RBC Insurance

Child Critical Illness

Insurance Application

IMPORTANT GUIDELINES

- Print legibly in ink, preferably black for photocopy purposes. DO NOT use ditto marks.
- DO NOT make erasures or use liquid paper. Stroke out an error and have the applicant initial it.
- After the application has been signed, have additions initialed by the applicant. The application is a legal document forming part of the policy contract.

Your Privacy Matters To Us

At RBC Insurance®, we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information
We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information
We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group™ companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary.

Please note that this paragraph is not applicable if this application is submitted by an independent representative or a representative who is attached to a firm other than RBC Insurance.

Other ways we use your information
When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other companies of the RBC Financial Group. However, we will never use or share your health information for these purposes. To better manage your relationship with other companies of RBC Financial Group, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information", please let us know by calling us at 1-800-663-0417.

Your right to access your information
You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: (800) 663-0417
Facsimile: (905) 813-4816

If you would like more information about client privacy
RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, you can contact us and we would be pleased to send one to you.

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

CHILD CRITICAL ILLNESS RECOVERY PLAN APPLICATION

RBC Life Insurance Company

PART 1 **You/Your** refers to the Proposed Owner. Proposed Insured refers to the child for whom coverage is applied. If there is insufficient space on the Application to answer any question in full, please attach a separate page signed by You.

PROPOSED INSURED(S) - (If approved, separate policies will be issued for each child.)

1. PRINT Name as legally known	Proposed Insured #1	Proposed Insured #2	Proposed Insured #3
a. Last			
b. First & Middle			
c. Birth Date (month/day/year)			
d. Age (nearest)			
e. Birth Place (Province/Country)			
f. Sex			

2. a. Residence Address: Apt. No. ____________ Street ____________

City ____________ Prov.____________ Postal Code____________

b. Home Phone No. ( ) ____________ c. How long has the family resided in Canada? ____________

d. Aside from vacations, are any of the Proposed Insureds planning to reside outside of Canada?……….....……..Yes ☐ No ☐

If **"Yes"**, give details ____________

e. Do You read & speak English fluently? Yes ☐ No ☐
f. Do You read & speak French fluently? Yes ☐ No ☐
g. Is a French policy requested? Yes ☐ No ☐

OWNERSHIP Must be completed. Ownership is restricted to the parent(s) or legal guardian(s) of the Proposed Insured(s). Ownership can be assigned when the Proposed Insured(s) reach(es) the age of majority.

3. Proposed Owner ____________ Relationship ____________

Address ____________ Telephone # ____________

BENEFIT RECIPIENT DESIGNATION (Return of Premium benefits are payable to You. Critical Illness benefits will be paid to the Proposed Insured unless You designate a different Recipient below. Note: If any benefits become payable to a person under the legal age of majority, the benefits will automatically become payable to You.)

4. ____________ ____________

Recipient (Print full first and last name) Relationship

EXISTING AND PENDING COVERAGE FOR PROPOSED INSURED(S), AND PARENTS AND SIBLINGS OF THE PROPOSED INSURED(S).

(Must be answered in all cases and must include names of ALL siblings and parents)

5. Describe **all** coverage in force or pending (other than this Application). Include life, accident and critical illness coverage.

IF THERE ARE SIBLINGS OR PARENTS WITHOUT COVERAGE (IN FORCE OR PENDING), IDENTIFY THEM AND WRITE "NONE".

Name	Name	Company	Type of coverage	Amount in force	Amount pending	To be cont'd Yes No
Proposed Insured # 1						
Proposed Insured # 2						
Proposed Insured # 3						
Parent/Guardian						
Parent/Guardian						
Sibling # 1						
Sibling # 2						

6. Has anyone applied for Critical Illness coverage on any of the Proposed Insureds concurrently or within the past six months with any other company? . . . . Yes ☐ No ☐ If **"Yes"**, give details above.

7. Is the coverage applied for intended to change or add to any existing insurance? . . . Yes ☐ No ☐ If **"Yes"**, give details above.

ADDITIONAL INFORMATION

8. Have any of the Proposed Insureds ever had an application for insurance rated, modified, rejected, cancelled or been denied renewal or reinstatement? . . . . Yes ☐ No ☐

9. Within the past two years, have any of the Proposed Insureds engaged in: motorcycle riding, scuba diving, bungee jumping, parachuting, hang-gliding, motor vehicle or motorboat racing, rodeo activities, mountain climbing, piloting a plane, ultralight , glider or any intention of doing so in the future? . . . . Yes ☐ No ☐

If You answered **"Yes"** to any of the questions above, please provide details below:

Question #	Proposed Insured's Name	Details

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

PART 2 : MEDICAL HISTORY

Name(s) of Proposed Insured(s)______________________________

1. Have any of the Proposed Insureds lost weight in the past year? . . . . Yes ☐ No ☐
   If **"Yes"** please provide details below:

Proposed Insured's Name	Details

2. Are any of the Proposed Insureds under observation or treatment, therapy, counselling or taking medication? . Yes ☐ No ☐

   If **"Yes"** , give details below including the full name, address and telephone number (including area code) of the physician or health care facility providing the treatment.

