

When completed, send the application to the following agency address:
 Hunter McCorquodale Inc.
 2300 Yonge St., Suite 2910, P.O. Box 2396
 Toronto, Ontario M4P 1E4

APPLICATION FOR TRANSITION L.T.D.
 Long Term Disability Insurance
 for Outplaced Employees



Section A PERSONAL INFORMATION	1. Name of Proposed Insured: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Title _____					
	First:	Middle:	Last:	Maiden if Applicable:		
	2. Residence Address:			3. Date of Birth:	4. Age	5. Sex
	Street, Apt./Ste. #	City/Town	Prov.	Postal Code	____ / ____ / ____ Day Month Year	
6. Mailing Address, if other than residence address:			7. Place of Birth (Province/Country):			
Street, Apt./Ste. #	City/Town	Prov.	Postal Code			
8. Telephone:			9. Social Insurance Number:			
() _____ - _____ () _____ - _____ _____ Daytime Evening Best Time to Call						

Section B EMPLOYMENT INFORMATION	1. Employer Name at Date of Job Termination:				
	2. Employer Address:				
	Street, Ste. #	City/Town	Province	Postal Code	
	3. Start Date:	4. Last Day Worked:	5. Contact Name:	6. Telephone:	
	____ / ____ / ____ Day Month Year	____ / ____ / ____ Day Month Year			
	7. Occupation and Duties:				
8. Previous Employment History Over the Past Three Years:					
From Month/Year	To Month/Year	Employer Name	Occupation	Final Annual Salary	

Section C FINANCIAL INFORMATION	1. Annual Base Salary at Date of Job Termination: \$ _____				
	2. Amount of Severance: a. <input type="checkbox"/> Lump Sum of \$ _____ and/or b. <input type="checkbox"/> Salary Continuation for _____ months				
	3. Expiry Date of Group LTD Coverage a. <input type="checkbox"/> Last Day Worked or b. <input type="checkbox"/> Other (specify) ____ / ____ / ____ Day Month Year				
	4. Do you have any other disability income insurance in force or applied for? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes" give details) <u>Company</u> <u>Year Issued</u> <u>Monthly Benefit</u> <u>Benefit Period</u> <u>Elimination Period</u> _____				

Section D PLAN INFORMATION	1. Coverage Period (#months): <input type="checkbox"/> 6 <input type="checkbox"/> 9 <input type="checkbox"/> 12 <input type="checkbox"/> 15 <input type="checkbox"/> 18 <input type="checkbox"/> 21 <input type="checkbox"/> 24				
	2. Monthly Benefit Amount: \$ _____		3. Benefit Period <input type="checkbox"/> to age 60 <input type="checkbox"/> to age 65		
	4. Indexing: <input type="checkbox"/> Yes <input type="checkbox"/> No		5. Premium to be Paid by: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Employer		

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Section E		YES	NO
GENERAL INFORMATION	1. Have you ever had an application for disability income insurance declined, postponed, rated or modified in any way? If "yes", give details including company, date and specific nature of decision _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
	2. During the past 3 years have you:		
	a. flown as a pilot, student pilot or crew member, or do you contemplate doing so?	<input type="checkbox"/>	<input type="checkbox"/>
	b. participated in racing (automobile, snowmobile, motorcycle, boat), scuba diving, sky diving, hang gliding, bungee jumping, mountain or rock climbing, or any other hazardous sport or avocation, or do you contemplate doing so?.....	<input type="checkbox"/>	<input type="checkbox"/>
	c. had your driver's license suspended or revoked, been charged with 3 or more moving violations, or been convicted of driving while under the influence of drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
	If "yes", driver's license # _____ Province _____		
	d. been unemployed for more than 30 days?.....	<input type="checkbox"/>	<input type="checkbox"/>
	e. filed for personal or business bankruptcy?.....	<input type="checkbox"/>	<input type="checkbox"/>
	f. had a license to practice your occupation suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
	g. been convicted of a criminal offense?	<input type="checkbox"/>	<input type="checkbox"/>
	If "yes" to any of 2.a to 2.g give details _____ _____		
	3. Do you have any intention of spending more than 1 month at a time outside Canada or the United States within the next 2 years? If "yes" give details _____	<input type="checkbox"/>	<input type="checkbox"/>
	4. Have you ever made a claim or received a pension, payments or compensation for any sickness or injury? If "yes" give details _____	<input type="checkbox"/>	<input type="checkbox"/>

