Reason(s) for submission of evidence of insurability □ Late Application □ Increase in coverage □ Optional coverage □ Plan requirement
□ Excess coverage □ Loss of coverage, explain _____

Excess/ OPTIONAL Insurance Amount Applied For
Life $_____ Dependent Life $_____ **Supplemental/Optional Life $_____** AD&D $_____
LTD $_____ STD $_____

Instructions
Please ensure that all applicable parts are completed.
Part 1 - Employer Statement ***Part 3 – Employee Medical Declarations*** ***Part 5 – Spouse/Legal Dependent Medical Declarations***
Part 2 – Employee Statement ***Part 4 – Spouse/Legal Dependent Statement*** ***Part 6 - Declaration and Authorization***

Please print all answers

Part 1 – EMPLOYER STATEMENT	
Please see cover page provided by WEBS.	

Part 2 – **EMPLOYEE STATEMENT** ***Please remember to attach employee cover page provided by WEBS**			
Employee Name (last name, first name, middle initial)	Date of Birth YYYY MM DD	Sex □ Male □ Female	Certificate/S.I.N.
Residence Address (number, street, city, province)			Postal Code
Height □ m □ cm □ f t □ in	Weight □ kg □ lb	Home Phone # ( )	
Name of family physician (last name, first name)			
Address of family physician (number, street, city, province)			Postal Code

Part 3 – EMPLOYEE MEDICAL DECLARATIONS – If you answer **YES** to any questions in this Section, please provide details in the space provided at the bottom of this page.	
(1) Are you now actively employed on a permanent basis, working not less than 30 hours per week? If no, give the number of hours regularly scheduled to work: _____	□ Yes □ No
(2) Have you ever had an application for life or health insurance declined, postponed or modified in any way?	□ Yes □ No
(3) Have you been medically diagnosed or received medical treatment for HIV, AIDS, or AIDS Related Complex?	□ Yes □ No
(4) In the last 5 years, have you applied for or received disability benefits from any source?	□ Yes □ No
(5) In the last 12 months, have you used any tobacco, marijuana, or nicotine substitute?	□ Yes □ No
(6) In the last 5 years, have you used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol abuse?	□ Yes □ No
(7) Are you currently pregnant? If yes, expected due date _____	□ Yes □ No

(8) In the last 5 years, have you been medically diagnosed with, treated for, or had any known indication of any injury, disease, or disorder listed below?

Yes	No		Yes	No	
		Brain Disorder, Nervous System Disorder, Paralysis, Epilepsy, Convulsions, or Fainting			Liver Disorder, Gall bladder Disorder, Jaundice, Cirrhosis, or Hepatitis
		Lung Disorder, Tuberculosis, Bronchitis, or Asthma			Cancer, Tumor, Polyp, or Neoplasm
		Heart or Chest Pains			Diabetes
		Stroke, Transient Ischemic Attack, or Angina			Arthritis, Rheumatism, or Neuritis
		Circulatory System Disorder			Fibromyalgia or Chronic Fatigue Syndrome
		High Blood Pressure			Muscle, Bone or Joint Disorder
		Multiple Sclerosis			Disorder of the Eyes or Ears
		Stomach Disorder, Digestive Disorder, or Esophagistis			Neck or Back Pain or Impairment
		Hiatus Hernia, Umbilical Hernia, or other Hernia			Thyroid Disorder
		Bladder Disorder, Prostate Disorder, Kidney Disorder			Genito-Urinary Disorder or Reproductive Organ Disorder
		Bowel Disorder, Crohn's Disease, or Colitis			Mental Disorder, Psychological Disorder, or Emotional Disorder

(9) Have you ever been medically diagnosed with, treated for, or had any known indication of any condition not listed above? ☐ Yes ☐ No

(10) Are you currently taking medications or under the care of a physician for any condition? ☐ Yes ☐ No

(11) Within the next 12 months, are you planning on travelling outside North America for a period of greater than 2 consecutive months? ☐ Yes ☐ No

Please provide details below, if you have answered "yes" to questions 2 to 11 inclusive.

Question Number	Details or Name of the Condition	Date & Duration (# episodes/attacks)	Details of Treatment & Results (Recovery or Remaining Effects)	Physician's Name Hospital Name

Please print all answers

Part 4 – SPOUSE/LEGAL DEPENDENT STATEMENT Please provide the following information for each individual to be insured

Complete Name of Spouse and/or Legal Dependent(s)	Relationship to Employee	Date of Birth (Year Month Day)	Height □ m □ cm □ f t □ in	Weight □ kg □ lb

Part 5 – SPOUSE/LEGAL DEPENDENT MEDICAL DECLARATIONS – If you answer **YES** to any questions in this Section, please provide details in the space provided at the bottom of this page.

(1) Have any of the above applicants ever had an application for life or health insurance declined, postponed or modified in any way? □ Yes □ No

(2) Have any of the above applicants been medically diagnosed or received medical treatment for HIV, AIDS, or AIDS Related Complex? □ Yes □ No

(3) In the last 12 months, have any of the above applicants used any tobacco, marijuana, or nicotine substitute? □ Yes □ No

(4) In the last 5 years, have you used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol abuse? □ Yes □No

(5) In the last 5 years, have you been medically diagnosed with, treated for, or had any known indication of any injury, disease, or disorder listed below?