Proposed Insured's Name	Details

3. Please provide the name(s), address(es) and phone number(s) (including area code), of each Proposed Insured's attending physician(s) or health care facility(ies) : **if none, write "none"** :

Proposed Insured's Name	Physician(s) or Health Care Facility(ies)

4. Date, reason for and result of last consultation with a physician:

Proposed Insured's Name	Date, reason and results of last consultation with a physician

MEDICAL DETAILS - Indicate appropriate concern and give details of all " Yes " answers on page 4

5. Have any of the Proposed Insureds ever had any indication of, or been treated for :

   a. Any disease or disorder of the eyes, ears, nose or throat (including loss of speech)? . . . . Yes ☐ No ☐
   b. Heart murmur, irregular pulse, high blood pressure, abnormal ECG or other heart or circulatory disorder? Yes ☐ No ☐
   c. Any disease or disorder of the kidneys, urinary tract or bladder? . . . . Yes ☐ No ☐
   d. Headaches, seizures, epilepsy, head injury, paralysis, multiple sclerosis, cerebral palsy, muscular dystrophy, motor neuron disease, muscle weakness or any neurological disorder? . . . . Yes ☐ No ☐
   e. Anxiety, depression, mental or nervous disorder? . . . . Yes ☐ No ☐
   f. Arthritis, lupus, severe burns or any disorder of the skin, muscles, bones, joints or spine, or deformity? . . . Yes ☐ No ☐

g. Any disease or disorder of the blood or glandular system such as : Acquired immune deficiency syndrome (AIDS), AIDS related complex or AIDS related conditions, anemia, enlarged glands, thyroid disease, hemophilia or diabetes? . . . . Yes ☐ No ☐

h. A tumour, cancer, polyp, or other growth, any disease or disorder of the skin or lymph glands, leukemia, blood disorder or any other form of malignant disease? . . . . Yes ☐ No ☐

i. Colitis, liver disorder, hepatitis or other disease or disorder of the stomach, pancreas, colon or intestines? Yes ☐ No ☐

j. Asthma, cystic fibrosis or any chronic lung or respiratory disease or disorder? . . . . Yes ☐ No ☐

k. Any congenital abnormality, hereditary disorder, medical disorder or developmental problems not mentioned above? . . . . Yes ☐ No ☐

6. Other than if fully disclosed above, have any of the Proposed Insureds ever :

a. Been hospitalized, had diagnostic tests, surgery or been under treatment or been advised to have any test, surgery or treatment which has not been completed? . . . . Yes ☐ No ☐

b. Had any symptoms or complaints for which a physician has not yet been consulted or treatment sought? . Yes ☐ No ☐

Give full and accurate details below to any "Yes" answers. For each answer, include symptoms, diagnosis, treatment, date and duration of each occurrence, whether recovery is complete and if not, provide details of any continuing symptoms or effects. Also provide the name, complete address and telephone number (including area code) of the doctor and medical facilities.

Question #	Proposed Insured's Name	Details

7. Have any of the Proposed Insured's natural parents, brothers, sisters, either living or dead, ever suffered from any of the following conditions: heart or polycystic kidney disease, diabetes, cancer (specify type), cystic fibrosis, hemophilia, multiple sclerosis, Alzheimer's, Huntington's Chorea, Motor Neuron Disease, muscular dystrophy or any form of inherited disease? . . . . Yes ☐ No ☐

If " **Yes** ", complete the chart below :

Family Member Relationship/Name	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death
Father					
Mother					
Brother(s) (No.)					
Sister(s) (No.)					

