

# APPLICATION

To be issued by:



## **THIS PAGE MUST BE DELIVERED TO THE PROPOSED INSURED AND THE OWNER**

**Thank you for applying for insurance with Transamerica Life Canada, herein referred to as "Transamerica".**

**Before submitting this application to Transamerica, please ensure that you have carefully read each of the notices on this page, and in particular each of the pages that require your signature.** On receipt of this application, Transamerica will assess the eligibility of each Proposed Insured for the insurance requested. Transamerica assesses each Proposed Insured primarily on the basis of the information that is provided in this application, or any other written statement that may be submitted in connection with this application. Factors which Transamerica will consider when underwriting an application for insurance include, but are not limited to, information concerning the Proposed Insureds' medical history, physical condition, occupation or avocation, lifestyle and financial situation. Once Transamerica has determined the degree of risk that the Proposed Insured represents, Transamerica will determine if the insurance applied for can be issued. For information regarding any compensation plan that may affect the proposed insurance, you may call the Canadian Life and Health Insurance Compensation Corporation (COMPCORP) at 1-800-268-8099, or write to them at 1 Queen Street East, Suite 1700, Toronto, Ontario, M5C 2X9. We appreciate the confidence you have shown in Transamerica by applying for insurance with us. Should you ever have any questions about your policy, please do not hesitate to contact your Transamerica Advisor or our Life Client Service Department. Our mailing address is: Transamerica Life Canada, 300 Consilium Place, Toronto, Ontario, M1H 3G2.

### **NOTICES**

#### **NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)**

Information regarding your insurability will be treated as confidential. Transamerica and/or its reinsurers may make a brief report to the Medical Information Board ("MIB"). The MIB is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The purpose of the MIB is to ensure the availability and accuracy of facts relevant to an applicant's insurability. This is essential for ensuring that insurance costs are kept as low as possible. Information held by the MIB does not reveal whether applications for insurance are accepted, rated or declined.

Transamerica and/or its reinsurers will collect information from the MIB in connection with this application. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will provide the company with the information in its file.

You can write to the MIB to request access to any of your personal information it may have in its file and to correct any inaccuracies. The address for its information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, M5G 1R7. Telephone 416-597-0590.

For the purposes described above, Transamerica and/or its reinsurers may also disclose information in its file directly to other life insurance companies, or their reinsurers, to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

#### **NOTICE REGARDING INVESTIGATIVE CONSUMER REPORTS AND COLLECTION**

In connection with this application, an investigative consumer report or credit report may be obtained from an investigative or consumer reporting agency and/or credit bureau. We collect information for this report through personal interviews with your neighbours, colleagues, friends or others with whom you are acquainted. Personal information collected may include information about your character, general reputation, personal characteristics, finances, credit and lifestyle. A firm representative who is employed to make such reports may contact you in person or by telephone in connection with this investigation. The information collected in the investigative report obtained by Transamerica is used for the purpose of evaluating risks for life and health insurance in connection with this application. If you would like more details about the nature of this report, you may write to: Life Client Services Department, Transamerica Life Canada, 300 Consilium Place, Toronto, Ontario, M1H 3G2.

#### **NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Transamerica collects, uses and discloses your personal information as described in the Notices regarding the Medical Information Bureau and Investigative Consumer Reports and the Personal Information Authorization section of this application. In addition, we collect personal information about you from this application and any supplementary forms and questionnaires, as more particularly described in the above Notices, and from the following sources:

- Physicians and other medical and health care practitioners and providers
- Hospitals, clinics and other medical facilities
- The Medical Information Bureau and other insurers and reinsurers
- Investigation, consumer and credit reporting agencies
- Motor vehicle and driver record authorities in any relevant jurisdictions
- Transamerica's advisors and agents, including from the Advisor's Report section of your application
- Transamerica's affiliates

The information collected from the above sources is used for the following purposes:

- Evaluating, assessing and investigating this application, our insurance risks and any claims you submit.
- Evaluating your insurance and financial needs.
- Administering and servicing the insurance and/or financial products we provide.
- If you provide your Social Insurance Number, it will be used for income reporting purposes.

