



Insurance Application / Waiver Affinity Advantage Platinum

FE0000778

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Group Policy Number: TMH600126

Underwritten by ACE INA Life Insurance (The "Insurer")

Applying for new coverage Change to existing coverage

Applicant Information			Advantage Platinum		Advantage Platinum Plus		To waive all coverages, initial here
Applicant	Name	Date of Birth (mm/dd/yyyy)	Premium per month*	Initial to accept	Only Available with Advantage Platinum Additional Premium per month* Initial to accept		
# 1	TESTING AIMM	12/27/1973	\$47.53		\$24.93		
# 2							

* Premium per month includes PST
Smoker Rates - 2.2 times the Advantage Platinum premiums

Joint Premium

Monthly Policy Fee \$5.75

- ◆ You are eligible to apply for the Advantage Platinum Mortgage Protection Plan if you are under age 65.
- ◆ You are not eligible for the Advantage Platinum Plus Mortgage Protection Plan if you are self-employed.

Please initial your selection here.

Mortgage Information				
Mortgage Application #	Print Date	Initial Mortgage Balance	Mortgage Payment	Mortgage Funding Date (mm/dd/yyyy)
BCD1-1	01-08-2010 2:33 PM	\$254,375.00	\$1,479.46	01/01/2010

Requested Effective Date: I/we would like our insurance to start: As soon as my/our Application is approved Not until the Mortgage Funding Date shown above

Pre-Authorized Debit (PAD) Agreement and Banking / Account Information (Complete this section or attach a "voided" cheque to this Application)

I authorize the Insurer, ACE INA Life Insurance ("ACE Life"), and the financial institution designated to debit the account referenced on the sample "VOID" cheque attached to my Application, for all regular recurring premium payments due (including tax, if applicable) with respect to the coverage applied for under Group Policy Number TMH600126. I understand that if joint coverage is selected the entire insurance premium will be charged to the account referenced. I agree that for the purposes of this PAD Agreement all pre-authorized debits from my account will be treated as Personal.

The debit amount will be as shown on the confirmation of coverage letter that I will receive from ACE Life. The debit will occur on the first business day of each month. I understand that if a PAD is returned due to insufficient funds in my account (NSF) or "Funds Not Cleared", ACE Life will represent the PAD once on the next billing date. The represented debit will be for exactly the same amount as the returned debit. If the represented debit is returned another time, I will receive a notification letter from ACE Life.

I waive the right to pre-notification at least 10 days before my first PAD, as well, I waive the right to 10 days' notice of an increase or decrease in the amount of the automatic withdrawal. I may revoke my authorization at any time by giving written notice to ACE Life at the address below at least 10 business days before the next scheduled debit. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Attach VOID cheque Or Financial Institution: _____ Branch: _____ Account No.: _____

Health Questions (Do not complete if you are waiving coverage)		Applicant #1		Applicant #2	
		No	Yes	No	Yes
1.	Have you ever had or been treated for: heart disorder, chest pain, stroke, narrowing or blockage of an artery, aneurysm, cancer, tumours, lung or liver disorder including hepatitis or carrier state, diabetes, disorder of the pancreas, chronic fatigue, fibromyalgia or other form of chronic pain, any immune system abnormality, a positive HIV test, AIDS, or advised to stop or reduce drug use or alcohol consumption?	Initial	Initial	Initial	Initial
2.	During the past three (3) years have you: a) had or been treated for mental or nervous disorder (depression, anxiety, stress, etc.), neurological disorder including seizures, high blood pressure, kidney or urinary disorder, gastro-intestinal bleeding, back or knee pain, arthritis, other muscular-skeletal disorder or any other illness, disease, operation, injury, or congenital defect not listed? OR b) been absent from work for medical reasons for a month or longer?	Initial	Initial	Initial	Initial
3.	Are you currently under investigation or using medication or other treatment, or have you been advised to have further investigation, treatment, surgery, or referral to another doctor?	Initial	Initial	Initial	Initial
4.	During the past three (3) years, have you had an application for life or disability insurance declined?	Initial	Initial	Initial	Initial
5.	During the past 12 months have you smoked any substance or used any form of tobacco or nicotine product (including the nicotine patch)? Please note that if you answer "Yes", you will be classified as a smoker and Smoker Rates will apply (Advantage Platinum premiums x 2.2).	Initial	Initial	Initial	Initial

If "Yes" applies to No. 1 to 4 of the above Health Questions, please provide details below.

Applicant	Name of Disorder	Date and Duration	Treatment and Result	Name of Doctor/Hospital
#1				
#2				

Declaration: I declare that I have read and understood the Health Questions above, and that the statements contained in the Application are true and complete. I understand that if I provide incomplete or inaccurate information about my health, my insurance coverage may be fully revoked which means I will not be able to make a claim for any cause or condition. I authorize any person to provide the Insurer and/or its administrator of the policy and/or its reinsurer with my medical information to process this Application and any subsequent claim. I acknowledge the need for this information and my authorization takes effect on the date this Application is signed. I may withdraw my authorization at any time; however, doing so may result in insurance coverage not being offered and/or claims not being paid. I understand that I may cancel this insurance at any time by notifying the Insurer in writing.

By initialing above, I hereby apply for, or waive, the insurance under the Policy. I have received the Affinity Advantage Protection Plan brochure that contains the Notice on Privacy and Confidentiality (the "Notice"), and describes the Plan that I am applying for. I authorize the Policyholder and/or the Lender to provide to the Insurer this Application and to release and exchange with the Insurer or its representatives information relating to the Mortgage for the purposes described in the Notice. If I do not wish my personal information to be used for the optional purpose of offering additional products or services, I can contact the Insurer at the phone number or address shown in the Affinity Advantage Protection Plan brochure.

I understand that this Application may be transmitted to the Insurer as an original or fax copy ("Submitted Application"), with a copy being as valid as the original, and the Submitted Application will form part of any contract of insurance issued. I can decline coverage, in writing, within 30 days of the mailing date of any coverage issued to me and I will receive a full refund of any premium I have paid. I agree to be bound by the terms and conditions of the Policy, including the Exclusions and Limitations, as outlined in my Certificate of Insurance. I understand that the Policyholder receives remuneration for performing administrative duties in respect of the Policy.

Date Insurance Begins: If the answer is "No" to No. 1 to 4 of the Health Questions above, and if the Initial Mortgage Balance does not exceed \$300,000, as long as the first Premium is paid when due, the Date Insurance Begins is on the later of the Requested Effective Date or the date on which the Insurance Application is properly completed and signed. In all other cases, the Insurer or its administrator may request a medical examination or tests such as a general blood profile which will be carried out at no expense to the Applicant(s) or other additional information (the "Medical Evidence"). After reviewing the Application and Medical Evidence, the Insurer may either approve or decline coverage and the Insurer will notify the Applicant(s) accordingly, as long as the first Premium is paid when due, the Date Insurance Begins will be the date of such approval or, if later, the Requested Effective Date.

By signing here, I apply for coverage and agree to the terms for the collection of premiums described in the PAD Agreement above, or I confirm that I waive the insurance.

Applicant #1 Signature _____ Date (mm/dd/yyyy) _____ Applicant #2 Signature _____ Date (mm/dd/yyyy) _____

Insurer Address: ACE INA Life Insurance, PO Box 1097, Station B, Willowdale, Ontario M2K 3A2

Toll Free: 1 888 316-2466

AIMM-PP-V2(2009/11)