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

AGREEMENT

RBC Life Insurance Company is herein referred to as "the Company"

It is understood and agreed as follows:

1. I have read the statements and answers provided in this Application. They are true, complete and correctly recorded. I understand that the Company is relying on those answers and statements and that this Application forms part of any policy(ies) issued. I understand that incorrect or incomplete answers to any questions will affect the coverage and benefits available under the policy, and may mean that the policy is void and there will be no coverage at all.
2. I will discontinue any policy(ies) shown to be discontinued immediately upon delivery to me of any policy(ies) issued by the Company as a result of this Application. I understand that the Company relies on this agreement in determining the amount, if any, of insurance it will issue. If the policy(ies) shown to be discontinued is (are) not discontinued, the applicable policy(ies) which was (were) issued by the Company as a result of this Application, shall be void.
3. I understand that no agent or broker can authorize or approve of inaccurate or incomplete answers to the questions in this Application, or decide on any issue of insurability, or waive any of the Company's rights or responsibilities or make any changes to the policy or the rights and obligations created by it. The Company will not be bound by any statement made to or by any agent or broker which is not recorded in this Application.
4. The Company has the right to require medical exams and tests on the Proposed Insured(s) to determine insurability.
5. The insurance applied for will take effect only if and when: the policy actually has been delivered to the Proposed Owner, any and all conditions for delivery of the policy to the Proposed Owner have been satisfied completely and there has been no change in the insurability of the Proposed Insured(s) between the date of this Application and the date of delivery. The only exception to this is provided in the Receipt and Conditional Insurance Agreement(s) detached herefrom and issued, provided all the questions in the Conditional Insurance Agreement(s) have been correctly answered "no" and the premium for each Proposed Insured is paid in advance. I will immediately advise the Company in writing, of any changes in the answers to the questions in the Application or the Conditional Insuring Agreement(s).
6. Acceptance of delivery by the Proposed Owner of any policy(ies) issued as a result of this Application will ratify any changes and/or differences between the coverage applied for and the coverage provided under any policy(ies) issued by the Company.
7. I hereby acknowledge receipt of the Pre-Notice form describing Medical Information Bureau procedures.
8. A photostatic copy of the Application will not be automatically included in the policy(ies), except in the Province of Quebec, in accordance with provincial law. A photostatic copy of the Application will be made available upon request.
9. I understand that any policy(ies) issued by the Company as a result of this Application will provide coverage only for Critical Illnesses which are very specifically defined in the policy, and only if every sign or symptom of them, or of the sickness or accidental bodily injuries which caused them, becomes first manifest after the delivery of the policy(ies) and while the policy(ies) is (are) in force. I understand that unless specifically excluded, the policy(ies) will provide coverage for Critical Illnesses, even if they or the sicknesses or injuries which cause them, became first manifest before the policy(ies) became effective, but only if the Proposed Owner has fully and accurately advised the Company on this Application, or otherwise in writing, prior to the delivery of the policy(ies), of all information known or reasonably available regarding the signs, symptoms or other manifestations of the said Critical Illness, or the sickness(es) and/or injury(ies), which caused them.
10. Delivery of any policy issued with an amendment form is conditional upon execution of the unaltered amendment form by me and return to, and receipt by the Company, failing which the policy will not become effective.
11. I understand that the Company will create and maintain at its office a file for the purposes of this Application and any subsequent claim. Only the employees, mandataries or agents responsible for such purposes will have access to it. I am entitled to consult the personal information about me or the Proposed Insured(s) and where applicable have it rectified, by formulating a written request to the Company.

I understand that I am responsible for the accuracy of the statements and answers even if I have not read them. Before signing, I have verified that all answers are correct and complete and I have initialled any changes to those answers. Inaccurate answers to any questions may affect eligibility for coverage and/or benefits. I have read, understood and agree with the terms of the Conditional Insurance Agreement and Receipt (s) (applicable only if Minimum Payment(s) has (have) been properly made, all questions have been correctly answered "no" on the Conditional Insurance Agreement and Receipt(s), and the Receipt(s) has (have) been properly detached from the Application).

Signed at: ______________________ (City/Province)   Date: ______________________ (MM/DD/YYYY)

Proposed Owner (Signature): **X** ______________________

WITNESS

Name (Please print) : ______________________   Signature : **X** ______________________

Address : ______________________   Signed at : ______________________ (City/Province)

Telephone : ______________________   Date : ______________________ (MM/DD/YYYY)

Note : Witness cannot be related to the Proposed Owner or the Proposed Insured(s). Witness may be the Producer, if present.

Please see reverse for Producer Declaration

PRODUCER DECLARATION

I declare that I have clearly explained the provisions and limitations of the policy(ies) that is (are) being applied for, and if applicable, the provisions and limitations of the Conditional Insurance Agreement(s). All of the questions contained in the Application were clearly asked of, or read by, the Proposed Owner. To the best of my knowledge, they understood all of the questions. To the best of my knowledge, all of the answers on this Application have been fully and accurately recorded. All pertinent information about the Proposed Insured(s), if applicable, that I am aware of, has been disclosed in this Application. If a policy is issued, I will deliver it to the Proposed Owner, only after confirming with the Proposed Owner that all conditions for delivery have been completely satisfied and that there have been no changes in the insurability of any of the Proposed Insured(s) since completing this Application. I also agree that I cannot change the rights or responsibilities of the Company or the Proposed Owner under any agreement, or make any changes to the Conditional Insurance Agreement(s). I personally have negotiated the insurance applied for on behalf of the Proposed Owner.