Your personal information may be shared with the entities and persons identified above for the purposes of obtaining the information required, and it may otherwise be shared with or disclosed to Transamerica's managing general agencies, distributors, market intermediaries, and your advisor of record for purposes identified above. Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit authorization and direction. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

**From time to time Transamerica may use your personal information to determine which other insurance and financial products and services may meet your needs and to offer them to you. Transamerica may also disclose your personal information to its affiliated companies for their own use for such purposes. However, Transamerica will not disclose your health information to its affiliates for such purposes.**

**By signing and submitting this application on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this application, including the Notices regarding the Medical Information Bureau and Investigative Consumer Reports and the Personal Information Authorization section of this application.**

Upon receiving your application, Transamerica will establish and maintain a file containing your personal information, which will be accessible at Transamerica's Head Office. Your file will only be accessible to employees and authorized representatives of Transamerica responsible for administering your file, and other persons authorized by you or by law. Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Officer, Transamerica Life Canada, 300 Consilium Place, Toronto, Ontario, M1H 3G2. Your personal information will be collected, used, disclosed, shared and treated as described herein, or as otherwise described at or before the time of collection, use or disclosure, or as otherwise permitted by law.

#### **DISCLOSURE BY TRANSAMERICA ADVISOR FOR BRITISH COLUMBIA**

The insurance product you are being offered is supplied by Transamerica, a company licensed to conduct business in all provinces and territories of Canada. The advisor/distributor soliciting this insurance application is a licensed insurance advisor representing Transamerica and will receive compensation from Transamerica on the completion of this transaction. You are not obligated to transact any other business with Transamerica, the advisor/distributor or any other person or entity as a condition of this application.



### 11. CHILDREN TO BE INSURED (For additional children, complete another application.)

Provide the names of all children to be insured:

FIRST NAME	LAST NAME	GENDER M / F	DATE OF BIRTH DD / MM / YYYY	RELATIONSHIP TO PROPOSED INSURED(S)
A		<input type="checkbox"/> M <input type="checkbox"/> F		
B		<input type="checkbox"/> M <input type="checkbox"/> F		
C		<input type="checkbox"/> M <input type="checkbox"/> F		
D		<input type="checkbox"/> M <input type="checkbox"/> F		

### 12. OWNER

Note: The policy ownership includes the coverages on all Life Insured(s). The owner must be at least 16 years of age (at least 18 years of age in Province of Quebec).

The owner will be:

- All of the Adult Proposed Insureds as joint tenants with rights of survivorship (does not apply to Quebec residents)
- All of the Adult Proposed Life Insureds as tenants in common.
- Insured 1 only     Insured 2 only

(Please specify below. Note: The Owner must be at least 16 years of age and at least 18 years of age in the Province of Quebec.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Legal Corporate Name \_\_\_\_\_ Corporation Registration Number: \_\_\_\_\_

Current Address (No. and Street, City, Province, Postal Code) \_\_\_\_\_

Owner's S.I.N.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Proposed Insured(s): \_\_\_\_\_  
(optional)

Home Phone Number (    ) \_\_\_\_\_ Business Phone Number (    ) \_\_\_\_\_

Does the Proposed Owner(s) have a permanent Canadian residence?  YES  NO

If no, please provide details:

**Billing Address** (Complete only if other than Owner's address as shown above) (No. and Street, City, Province, Postal Code)  
\_\_\_\_\_  
\_\_\_\_\_

What language do you prefer related documents be in?  ENGLISH  FRENCH

### 13. PAYMENT DETAILS

Amount paid with this application: \$ \_\_\_\_\_

Mode of Premium Payment/Deposit:  Annual Direct

Pre-Authorized Debit (P.A.D.)

Preferred date of withdrawal (days 1-28 only)

Monthly P.A.D.\*

Quarterly P.A.D.\*

**\*Complete authorization for P.A.D. on page 6.**

ALL CHEQUES MUST BE MADE PAYABLE TO TRANSAMERICA LIFE CANADA



Are any Proposed Insured(s) adopted? If yes, please indicate name of insured(s) \_\_\_\_\_ If family history is unknown, please respond to Section C and Section D as not to be interpreted as not applicable.

**Section C**

- Have **2 or more** immediate family members (natural parents, brothers, sisters) been diagnosed with cancer prior to age 60? .....
- Have **2 or more** immediate family members been diagnosed with cardiovascular disease (heart attack, angina, stroke) prior to age 60? .....
- Have **2 or more** immediate family members been diagnosed with Multiple Sclerosis prior to age 60? .....

