

In this application *you* and *your* refer to the person applying for insurance. *We, our and us* and *the Company* refer to Canadian Premier Life Insurance Company (“Securian Canada”).

Please PRINT clearly.

1. General information

Continuum insurance coverage is available across Canada, except Quebec. You must be a resident of Canada and covered under the provincial health care plan in your province of residence or a government health insurance plan.

Information about you

| | | | |
|--|------------------|--|--|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Former/maiden name (if applicable) | | Date of birth (dd-mm-yyyy) | |
| Province of birth | Country of birth | Language <input type="checkbox"/> English <input type="checkbox"/> French | |
| Residence address (street number and name) | | | Apartment or suite |
| City | Province | Postal code | |
| Telephone (home) | | Fax | |
| Email address | | | |
| Are you a resident of Canada? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you covered under the provincial health care plan in your province of residence or a government health insurance plan? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| You are not eligible for coverage if you answered no to any of these questions. | | | |
| Name of school attended in last academic year | | Name of student association | |
| Student ID number | | | |

Information about your spouse

Please complete if applying for spousal insurance.

| | | | |
|---|------------------|--|--|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Former/maiden name (if applicable) | | Date of birth (dd-mm-yyyy) | |
| Province of birth | Country of birth | Language <input type="checkbox"/> English <input type="checkbox"/> French | |
| Email address | | | |
| Is your spouse a resident of Canada? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your spouse covered under the provincial health care plan in your province of residence or a government health insurance plan? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered no to any of these questions, they are not eligible for coverage. | | | |

Information about your dependent child(ren)

Please complete if applying for dependent child(ren) insurance.

| | | | | | |
|--|----------------|-----------|--|----------------------------|---|
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child a resident of Canada? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child covered under the provincial health care plan in your province of residence or a government health insurance plan? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered no to any of these questions, they are not eligible for coverage. | | | | | |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child a resident of Canada? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child covered under the provincial health care plan in your province of residence or a government health insurance plan? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered no to any of these questions, they are not eligible for coverage. | | | | | |
| First name | Middle initial | Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (dd-mm-yyyy) | Student <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child a resident of Canada? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your dependent child covered under the provincial health care plan in your province of residence or a government health insurance plan? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered no to any of these questions, they are not eligible for coverage. | | | | | |

2. Coverage applying for

Please visit www.continuumplan.com for product details.

Health Plan

Single Couple Family

Health & Dental Plan

Single Couple Family

3. Statement of insurability

Please answer the following questions completely and accurately. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Do not tell us about genetic testing or genetic test results.

3.1 Background information

Information about you

| | | | |
|---|---|--|---|
| Height ft in m cm | Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain: <input type="checkbox"/> Loss: | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Reason for weight change | | | |
| Name of physician, address, date and reason for last consultation with physician (if none, please state <i>none</i>) | | | |
| Diagnosis, treatment given, results, medication prescribed | | | |
| If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them. | | | |
| | | | |

Information about your spouse

Please complete if applying for spousal insurance.

| | | |
|---|---|---|
| Height ft in m cm | Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain: <input type="checkbox"/> Loss: <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Reason for weight change | | |
| Name of physician, address, date and reason for last consultation with physician (if none, please state <i>none</i>) | | |
| | | |
| Diagnosis, treatment given, results, medication prescribed | | |
| If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them. | | |
| | | |

Information about your dependent child(ren)

Please complete if applying for dependent children coverage.

| | | |
|----------------------------|---|---|
| First name | Middle initial | Last name |
| Height ft in m cm | Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain: <input type="checkbox"/> Loss: <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Reason for weight change | | |
| First name | Middle initial | Last name |
| Height ft in m cm | Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain: <input type="checkbox"/> Loss: <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Reason for weight change | | |
| First name | Middle initial | Last name |
| Height ft in m cm | Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg | Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain: <input type="checkbox"/> Loss: <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Reason for weight change | | |

If you need more space, please complete on separate sheet of paper, and sign and date it.

3.2 Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

| You | Your spouse | Your dependent child(ren) |
|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please complete the table below.

| Name of person to be insured | Condition | Medication, devices, accessories or treatment | Monthly cost | Strength | Daily dosage | Length of time |
|------------------------------|-----------|---|--------------|----------|--------------|----------------|
| | | | \$ | | | |
| | | | \$ | | | |
| | | | \$ | | | |
| | | | \$ | | | |

3. Statement of insurability (continued)

3.3 Health and lifestyle questionnaire

Do not tell us about genetic testing results.