Name of Producer (Please print) : ______________________

Signature : **X** ______________________

Date : ______________________ (MM/DD/YYYY)   Signed at : ______________________ (City/Province)

Name of Witness (if Producer is related to Proposed Owner):

____

Signature of Witness : **X** ______________________

Date : ______________________ (MM/DD/YYYY)

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

PART 3 : COVERAGE APPLIED FOR AND PREMIUM INFORMATION

COVERAGE APPLIED FOR

Proposed Insured # 1

☐ Amount ____________________

☐ guaranteed renewable to age 65

☐ guaranteed renewable to age 75

☐ non-cancellable to age 75

☐ non-cancellable to age 100

☐ Return of Premium Benefit Rider

☐ Scheduled Increase Benefit Rider

Proposed Insured # 2

☐ Amount ____________________

☐ guaranteed renewable to age 65

☐ guaranteed renewable to age 75

☐ non-cancellable to age 75

☐ non-cancellable to age 100

☐ Return of Premium Benefit Rider

☐ Scheduled Increase Benefit Rider

Proposed Insured # 3

☐ Amount ____________________

☐ guaranteed renewable to age 65

☐ guaranteed renewable to age 75

☐ non-cancellable to age 75

☐ non-cancellable to age 100

☐ Return of Premium Benefit Rider

☐ Scheduled Increase Benefit Rider

PREMIUM INFORMATION

1. Initial deposit collected?

Proposed Insured # 1 ☐ Yes ☐ No - COD
Proposed Insured # 2 ☐ Yes ☐ No - COD
Proposed Insured # 3 ☐ Yes ☐ No - COD

If initial deposit collected, it is in exchange for the Conditional Insurance Agreement and Receipt.
Make cheque(s) payable to RBC Life Insurance Company

2. Premium Mode

Available Options:

A - Pre-Authorized Chequing: monthly, semi-annual, annual (**complete authorization form**)
B - Direct Bill: semi-annual or annual

Please indicate method of payment for each Proposed Insured:

	A or B	Frequency
Proposed Insured # 1		
Proposed Insured # 2		
Proposed Insured # 3		

Select Discount is applied for ☐ (only available if the parents or legal guardians of each Proposed Insured(s) has (have) Critical Illness coverage in force or applied for with the Company.)

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

PRODUCER REMARKS

To be completed by the Producer in every case to ensure prompt handling of the Application

1. Were the negotiations for this Application started by :

   You? ☐ Proposed Owner? ☐

2. How long have you known the Proposed Owner? ______________________________

3. The Proposed Owner may be contacted by telephone for a confidential history interview. When is the most convenient time and place to contact them?

   Business ☐ Telephone # ________________ or

   Residence ☐ Telephone # ________________

   at ______________________________ local time.

______________________________ ______________________________

Name of Producer (Print) Signature of Producer

Producer / Branch comments :

(If not all of the siblings and parents/legal guardians of the Proposed Insured(s) have Critical Illness coverage applied for or in force, or if the amounts applied for or in force for any of the Proposed Insured(s), their siblings and parents/legal guardians are not for the same amounts, please include detailed reasons below) :

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

COMPLETE IN ALL CASES - AUTHORIZATION FOR INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, consumer reporting agency, insurance or reinsurance company, M.I.B. Inc., or other organization, institution or person, or personal information agent, that has any records or knowledge of the health of the Proposed Insured(s), to give to RBC Life Insurance Company and our participating reinsurers any such information to be used to assess this Application for insurance and/or for claims evaluation, which are also expressly authorized to conduct any investigation deemed necessary for such assessment and/or evaluation. To facilitate rapid submission of medical information, I authorize any licensed physician, medical practitioner, hospital, clinic or medically related facility, to give such information to a medical transcription provider exclusively for RBC Life Insurance Company and its participating reinsurers. I also authorize the communicating of any such information to the Medical Information Bureau Inc., and to any other insurance company, as directed by the Medical Information Bureau Inc. A photocopy of this authorization shall be valid as the original.