**Section D**

Have **1 or more** of your immediate family members (natural parents, sisters, brothers) been diagnosed with any **one** of the following diseases prior to age 60:

- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease/ALS)? .....
- Alzheimer's Disease? .....
- Huntington's Chorea? .....
- Parkinson's Disease? .....
- Polycystic Kidney disease? .....

**To the best of your knowledge and understanding, is there any person named in the application who during the last 2 years has:**

- a) had an abnormal result of any of the following: Electrocardiogram (EKG), stress electrocardiogram, echocardiogram, mammogram, Prostate Specific Antigen (PSA), sigmoidoscopy or colonoscopy, biopsy? .....
- b) had an abnormal result of any of the following: X-ray, Computerized Axial Tomography (CT Scan) scan or Magnetic Resonance Imaging (MRI) (other than for the common cold, osteoarthritis, fractures or injuries)? .....
- c) had elevated blood pressure or cholesterol, which has not been controlled with medical treatment? .....
- d) had any unexplained anemia, unexplained blood loss or unexplained weight loss of more than 10 lbs./4.5 kg? .....

Adult Proposed Insured		Child Proposed Insured									
1		2		A		B		C		D	
Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please provide the name and address of your usual medical advisor:

NAME OF PROPOSED INSURED	NAME OF PERSONAL PHYSICIAN	ADDRESS OF PERSONAL PHYSICIAN
1		
2		
A		
B		
C		
D		



**Transamerica Life Canada AUTHORIZATION FOR PRE-AUTHORIZED DEBIT (P.A.D.)**

**I/We hereby authorize and direct** Transamerica Life Canada (Transamerica) to debit the account at the financial institution which is identified on the attached voided specimen cheque (P.A.D. Account) in the amount and frequency indicated below for the purpose of making premium payments to the policies listed below, and any policy that may be issued pursuant to the applicable application (the "Policy") (collectively the "Policies"), except that I/we authorize and direct Transamerica to increase the debit amount when required to maintain the Policies in force, including for renewal and conversion premiums, which may increase in accordance with the provisions of the Policies. I/We acknowledge and agree that the premiums/cost of insurance including any applicable increases for the Policies are expressly stated in the contract for the Policies and therefore I/we require no further notification from Transamerica of corresponding P.A.D. increases. I/We request that Transamerica apply the P.A.D. amount first to ensure that all such Policies remain in force and then to each of the Policies equally, unless I/we provide other instruction. I/We warrantee that all required signatures for the authorization of debits to the P.A.D. Account are present in this Authorization. I/We further authorize such financial institution and any of its branches to deal with these debits as if authorized by me/us. I/We also understand and agree to all of the terms and conditions printed on the reverse side of this form. I hereby direct Transamerica to:

- Establish a new P.A.D. Account  Change existing P.A.D. Account information  Add the policies shown below to an existing P.A.D. Account  
(Identify policy number or P.A.D. multiple account number.)

**Policy Number(s) to Which This Request Applies:**


**Application for Insurance:**

Name of Life 1:

Name of Life 2:

- Account Type:**  Personal Chequing  Chequing/Savings  Current

Date: DD / MM / YYYY

Signature(s) of Payor(s)

Name(s) of Payor(s)

Signature of Policy owner(s), if other than Payor(s)

✓ \_\_\_\_\_ ✓ \_\_\_\_\_  
 ✓ \_\_\_\_\_ ✓ \_\_\_\_\_

**NOTE: A VOIDED SPECIMEN CHEQUE MUST BE ATTACHED HERETO FOR THIS AUTHORIZATION TO BE EFFECTIVE**

**TERMS AND CONDITIONS OF PARTICIPATION IN THE PRE-AUTHORIZED DEBIT (P.A.D.)**

**Effective Date**

**I/We understand and agree** that the Authorization on the reverse side of this form will not take effect unless a voided specimen cheque has been provided with the Authorization. This cheque must identify the financial institution, branch and the account number specified as the P.A.D. (P.A.D. Account). Provided that the above condition is satisfied, the Authorization will take effect for the Policies identified in the Authorization, on the latest of the following dates:

- i) the date the Authorization is received by the Head Office of Transamerica Life Canada (Transamerica);
- ii) the date the full amount of the first premium for the Policy is received by Transamerica's Head Office; and
- iii) the date when the Policy applied for is first placed in full force and effect by Transamerica.

