BMO Insurance within 10 days of delivery.

17.3 – AUTHORIZATIONS AND SIGNATURES: "I" (being the proposed undersigned policy owner, life insured, or payor of the policy either individually or collectively) by signing below indicate that:

1. I consent to the collection, use and disclosure of my personal information by BMO Insurance for the Insurance Purposes. I understand that BMO Insurance may share my personal information with companies that provide services on its behalf. In some cases, these other companies may be located outside of Canada (such as the United States).
2. I consent to BMO Insurance obtaining a credit bureau report, conducting a criminal records check and obtaining information relating to my driving history, as required, for the Insurance Purposes.
3. I authorize any health care professional, hospital, public or private health or social services establishment, or other medical or medically related facility, and insurance company, advisor or broker or its affiliate, the MIB, LLC, and any financial institution, other organization, institution or person that has any records or knowledge of me or my health, to provide and exchange all such information and records with BMO Insurance or its reinsurers.
4. I consent to the testing of specimens(s) provided by me, which may include AIDS Virus (HIV) antibody/antigen testing, unless I expressly revoke this consent.
5. I consent to BMO Insurance releasing the results of any tests, reports and personal information gathered about me to its reinsurers and other authorized insurers, to my personal physician, and to the MIB, LLC.
6. I understand that if the proposed life insured is not the only proposed life insured or is different than a proposed policy owner(s), that the personal information (including health information) of the proposed life insured will be shared with any additional proposed life insured or policy owner and I consent to this.
7. I have read, understood and agree to the collection, use and disclosure of my personal information as set out in the *Privacy and Personal Information and MIB, LLC Notice* provided to me at the time of Application.
8. Acceptance of any policy issued on the Application constitutes approval of the provisions of the policy and ratification of any additions or endorsements or amendments.
9. **Quebec residents:** I have been given the French version of the application ; (ii) expressly requested to conclude the application exclusively in English; (ii) agree to be bound exclusively by the English version of the application and to receive all related documents in English.

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

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

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

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

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

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

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

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

The Authorization you provide when you sign this form
By signing below, you authorize the Company to disclose your personal information that was collected in the scope of this application.

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

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

Your agreement and signature
By signing this authorization, you agree:
1. You have read and understood the terms of this authorization;
2. You are authorizing us to disclose information, set out in this authorization, to your advisor or designated consultant;
3. Even though you have signed this form, we have the right to withhold highly sensitive personal information from your advisor or designated consultant;
4. You may cancel this authorization at any time by sending us a letter in writing to BMO Life Assurance Company, 9-250 Yonge Street, Toronto, ON M5B 2L7; and
5. You understand that this authorization is valid until 30 days after the later of the date we;
   a. issue a policy as applied for or amend an existing insurance policy, or
   b. notify you that your application has been declined.

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

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

Section 19 – Authorization to Share Information

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

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

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

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

Section 20 – Privacy and Personal Information and MIB, LLC Notice

Please detach and give to Proposed Insured(s)

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

To learn more about how we collect, use, disclose and safeguard your personal information, your choices, and the rights you have, please see our Privacy Code (available at bmoinsurance.com).

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

We collect and use your Personal Information and maintain this file to:

- Determine your eligibility for our products and services;
- Support and streamline the underwriting process;
- Confirm your identity and ensure we have accurate information about you;
- Manage our relationship, including issuing, servicing and administering your contract of insurance, even after your contract has ended;
- Assess any claim for benefits under your contract;
- Protect you against fraud and manage other risks;
- Communicate with you regarding products and services that may be of interest;
- Understand our customers, including through analytics, and to develop and tailor our products and services;
- Comply with legal or regulatory requirements, or as permitted by law; and
- Respond to questions you may have.

If we use your personal information for a different purpose, we will identify that purpose.

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

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

- BMO Insurance employees;
- Your insurance advisor and the managing general agent that your advisor is associated or connected to;
- Our reinsurers;
- Our third party service providers related to the administration, processing and servicing of your contract;
- Other third parties that you authorize or those authorized by law;
- Where necessary, your named beneficiary(ies) in the event of a claim.

You may access your personal information and exercise your rights under applicable privacy laws by sending a written request to Privacy Officer, BMO Life Assurance Company, 9-250 Yonge Street, Toronto, ON M5B 2L7.

MIB, LLC Notice:

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

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

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

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

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

BMO Insurance

BMO Life Assurance Company
9-250 Yonge Street
Toronto, ON M5B 2L7

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

BMO Insurance

BMO Life Assurance Company
9-250 Yonge Street
Toronto, ON M5B 2L7

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

Section 21 – Temporary Insurance Agreement and Receipt

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

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

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

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

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

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

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

Temporary life insurance agreement

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

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

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

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

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

When does temporary life insurance end?
Temporary life insurance under this Agreement ends on the earliest of:

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

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

Amount we will pay - The total amount we will pay on the death of the Proposed Life Insured(s) is the lesser of:
1. the amount of insurance applied for in this application, or
2. the maximum amount of $1,000,000.

For the purposes of this section, the maximum amount is determined as follows:
1. If more than one insured is covered under this Agreement, the maximum amount of $1 million is for all insureds.
2. If an insured is covered under this and all other temporary insurance agreements with BMO Insurance, the maximum amount we will pay under all temporary insurance agreements is $1 million.

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

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

Exclusions and limitations – We will not pay a benefit under this Agreement if:
1. any information has been misrepresented on or omitted from this Application;
2. the Insured commits suicide, while sane or insane. In this case, we will refund the premium; or
3. the Insured dies before reaching the age of 15 days.

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

Temporary critical illness insurance agreement

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

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

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

What is the temporary critical illness insurance agreement?

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

When does temporary critical illness insurance comes into effect?

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

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

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

When does temporary critical illness insurance end?

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

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

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

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

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

Amount we will pay - The total amount we will pay on the occurrence of a covered condition of the Proposed Life Insured(s) is the lesser of:

1. the amount of insurance applied for in this application, or
2. the maximum amount of $500,000.

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

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

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

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

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

Section 22 – Advisor Report

22.1 – General information

1	**How long have you known the Proposed Life Insured(s)?** **Relationship to the Proposed Life Insured(s)?** ◯ 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 **If No, do not submit this application.** You must use the SmartApp
4	**Underwriting requirements ordered:** ◯ Urinanalysis ◯ Tele-Interview & Vitals ◯ Paramedical ◯ Resting ECG ◯ Doctor's Medical ◯ Stress ECG ◯ Blood Profile ◯ APS ◯ Inspection Report ◯ MVR ◯ Other _____ **APS** (if ordered, name of Physician) Dr._____ **MVR for Quebec and British Columbia residents:** Include a MVR Authorization if required due to Age & Amount Requirements. **Name of Paramedical facility or Medical Examiner**

22.2 – Advisor declaration

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

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

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

22.3 – Advisor information

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

22.4 – Licensed administrative assistant's declaration

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

I, the licensed administrative assistant confirm that:

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

Licensed administrative assistant's full name (please print)	**Licensed administrative assistant's signature** X	**Licensed administrative assistant's licence number**	**Date** (DD/MMM/YYYY)

APP NO.

BMO Life Assurance Company
9-250 Yonge Street
Toronto, ON M5B 2L7

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

bmoinsurance.com

BMO Insurance