HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

DISABILITY, LIFE AND CRITICAL ILLNESS

Change application

For the advisor

1. Write legibly in blue or black ink.
2. Please attach a copy of your illustration for any increase of Prodige, Term Critical Illness coverage.
   - The application must be signed by the person to be insured and the policyowner if other than the person to be insured.
   - The application must be dated the day it is signed by the person to be insured, or the legal guardian for a minor.
   - Detach **page 7** of this application and leave it with the person to be insured.
3. Exchange right (HuGO)
   - Between the 1st and the 5th anniversary of the policy.
   - The application must be signed by the person to be insured and the policyowner if other than the person to be insured.
   - The application must be dated the day it is signed by the person to be insured, or the legal guardian for a minor.
   - Complete parts 1, 2, 4 and 5.
   - Detach **page 7** of this application and leave it with the person to be insured.
4. In the event that the documents necessary to make the change require a Statement of Good Health Form and a Teleunderwritting Interview, the Statement of Good Health Form is not required.

Part 1 - The Person to be Insured

Policy no.:

Last Name:

First Name: Sex: ☐ M ☐ F

Middle Name:

Phone number:

Date of Birth:
day / month / year

Occupation:

Part 2 - Type of Change Permitted at All Times

Change requested	Document to make the changes
☐ Decrease monthly benefit: From _____ to _____	None
☐ Increase elimination period: From _____ to _____	None
☐ Decrease benefit period: From _____ to _____	None
☐ Exchange right (HuGO) between the 1st and the 5th anniversary of the policy: ☐ The total insured amount ☐ Or part of the insured amount ☐ Amount to exchange: _____ Should the balance of the total amount remain in force? Yes ☐ No ☐	None
☐ Change status from smoker to non-smoker:	Declaration of insurability and tobacco use forms

Part 2 - Type of Change Permitted at All Times (...continued)

Change requested	Document to make the changes
☐ Transformation of Life Insurance:	None
☐ Transformation of Critical Illness	None
☐ Guarantee of benefit amount	Proof of income of the last 2 years Declaration of insurability form *
☐ Cancellation guarantee:	None

Indicate canceled coverages _____

☐ Other change requested: _____

* Humania Assurance reserves the right to request any requirement deemed necessary by underwriting regardless of age, amount or product.

Part 3 - Type of Change Permitted at the Anniversary Date

For Prodige, Term Critical Illness coverage.

Change requested	Document to make the change
☐ Increase face amount:	Teleunderwriting interview *

From _____ to _____

Indicate added coverages: _____

Part 4 - Identification of Financial Advisor

Complete name of service advisor/representative

Code | | | | | | | % | | | | Telephone No.

Complete name of other advisor/representative

Code | | | | | | | % | | | | Telephone No.

Confirmation of Advisor Disclosure

I hereby confirm that I have provided my client in writing with the necessary information, as outlined in the document entitled "Advisor Disclosure", namely: (a) the company(ies) I represent; (b) my compensation; (c) bonuses and conference incentives; and (d) any potential conflict of interest.

I certify that I have fully explained to the insured the nature and effect of making an irrevocable designation of beneficiary and such explanation was given to the insured not in the presence of the beneficiary and that the insured indicated that he/she was aware of the irrevocable nature of the designation so made by him/her.

Signature of Representative:

Part 5 - Authorizations and Signatures

I, the undersigned, as the Policyowner or the proposed Insured, declare that the information provided is complete and true, and I accept that it is an integral part of my application for insurance. I acknowledge that any false declaration or omission could void the coverage obtained through this application.

I authorize Humania Assurance Inc., its agents, service providers, reinsurers and other partners (hereinafter *"Business Partners"*) to collect, by any electronic means, email, fax or mail, and to use all personal information relevant to the determination of my insurability in connection with this insurance policy.