**General**

**I/We also understand and agree** to all of the following terms and conditions:

- a) I/We certify that the information provided with respect to the P.A.D. Account is accurate. I/We will provide Transamerica with a new voided specimen cheque, if the P.A.D. Account is changed.
- b) The amount drawn on the P.A.D. Account shall be a total of all amounts required to pay the applicable premium payments for all Policies identified on the reverse and the Policy.
- c) The Authorization shall apply to all Policies listed on the reverse and the Policy, including any renewal, conversion or increase in cost of insurance specified in the contract.
- d) The Authorization and all its terms and conditions are subject to all of the terms and provisions of the applicable Policies.
- e) If Transamerica has not received a premium payment within the time required, for example, your P.A.D. is not honoured, or for any other reason, then the Policy will lapse and become null and void, unless it is otherwise provided in the Policy.
- f) I/We consent to disclosure of any personal information that may be contained on this Authorization to Transamerica's designated financial institution to the extent necessary for the purposes described in the Authorization and these Terms and Conditions.

**Termination**

The Authorization will be terminated only on the earliest of the following dates:

- a) either I/we or Transamerica provide(s) written notice to the other to that effect;
- b) a P.A.D. is not honoured by your financial institution when presented by Transamerica, in accordance with Transamerica's then current administrative procedures; and
- c) all of the Policies to which the Authorization applies are no longer in full force and effect.

The revocation of the Authorization does not affect your rights under the Policies.

**I/We further understand and agree** that (a) if the Authorization is terminated, a direct modal premium shall become payable for all Policies to which the Authorization applies; and (b) the amount and frequency of the premium payable under the Policies will be specified in the pages entitled "POLICY DATA"/"Schedule of Benefits and Premiums" attached to the Policy and may, in some cases, be more than the premium payable under a P.A.D. plan.

## ADVISOR'S REPORT

1. What is your relationship to the Proposed Insured(s)? .....
2. Can each Proposed Insured read, speak and understand .....  
If No, have you fully explained the details of the Application to each Proposed Insured and are you satisfied that the application is fully understood?  
If No, clarify below: .....

<b>1</b>
_____
<input type="checkbox"/> English <input type="checkbox"/> French
<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>2</b>
_____
<input type="checkbox"/> English <input type="checkbox"/> French
<input type="checkbox"/> Yes <input type="checkbox"/> No

### Advisor's Notes:

Do you have any knowledge of each Proposed Insured's personal habits, health, avocations, finances or reputation that might affect our decision to approve coverage? If so, please give details below.

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Advisor's e-mail address \_\_\_\_\_

**I/We hereby declare** that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief, and that I/we am/are not aware of additional information material to the Proposed Insured(s) except as stated above in the Advisor's Notes section on this page.

Signed at     CITY         PROVINCE    

on DD / MM / YYYY

Signature of Transamerica Advisor

Name of Transamerica Advisor

✓ \_\_\_\_\_

\_\_\_\_\_

Signature of Transamerica Advisor

Name of Transamerica Advisor

✓ \_\_\_\_\_

\_\_\_\_\_

### TO BE COMPLETED BY DISTRIBUTOR

The individual who wrote this application must be listed below as either Advisor 1, 2 or the Writing Advisor and MUST have his/her own SA code.

Distributor Staff	_____	Distributor Name	_____
Distributor Email:	_____	Distributor Office Code:	_____
Advisor 1:	_____	SA Code:	_____ Share %
Advisor 2:	_____	SA Code:	_____ Share %
Writing Advisor (if other than Advisor 1 or 2)	_____ (Last Name)	SA Code:	_____ (Given name)

**NOTE: PLEASE COMPLETE WHEN PARTNERSHIP, BUSINESS OR FAMILY APPLICATIONS ARE BEING SUBMITTED.**

Group With \_\_\_\_\_  
\_\_\_\_\_

(Last Name) (Given name)

### PAYMENT SUBMITTED WITH THIS APPLICATION

\$ \_\_\_\_\_

**All cheques must be made payable to Transamerica Life Canada (no post dated cheques).**



300 Consilium Place  
Toronto, Ontario M1H 3G2  
[www.transamerica.ca](http://www.transamerica.ca)

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Any policy issued on this application will be issued solely by Transamerica Life Canada. Best Doctors is a service provider to Transamerica Life Canada. Best Doctors is not an insurance company, involved in the issuance of any policies on this application, or an agent or broker for Transamerica Life Canada.

A member of the  AEGON® Group