Name of Parent or Legal Guardian of Proposed Insured(s) - Please Print ______________________

Signature of Parent or Legal Guardian of Proposed Insured(s)

X ______________________ Date ______________________
(MM/DD/YYYY)

COMPLETE IN ALL CASES - AUTHORIZATION FOR INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, consumer reporting agency, insurance or reinsurance company, M.I.B. Inc., or other organization, institution or person, or personal information agent, that has any records or knowledge of the health of the Proposed Insured(s), to give to RBC Life Insurance Company and our participating reinsurers any such information to be used to assess this Application for insurance and/or for claims evaluation, which are also expressly authorized to conduct any investigation deemed necessary for such assessment and/or evaluation. To facilitate rapid submission of medical information, I authorize any licensed physician, medical practitioner, hospital, clinic or medically related facility, to give such information to a medical transcription provider exclusively for RBC Life Insurance Company and its participating reinsurers. I also authorize the communicating of any such information to the Medical Information Bureau Inc., and to any other insurance company, as directed by the Medical Information Bureau Inc. A photocopy of this authorization shall be valid as the original.

Name of Parent or Legal Guardian of Proposed Insured(s) - Please Print ______________________

Signature of Parent or Legal Guardian of Proposed Insured(s)

X ______________________ Date ______________________
(MM/DD/YYYY)

SUBMIT WITH APPLICATION

PRE-AUTHORIZED PAYMENT PLAN AUTHORIZATION

I (we) authorize the Company and noted Financial Institution, or any other Financial Institution that I (we) might later designate to withdraw funds from my (our) account for the purposes of paying premiums. A debit in paper, electronic or other form may be drawn on my (our) account beginning immediately. Premium payments are subject to the provisions of the policy(ies). I (we) will notify the Company in writing of any changes in the account information or termination of this authorization prior to the next withdrawal date of the pre-authorized payment. I (we) also understand that should any withdrawal not clear my (our) account for reason of insufficient funds, the Company will automatically attempt to withdraw these funds within 10 days of the returned item without prior notification. I (we) acknowledge that delivery of this authorization to the Company constitutes delivery by me (us) to the noted Financial Institution. This agreement may be cancelled by either me (us) or the Company in writing.

Name of Bank: ______________________

Address of Bank: ______________________

Withdrawal Day: ____________ (1st to 28th)

Signature of Account Holder(s): **X** ______________________ Please Print: ______________________

Signature of Account Holder(s): **X** ______________________ Please Print: ______________________

Date: ____________ **Attach sample cheque or indicate add-to-policy number** ______________________
(MM/DD/YYYY)

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

APPLICATION FOR CONDITIONAL INSURANCE ON CHILD CRITICAL ILLNESS APPLICATION FOR PROPOSED INSURED # 1

DO NOT DETACH FROM APPLICATION

1. Has Proposed Insured # 1 ever been treated for or had any indication of: heart or circulatory disease, Huntington's Chorea, heart attack, chest pain, abnormal ECG, stroke, transient ischemic attack (TIA), multiple sclerosis, paralysis, blindness, deafness, diabetes, elevated blood pressure, chronic kidney, liver or lung disease, any neurological disorder, any congenital condition or abnormality? . . . . Yes ☐ No ☐
2. Has Proposed Insured # 1 had any symptoms of or treatment for cancer or tumour, AIDS, ARC or HIV infections? . . . . Yes ☐ No ☐
3. Has Proposed Insured # 1 had any symptoms of or treatment for any medical condition that resulted in hospitalization within the last two years? . . . . Yes ☐ No ☐
4. Has any Application on Proposed Insured # 1's life ever been rated, declined or modified in any way? . . . . Yes ☐ No ☐
5. Does Proposed Insured # 1 have any signs or symptoms of illness for which treatment has not yet been sought or for which treatment is planned or pending? . . . . Yes ☐ No ☐

THE CONDITIONAL INSURANCE AGREEMENT MAY ONLY BE DETACHED AND GIVEN TO THE PROPOSED OWNER AND WILL ONLY BE VALID AND ENFORCEABLE IF ALL OF THE ABOVE QUESTIONS ARE CORRECTLY ANSWERED "NO".

I agree that the Conditional Insurance coverage provided by the Company for Proposed Insured # 1 will be subject to all of the terms and conditions of the Conditional Insurance Agreement and Receipt set out below. I agree that I will be bound by the said terms and conditions even if, for whatever reason, the Agreement and Receipt below is not detached and given to me. I agree that the definitions (both general and for the specific covered Critical Illnesses) contained in the Company's standard Critical Illness policy form in effect at the time of this Application, will apply to and form part of the Conditional Insurance Agreement, even though I have not seen or have not been told of those definitions. I agree that statements made by my broker or any other person concerning the coverage provided by the Conditional Insurance Agreement will not modify the terms and conditions of the Agreement and Receipt and will not be binding upon the Company.

