Equitable Life of Canada®

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APPLICATION FOR PLAN MEMBER OPTIONAL AND SPOUSAL OPTIONAL LIFE BENEFIT

Please note: This application form may be used by either a Plan Member (employee) Optional Life or a Spousal Optional Life applicant. If applying for both Plan Member (employee) Optional Life and Spousal Optional Life, please complete a separate form for each applicant. The signature of the actual applicant is required (Plan Member or spouse) on his/her own form.

Group Policy Number: _____ Group Division Number: _____

Name of Group Policyholder: _____

Plan Member's Name: _____ Plan Member's Certificate Number: _____

Plan Member's Date of Birth: _____

Name of Applicant: (either Plan Member or Spouse) _____

Date of Birth of Applicant: (either Plan Member or Spouse) _____

Options:

a) I am applying for Plan Member Optional Life for myself. Total amount of $_____
(Multiples of $10,000 to the maximum stated in your Group Policy. Minimum $10,000)

OR

b) I am the spouse of the Plan Member applying for Spousal Optional Life. Total amount of $ _____
(Multiples of $10,000 to the maximum stated in the Group Policy. Minimum $10,000)

Have you smoked a cigarette or marijuana in the last 12 months? ☐ Yes ☐ No

Beneficiary: _____ Relationship to Applicant: _____

Name of Trustee: _____
(if the Beneficiary is a minor.)

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.
I elect to make my spouse beneficiary designation: ☐ Revocable

NOTE: A Statement of Health (Form 452, Part 1) should be submitted with this form. No amount of Optional Life Insurance will be effective until The Equitable Life Insurance Company of Canada has accepted evidence of insurability.

I authorize the use of my S.I.N. for Identification purposes, if applicable, and designate the beneficiary as stated above.

I hereby certify all the information provided on this form is complete, current and accurate.
The personal information willingly provided by me to my employer, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits thereunder, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by, Equitable Life, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians and dentists, and any other person or party whom I authorize.

To submit this form and the completed, signed Statement of Health (Form 452, Part 1) mail or fax it directly to Equitable Life at the address or fax displayed at the top of this document. Please mark your correspondence "Attention: Group Accounts Department".

_____ _____
Signature of Applicant (Plan Member or Spouse) Date