Section F		YES	NO
HEALTH QUESTIONS (provide details of any "yes" answers on page 3)	1. Height _____ <input type="checkbox"/> cm <input type="checkbox"/> ft' in" Weight _____ <input type="checkbox"/> kg. <input type="checkbox"/> lbs. Has your weight changed more than 10 lbs. (5kg) in the last year? Gain _____ kg./lbs. Loss _____ kg./lbs.	<input type="checkbox"/>	<input type="checkbox"/>
	2. Within the past 12 months, have you used any form of tobacco, marijuana, nicotine products or nicotine substitutes?.....	<input type="checkbox"/>	<input type="checkbox"/>
	3. Have you taken any prescribed medication in the past 3 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
	4. In the past 10 years, have you had, been medically diagnosed as having, or been treated for:		
	a. dizziness, fainting, convulsions, numbness, chronic headache, epilepsy, stroke, or other disorder of the brain or nervous system?.....	<input type="checkbox"/>	<input type="checkbox"/>
	b. anxiety, depression, stress, burnout, chronic fatigue or other emotional, nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	c. asthma, bronchitis, sleep disorder, tuberculosis, pleurisy, emphysema, blood spitting, persistent cough, or other disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
	d. high blood pressure, high cholesterol, chest pain, palpitations, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
	e. ulcer, gastritis, intestinal bleeding, colitis, jaundice, hepatitis, hemorrhoids, hernia, or other disorder of the stomach, intestines, rectum, gallbladder, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
	f. sugar, protein, albumin, pus or blood in the urine, nephritis, kidney stone or other disorder of the kidneys or bladder?	<input type="checkbox"/>	<input type="checkbox"/>
	g. diabetes, cancer, tumour, gout, venereal disease, or disorder of the prostate or reproductive organs?....	<input type="checkbox"/>	<input type="checkbox"/>
	h. backache, rheumatic fever, rheumatism, arthritis, fibromyalgia, paralysis, or other disorder of the muscles or bones, including joints and spine?.....	<input type="checkbox"/>	<input type="checkbox"/>
	i. thyroid disorder, enlarged lymph glands, anemia, allergies, or other disorder of the glands or blood?	<input type="checkbox"/>	<input type="checkbox"/>
	j. disorder of the eyes, ears, nose, throat or skin?	<input type="checkbox"/>	<input type="checkbox"/>
	5. In the past 10 years have you been advised to seek treatment for drug or alcohol use?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been medically diagnosed as having or been treated for AIDS or HIV infection, or any other immunological disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever attempted to commit suicide?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have your parents, brothers, or sisters ever had diabetes, high blood pressure, heart or kidney disease?..	<input type="checkbox"/>	<input type="checkbox"/>	
9. In the past 5 years, other than as already disclosed , have you:			
a. missed more than 15 consecutive days from work due to sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	
b. been a patient in a hospital, clinic, sanatorium or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
c. had an electrocardiogram, X-ray, blood or urine test or other diagnostic test?.....	<input type="checkbox"/>	<input type="checkbox"/>	
d. had any other illness, surgery, injury or disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e. been examined by or consulted a physician, chiropractor, psychologist, physiotherapist or other practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you totally disabled or on sick leave, medical leave, or hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Are you contemplating medical attention or a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>	

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Section F (continued) HEALTH QUESTIONS	12. Personal Physician: a. Name		d. Date last consulted		
	b. Address: Number and Street		e. Reasons & results _____		
	City or Town	Province			Postal Code
	c. Telephone #				Fax #
	If answer is "yes" to any questions give details:				
	Question #	Details as to diagnosis, treatment, duration, present status	Date(s)	Name and address of physician and/or hospital	

(tear on dotted line)

RECEIPT FOR CASH PAYMENT

It is acknowledged that the sum of \$ _____ has been paid to Reliable Life Insurance Company, in connection with an application for disability insurance for

Print Name of Proposed Insured

It is expressly understood and agreed that the payment evidenced by this receipt does not put the proposed insurance in effect. Any policy issued based on this application takes effect only on delivery to the Owner and only if there has been no change in the insurability of the Proposed Insured subsequent to the completion of this application.

Signed at _____ this _____ day of _____,

Agent's Signature _____

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<p>Section G</p> <p>DECLARATION AND AUTHORIZATION</p>	<p>FRAUD STATEMENT</p> <p>Any person who, knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.</p> <p>-----</p> <p>To the best of my knowledge and belief, all statements and answers recorded on this application are true and complete.</p> <p>I understand and agree that any policy issued on this Application takes effect only on delivery and on payment in full of the premium and then only if there has been no change in my insurability subsequent to the completion of this application. I understand that I will have a 10 day period after delivery of the policy during which I may cancel it for any reason and receive a full refund of any premium paid.</p> <p>I hereby authorize any physician, medical or health practitioner, hospital, clinic or medically related facility, insurance company, employer or former employer, the Medical Information Bureau, Inc., or any other organization, institution, or person which has any records or knowledge of me, my health or other personal information, to give to Hunter McCorquodale Inc., Reliable Life Insurance Company or its reinsurers all such information to use to determine eligibility for insurance or for benefits under an existing policy. This authorization shall be valid for 26 months, and a copy shall be as valid as the original. I may receive a copy upon request. I have received and read the Disclosure Notice.</p>
	<p>Signed at _____ this _____ day of _____, _____</p>
	<p>Signature of Proposed Insured _____</p>

<p>Section H</p> <p>AGENT/BROKER STATEMENT</p> <p>(if application is submitted by a licensed agent or broker)</p>	<p>AGENT/BROKER STATEMENT</p> <p>I certify that I have asked all questions and have accurately recorded on the application all information supplied by the Proposed Insured, and I have no knowledge of information which is not fully disclosed. I also certify that the Proposed Insured reads and understands English.</p>
	<p>Name of Agent/Broker: _____</p>
	<p>Signed at _____ this _____ day of _____, _____</p>
	<p>Signature of Agent/Broker _____</p>

IMPORTANT: Detach and retain this DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Reliable Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Under some circumstances, medical information will be disclosed only to your attending physician. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7 - (416) 597-0590.

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

INFORMATION PROCEDURES: Personal information about you obtained by the Company will not be disclosed to any other party without your consent, except to public health authorities or where otherwise required by law. You have a right to access and to seek correction with respect to personal information gathered. Details on these procedures will be furnished on request.