Yes	No		Yes	No	
		Brain Disorder, Nervous System Disorder, Paralysis, Epilepsy, Convulsions, or Fainting			Liver Disorder, Gall bladder Disorder, Jaundice, Cirrhosis, or Hepatitis
		Lung Disorder, Tuberculosis, Bronchitis, or Asthma			Cancer, Tumor, Polyp, or Neoplasm
		Heart or Chest Pains			Diabetes
		Stroke, Transient Ischemic Attack, or Angina			Arthritis, Rheumatism, or Neuritis
		Circulatory System Disorder			Fibromyalgia or Chronic Fatigue Syndrome
		High Blood Pressure			Muscle, Bone or Joint Disorder
		Multiple Sclerosis			Disorder of the Eyes or Ears
		Stomach Disorder, Digestive Disorder, or Esophagistis			Neck or Back Pain or Impairment
		Hiatus Hernia, Umbilical Hernia, or other Hernia			Thyroid Disorder
		Bladder Disorder, Prostate Disorder, Kidney Disorder			Genito-Urinary Disorder or Reproductive Organ Disorder
		Bowel Disorder, Crohn's Disease, or Colitis			Mental Disorder, Psychological Disorder, or Emotional Disorder

(6) Have any of the above applicants ever been medically diagnosed with, treated for, or had any known indication of any condition not listed above? □ Yes □ No

(7) Are any of the above applicants currently taking medications or under the care of a physician for any condition? □ Yes □ No

(8) Within the next 12 months, are any of the above applicants planning on travelling outside North America for a period of greater than 2 consecutive months? □ Yes □ No

Please provide details below, if you answered YES to questions 1 through 8 inclusive.

Question Number	Dependent Name	Details or Name of the Condition	Date & Duration (# episodes/attacks)	Details of Treatment & Results (Recovery or Remaining Effects)	Physician's Name & Full Mailing Address

Part 6 – DECLARATION AND AUTHORIZATION

I/we certify that all the information in this form is complete, current and accurate to the best of my /our knowledge and belief and that the above information will form part of my/our application for insurance. The insurance requested in this Application will not be effective until approved by the Home Office of the Insurance Company and their authorized representatives.

I/we authorize any physician, practitioner, health care professional, hospital, healthcare institution, medical organization, clinic and any other medical or medically related facility, insurance company, insurance broker or agent, the Medical Information Bureau (MIB), financial institution, or any other corporation, organization, institution, association or person that has any information, records or knowledge of me/us or my/our health, to release and exchange with AIG Life of Canada, Authorized Representatives or their reinsurers any such information or records. I/we further authorize AIG Life of Canada, Authorized Representatives or their reinsurers, any personal information agents, third party investigation agencies or organizations hired by AIG Life of Canada or Authorized Representatives to acquire information about me/us for appraisal of the risk or the evaluation of a claim. I/we understand that this authorization shall be valid throughout my/our relationship with AIG Life of Canada and beyond my/our death to evaluate and review any claim submitted.

I/we received the "Disclosure Notice" concerning the Medical Information Bureau and fully consent to the provisions therein.

I/we authorize with AIG Life of Canada, Authorized Representatives or their reinsurers to have performed such tests, examinations, x-rays, electrocardiograms, general blood profiles and blood tests for HIV as may be required to medically underwrite this application for Insurance. I/we consent to with AIG Life of Canada, Authorized Representatives or their reinsurers releasing the results of any tests, reports and personal information gathered about me/us to their reinsurers, if involved in the underwriting, to my/our attending physician, to the Medical Information Bureau, and other authorized insurers; and to inquire of them for the appraisal of the risk or the evaluation of a claim. **A copy of this authorization shall be as valid as the original.**

SIGNATURE OF EMPLOYEE	DATE SIGNED	SIGNATURE OF DEPENDENT (if 18 yrs. of age or older)	DATE SIGNED
SIGNATURE OF SPOUSE	DATE SIGNED	SIGNATURE OF DEPENDENT (if 18 yrs. of age or older)	DATE SIGNED

***(required only if evidence regarding insurability of spouse and/or dependent is provided in this form)**

DISCLOSURE NOTICE (Please detach and keep this notice)
MEDICAL INFORMATION BUREAU

Information given in your statement will be treated as confidential except that **AIG Life of Canada** may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another member insurance company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Medical Information Bureau will supply upon request, that company with any information that it may have in its files. The Bureau will arrange for release at your request, of any information that it may have about you. If you question the accuracy of information in the bureau's files, you may contact the bureau and seek correction. The address of the Bureau's Information Office is:

MEDICAL INFORMATION BUREAU 330 University Avenue, Suite 403, Toronto, Ontario M5G 1R7 Telephone (416) 597-0590

AIG Life of Canada may also release information in its file to other life insurance companies to whom you may apply for life and health insurance or to whom a claim for benefits may be submitted.