Dated at ____________________ this ________ day of ____________________ ____________

CITY/PROVINCE DAY MONTH YEAR

X ______________________________

SIGNATURE OF PROPOSED OWNER

CONDITIONAL INSURANCE AGREEMENT AND RECEIPT ON CHILD APPLICATION FOR PROPOSED INSURED # 1

(TO BE DETACHED AND LEFT WITH PROPOSED OWNER ONLY IF DEPOSIT SUBMITTED AND APPLICATION FOR CONDITIONAL INSURANCE IS COMPLETED FOR PROPOSED INSURED # 1 AND ALL QUESTIONS ARE CORRECTLY ANSWERED "NO")

The Company agrees to provide Conditional Insurance on the Proposed Insured # 1 on the following terms:

EFFECTIVE DATE AND COVERAGE

1. This coverage will become effective on the date the Proposed Owner completes the Application, but only if:
   (a) The minimum premium deposit (at least 10% of the aggregate yearly premium for the amount of the Proposed Insured # 1 Basic Plan, or one month's premium for monthly premium mode) is provided at the time the Application is completed and is received by the Company with the Application;
   (b) The Proposed Owner's premium deposit cheque is immediately negotiable and honoured on presentation;
   (c) The Proposed Owner has correctly answered the Conditional Insurance Application questions "no" on the same date he/she completes the Application for Critical Illness Insurance policy on Proposed Insured # 1;
   (d) The total amount of Critical Illness coverage pending or in force with other companies is: (i) less than $25,000 for Proposed Insureds age 2-4 or (ii) less than $100,000 for Proposed Insureds age 5-17;
2. Subject to the terms of this Agreement, the Critical Illness coverage provided by this Conditional Insurance Agreement will be for a single occurrence of the same specifically defined Critical Illnesses (excluding Cancer) which are contained in the Company's standard policy wording in effect at the time of the application, and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 1 were to be approved.
3. Subject to the Waiting Period, the Conditional Insurance benefit, in the amount stated below, will be paid to the Proposed Owner if the Proposed Insured # 1 is correctly Diagnosed, in the manner required, while this coverage is in force, with one of the covered Critical Illnesses.
4. Waiting Period: The Conditional Insurance Benefit will only be paid if the Proposed Insured # 1 meets the waiting period as specifically defined in the Company's standard Critical Illness policy wording in effect at the time of the Application and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 1 were to be approved.

(continued on reverse)

CONDITIONS

1. The amount of the Conditional Insurance benefit shall be limited to the LESSER of:
   a) The total amount of Critical Illness insurance applied for in the Application for Proposed Insured # 1, and either (b) or (c) below;
   b) $25,000 for Proposed Insureds age 2-4, less the amount of any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company or
   c) $100,000 for Proposed Insureds age 5-17, less any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company.
2. Insurance under only one Conditional Insurance Agreement can be in effect on Proposed Insured # 1. If more than one Application for Conditional Insurance is submitted on Proposed Insured # 1, effect will be given only to the one with the higher face amount that meets all of the provisions as set forth herein.

LIMITATIONS AND EXCLUSIONS

1. There is no coverage for, and no payment will be made under this Agreement for any type of cancer or any Critical Illness resulting from any type of cancer.
2. If the Proposed Insured # 1 suffers a covered Critical Illness as a result of an act of self-destruction, the Company's liability is limited to a refund of the payment made. An act of self-destruction occurs when the Proposed Insured, whether sane or insane, takes or attempts to take their own life or inflicts injuries on their own person, and the death or injury of the Proposed Insured results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.
3. There is no coverage under this Agreement if there is any material misrepresentation on the Proposed Insured #1 Critical Illness policy Application.

TERMINATION OF CONDITIONAL INSURANCE, occurs on the earlier of the following:

1. Conditional Insurance terminates automatically when a Policy providing insurance to Proposed Insured # 1 as a result of this Application becomes effective.
2. The Company may terminate this Conditional Insurance Agreement, and the coverage under it, by mailing a notice to that effect addressed to the Proposed Owner (termination being effective on the date the Company sends the notice), in which event any deposits paid on Proposed Insured # 1 will be refunded. Termination shall take place notwithstanding that such refund has not yet been received by the Proposed Owner.
3. In any event, Conditional Insurance will terminate automatically on the expiration of ninety days from the date of this Agreement.
4. Termination of this Conditional Insurance Agreement will not prejudice a claim, where the Proposed Insured # 1 commenced a Waiting Period while this coverage was in force.

It is acknowledged that the sum of $_________________was paid to the Company at the time of the completion of this Application.