Have any of the persons to be insured ever:

- a) consulted a physician for symptoms or had treatment for cancer or tumour, neurological disorder, cardiovascular disorder, high blood pressure, stroke, diabetes, liver or kidney disease, respiratory disorder, gastrointestinal disorder, mental or nervous disorder, substance abuse, hepatitis, endocrine disorder, blood disorder, genitourinary or reproductive system disorder, rheumatoid arthritis, multiple sclerosis, immunological disorder, or tested positive for HIV?
- b) had any other illness, injury, operation or treatment within the last five years?
- c) contemplated medical or surgical treatment, or a hospital stay in the next six months, or have you or your spouse in the last two years been unable to work for more than five consecutive days?
- d) had any symptoms and complaints for which a physician has not been consulted or been advised to have any further examinations or tests which have not been yet completed?
- e) received advice or treatment for the use of alcohol or drugs?
- f) had his or her driver's licence suspended or revoked, or had three or more moving violations in the last two years?
- g) engaged or intend to engage in, any hazardous sport or activity (e.g. auto or motorcycle racing, scuba or sky diving, or hang gliding)?
- h) had an application for insurance declined, postponed, rescinded, cancelled or modified in any way, or been denied for a renewal or reinstatement?

| | You | Your spouse | Your dependent child(ren) |
|--|--|--|--|
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please provide details below for any yes answers under sections 3.3 (a-h). Include the results of all physical examinations and check-ups. Do not tell us about genetic testing or genetic test results.

If you need more space, please complete on a separate sheet of paper, and sign and date it.

| Question | Name of person to be insured | Date (mm-yyyy) | Name and address of physician and hospital, if any | Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks duration, treatment and results |
|----------|------------------------------|----------------|--|--|
| | | | | |
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| | | | | |

4. Payment of premiums

a) Monthly pre-authorized debit (PAD)

Please complete the information below OR attach a personal blank cheque marked VOID across the front, to this application form, and sign below.

| | | |
|------------------------------|--|----------------|
| First name of account holder | Middle initial | Last name |
| Financial institution name | Financial institution address (street number and name) | |
| Transit number | Institution number | Account number |

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

| | | | |
|---|----------------|---------------------|--------------------|
| Payor(s) name (first and last) or full legal name of corporation/entity | | | |
| If applicable, date of birth (dd-mm-yyyy) | | Relationship to you | |
| Address (street number and name) | | | Apartment or suite |
| City | Province/state | Country | Postal/zip code |

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize Canadian Premier Life Insurance Company ("Securian Canada") to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that Securian Canada notify you of any payments after the first payment whether the amount of the monthly premium is changed or not.** You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Securian Canada is unable to make a withdrawal from your account.

This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting www.payments.ca.

Securian Canada may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the Company) without providing at least 10 days' prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit www.payments.ca.

Securian Canada
PO Box 963 Stn A
Toronto, ON, Canada M5W 1G5
Telephone: 1-877-363-2773

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

| | | |
|-----------------------------|---|--------------------------|
| Account holder printed name | Signature of account holder X | Date signed (dd-mm-yyyy) |
| Account holder printed name | Signature of account holder X | Date signed (dd-mm-yyyy) |

Send no money with this application. You will be notified with a premium statement.

4. Payment of premiums (continued)

b) Monthly Credit Card charge (Visa or MasterCard). Once we have approved your application, you will be contacted by Securian Canada to obtain your credit card information.

Terms and conditions

You authorize Canadian Premier Life Insurance Company ("Securian Canada") to collect the monthly premium (including applicable provincial tax) for the insurance through your credit card. You acknowledge that the amount of the monthly premium (including applicable provincial tax) charged to your credit card may vary. **You agree to waive the requirement that Securian Canada notify you of any charges after the first charge whether the amount of the monthly premium is changed or not.** You understand that the monthly premium will be charged on the first of each month. This agreement will be canceled automatically if Securian Canada is unable to charge your credit card. This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next charge is scheduled at the address provided below. Securian Canada may not assign this authorization to another company or person to permit them to charge your credit card for these payments (for example where there has been a change in control of the Company) without providing at least 10 days' prior written notice to you.

5. Declaration and authorization

I declare that my answers in this application form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application form will cause the insurance to be void.

I hereby certify that I have read the Medical Information Bureau (MIB, LLC) notice (see section 6), and having read the contents, I have, by the signature(s) below, authorized the MIB, LLC to give Canadian Premier Life Insurance Company ("Securian Canada"), or its reinsurers, any information it may have.

I authorize Securian Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudication of claims under this insurance coverage with any person who has relevant information about me including health professionals, institutions, the MIB, LLC, investigative agencies, insurers and reinsurers and to use and exchange information with ASEQ/studentcare.net/works for the purpose of administration.

A photocopy or electronic version of this authorization is as valid as the original.

| | | | |
|----------------------------|----------------------------|---|--|
| Your signature X | | Your spouse's signature (if applicable) X | |
| Location signed (city) | Location signed (province) | Date signed (dd-mm-yyyy) | |

Please return your completed application to:

Securian Canada
PO Box 963 Stn A
Toronto, ON, Canada M5W 1G5

6. Medical Information Bureau (MIB, LLC) notice

In the course of underwriting your application, Canadian Premier Life Insurance Company ("Securian Canada") may disclose information about you or your spouse to its reinsurers. Securian Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you and/or your spouse may apply for life or health insurance or to whom a claim for benefits may be submitted.

Securian Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB, LLC), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you and/or your spouse also applies for insurance coverage or submit(s) a claim with another life or health insurance company that is an MIB, LLC member, MIB, LLC will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB, LLC and correct anything that is inaccurate or incomplete.

You may write to MIB, LLC at:

Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7
or call 416-597-0590

7. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC, and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit <http://www.securiancanada.ca/privacy-statement>.