I further authorize Humania Assurance Inc. to exchange the personal information collected about me with its *Business Partners*, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate. I also authorize Humania Assurance Inc. to make a brief report of the personal information pertaining to my insurability to the *Medical Information Bureau (MIB)*.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or health professional, any public or private health and social services institution, any insurance or reinsurance company, the *Medical Information Bureau (MIB),* any financial institution, and any personal information officer or investigative agency.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector*, including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

The Insurer may contest any fraudulent statement beyond the contestability period. I acknowledge that I have understood any Conditional Insurance Receipt and that I have received and read the Personal Information Notice, the *Medical Information Bureau (MIB)* text, and the Disclosure Statement under the *Financial Institutions Act*. An insurance contract is based on good faith. Any incomplete disclosure of important facts in this declaration of insurability constitutes a breach that may result in the cancellation of the policy. Any policy issued in connection with this declaration of insurability will take effect on the date the Insurer approves the risk, provided that it is approved without change, the first premium has been paid, and no change has occurred in the proposed Insured's insurability since this declaration of insurability was signed.

Signed at: On:

Signature of Representative: Signature of Person to be insured (if aged 13 or older):

Signature of the Parent/Guardian of the person to be insured (if aged 13 or under):

Signature of Policyowner:

Part 6 - Authorizations in case of death

During my lifetime and in the event of my death, I authorize Humania Assurance Inc., its agents, service providers and other partners (hereinafter *"Business Partners"*) to collect, by any electronic means, email, fax or mail and to use all personal information relevant to the adjudication of any claim submitted under this insurance policy.

I further authorize Humania Assurance Inc. to exchange the personal information collected about me with its *Business Partners,* whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

In the event of my death, the holder, the subrogated holder and the beneficiary of my insurance policy, the heir and the liquidator of my estate are expressly authorized to provide Humania Assurance Inc. and its *Business Partners* with all authorizations and personal information for the purpose of adjudicating the claim.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician, psychologist or other health professional, any public or private health and social services institution, any occupational health and safety plan, motor vehicle accident insurance plan or health insurance plan, including the various provincial health plans, including but not limited to the Régie de l'assurance-maladie du Québec, any pharmacy, any financial institution including insurance or reinsurance companies, any personal information officer, and any investigative, police or security agency. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector*, including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

Signed at: _____ On: _____

Signature of the Person to be insured (if aged 14 or older): _____

Part 7 - General Comments

Please provide any information which may assist in underwriting this application or any additional instructions.

TO BE GIVEN TO THE PROPOSED INSURED OR POLICYOWNER

Notice Concerning Files and Personal Information

For the purposes of administering your insurance file and ensuring its confidential nature, Humania Assurance Inc. will create an insurance file containing the information regarding your (Policyowner and/or Insured) application for insurance, as well as information on any insurance claims.

Only employees or agents responsible for underwriting, investigations or claims, as well as any other people authorized by you, will have access to this file. Your file will be kept at the Company's head office.

You have the right to review the personal information contained in this file and, if required, have it corrected by submitting a written request to: **Access to Information Officer: Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6.**

You also have the right to withdraw, at any time, any authorization given in connection with the communication and use of the personal information contained in your file.

As part of the standard processing of insurance proposals, all insurance companies, including Humania Assurance Inc., may request a personal investigation or a consumer report containing personal information on the individuals to be insured. You may be contacted to this effect.

Notice – Medical Information Bureau

The information on your insurability will be kept confidential. However, Humania Assurance Inc., may submit a brief report to MIB Inc, formerly known as the *Medical Information Bureau (MIB)*, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply for life, critical illness or health insurance to another MIB Inc. member company, or if a claim for benefits is submitted to a member company, MIB Inc. will supply, on request, such company with the information in its file. Upon receipt of a request from you, MIB Inc. will arrange a disclosure of any information it may have in your file. If you question the accuracy of information in the MIB Inc. file, you may contact MIB Inc. and seek a correction.

MIB Inc. address is: 330, University Avenue, Toronto (Ontario) M5G 1R7 / Telephone No.: 416 597-0590.

Humania Assurance Inc., may also release information in this file to other insurance companies to which you may apply for life, critical illness or health insurance, or from which you may have claimed benefits.

DETACH HERE

Humania Assurance Inc.

1555 Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6
Web site: www.humania.ca

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2023/08