Date ________________________ Signature of Producer **X** ____

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

APPLICATION FOR CONDITIONAL INSURANCE ON CHILD CRITICAL ILLNESS APPLICATION FOR PROPOSED INSURED # 2

DO NOT DETACH FROM APPLICATION

1. Has Proposed Insured # 2 ever been treated for or had any indication of: heart or circulatory disease, Huntington's Chorea, heart attack, chest pain, abnormal ECG, stroke, transient ischemic attack (TIA), multiple sclerosis, paralysis, blindness, deafness, diabetes, elevated blood pressure, chronic kidney, liver or lung disease, any neurological disorder, any congenital condition or abnormality? . . . . Yes ☐ No ☐
2. Has Proposed Insured # 2 had any symptoms of or treatment for cancer or tumour, AIDS, ARC or HIV infections? . . . . Yes ☐ No ☐
3. Has Proposed Insured # 2 had any symptoms of or treatment for any medical condition that resulted in hospitalization within the last two years? . . . . Yes ☐ No ☐
4. Has any Application on Proposed Insured # 2's life ever been rated, declined or modified in any way? . . . . Yes ☐ No ☐
5. Does Proposed Insured # 2 have any signs or symptoms of illness for which treatment has not yet been sought or for which treatment is planned or pending? . . . . Yes ☐ No ☐

THE CONDITIONAL INSURANCE AGREEMENT MAY ONLY BE DETACHED AND GIVEN TO THE PROPOSED OWNER AND WILL ONLY BE VALID AND ENFORCEABLE IF ALL OF THE ABOVE QUESTIONS ARE CORRECTLY ANSWERED "NO".

I agree that the Conditional Insurance coverage provided by the Company for Proposed Insured # 2 will be subject to all of the terms and conditions of the Conditional Insurance Agreement and Receipt set out below. I agree that I will be bound by the said terms and conditions even if, for whatever reason, the Agreement and Receipt below is not detached and given to me. I agree that the definitions (both general and for the specific covered Critical Illnesses) contained in the Company's standard Critical Illness policy form in effect at the time of this Application, will apply to and form part of the Conditional Insurance Agreement, even though I have not seen or have not been told of those definitions. I agree that statements made by my broker or any other person concerning the coverage provided by the Conditional Insurance Agreement will not modify the terms and conditions of the Agreement and Receipt and will not be binding upon the Company.

Dated at ______________________ this ________ day of ______________________ ____________
CITY/PROVINCE DAY MONTH YEAR

X ________________________________
SIGNATURE OF PROPOSED OWNER

CONDITIONAL INSURANCE AGREEMENT AND RECEIPT ON CHILD APPLICATION FOR PROPOSED INSURED # 2

(TO BE DETACHED AND LEFT WITH PROPOSED OWNER ONLY IF DEPOSIT SUBMITTED AND APPLICATION FOR CONDITIONAL INSURANCE IS COMPLETED FOR PROPOSED INSURED # 2 AND ALL QUESTIONS ARE CORRECTLY ANSWERED "NO")

The Company agrees to provide Conditional Insurance on the Proposed Insured # 2 on the following terms:

EFFECTIVE DATE AND COVERAGE

1. This coverage will become effective on the date the Proposed Owner completes the Application, but only if:
   (a) The minimum premium deposit (at least 10% of the aggregate yearly premium for the amount of the Proposed Insured # 2 Basic Plan, or one month's premium for monthly premium mode) is provided at the time the Application is completed and is received by the Company with the Application;
   (b) The Proposed Owner's premium deposit cheque is immediately negotiable and honoured on presentation;
   (c) The Proposed Owner has correctly answered the Conditional Insurance Application questions "no" on the same date he/she completes the Application for Critical Illness Insurance policy on Proposed Insured # 2;
   (d) The total amount of Critical Illness coverage pending or in force with other companies is: (i) less than $25,000 for Proposed Insureds age 2-4 or (ii) less than $100,000 for Proposed Insureds age 5-17;
2. Subject to the terms of this Agreement, the Critical Illness coverage provided by this Conditional Insurance Agreement will be for a single occurrence of the same specifically defined Critical Illnesses (excluding Cancer) which are contained in the Company's standard policy wording in effect at the time of the application, and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 2 were to be approved.
3. Subject to the Waiting Period, the Conditional Insurance benefit, in the amount stated below, will be paid to the Proposed Owner if the Proposed Insured # 2 is correctly Diagnosed, in the manner required, while this coverage is in force, with one of the covered Critical Illnesses.
4. Waiting Period: The Conditional Insurance Benefit will only be paid if the Proposed Insured # 2 meets the waiting period as specifically defined in the Company's standard Critical Illness policy wording in effect at the time of the Application and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 2 were to be approved.

(continued on reverse)

CONDITIONS

1. The amount of the Conditional Insurance benefit shall be limited to the LESSER of:
   a) The total amount of Critical Illness insurance applied for in the Application for Proposed Insured # 2, and either (b) or (c) below;
   b) $25,000 for Proposed Insureds age 2-4, less the amount of any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company or
   c) $100,000 for Proposed Insureds age 5-17, less any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company.
2. Insurance under only one Conditional Insurance Agreement can be in effect on Proposed Insured # 2. If more than one Application for Conditional Insurance is submitted on Proposed Insured # 2, effect will be given only to the one with the higher face amount that meets all of the provisions as set forth herein.

LIMITATIONS AND EXCLUSIONS

1. There is no coverage for, and no payment will be made under this Agreement for any type of cancer or any Critical Illness resulting from any type of cancer.
2. If the Proposed Insured # 2 suffers a covered Critical Illness as a result of an act of self-destruction, the Company's liability is limited to a refund of the payment made. An act of self-destruction occurs when the Proposed Insured, whether sane or insane, takes or attempts to take their own life or inflicts injuries on their own person, and the death or injury of the Proposed Insured results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.
3. There is no coverage under this Agreement if there is any material misrepresentation on the Proposed Insured #2 Critical Illness policy Application.

TERMINATION OF CONDITIONAL INSURANCE, occurs on the earlier of the following:

1. Conditional Insurance terminates automatically when a Policy providing insurance to Proposed Insured # 2 as a result of this Application becomes effective.
2. The Company may terminate this Conditional Insurance Agreement, and the coverage under it, by mailing a notice to that effect addressed to the Proposed Owner (termination being effective on the date the Company sends the notice), in which event any deposits paid on Proposed Insured # 2 will be refunded. Termination shall take place notwithstanding that such refund has not yet been received by the Proposed Owner.
3. In any event, Conditional Insurance will terminate automatically on the expiration of ninety days from the date of this Agreement.
4. Termination of this Conditional Insurance Agreement will not prejudice a claim, where the Proposed Insured # 2 commenced a Waiting Period while this coverage was in force.

It is acknowledged that the sum of $_________________was paid to the Company at the time of the completion of this Application.

Date ________________________ Signature of Producer **X** ____

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

APPLICATION FOR CONDITIONAL INSURANCE ON CHILD CRITICAL ILLNESS APPLICATION FOR PROPOSED INSURED # 3

DO NOT DETACH FROM APPLICATION

1. Has Proposed Insured # 3 ever been treated for or had any indication of: heart or circulatory disease, Huntington's Chorea, heart attack, chest pain, abnormal ECG, stroke, transient ischemic attack (TIA), multiple sclerosis, paralysis, blindness, deafness, diabetes, elevated blood pressure, chronic kidney, liver or lung disease, any neurological disorder, any congenital condition or abnormality? . . . . Yes ☐ No ☐
2. Has Proposed Insured # 3 had any symptoms of or treatment for cancer or tumour, AIDS, ARC or HIV infections? . . . . Yes ☐ No ☐
3. Has Proposed Insured # 3 had any symptoms of or treatment for any medical condition that resulted in hospitalization within the last two years? . . . . Yes ☐ No ☐
4. Has any Application on Proposed Insured # 3's life ever been rated, declined or modified in any way? . . . . Yes ☐ No ☐
5. Does Proposed Insured # 3 have any signs or symptoms of illness for which treatment has not yet been sought or for which treatment is planned or pending? . . . . Yes ☐ No ☐

THE CONDITIONAL INSURANCE AGREEMENT MAY ONLY BE DETACHED AND GIVEN TO THE PROPOSED OWNER AND WILL ONLY BE VALID AND ENFORCEABLE IF ALL OF THE ABOVE QUESTIONS ARE CORRECTLY ANSWERED "NO".

I agree that the Conditional Insurance coverage provided by the Company for Proposed Insured # 3 will be subject to all of the terms and conditions of the Conditional Insurance Agreement and Receipt set out below. I agree that I will be bound by the said terms and conditions even if, for whatever reason, the Agreement and Receipt below is not detached and given to me. I agree that the definitions (both general and for the specific covered Critical Illnesses) contained in the Company's standard Critical Illness policy form in effect at the time of this Application, will apply to and form part of the Conditional Insurance Agreement, even though I have not seen or have not been told of those definitions. I agree that statements made by my broker or any other person concerning the coverage provided by the Conditional Insurance Agreement will not modify the terms and conditions of the Agreement and Receipt and will not be binding upon the Company.

Dated at ___________________ this ________ day of ____________________ ____________
CITY/PROVINCE DAY MONTH YEAR

X ______________________________
SIGNATURE OF PROPOSED OWNER

CONDITIONAL INSURANCE AGREEMENT AND RECEIPT ON CHILD APPLICATION FOR PROPOSED INSURED # 3

(TO BE DETACHED AND LEFT WITH PROPOSED OWNER ONLY IF DEPOSIT SUBMITTED AND APPLICATION FOR CONDITIONAL INSURANCE IS COMPLETED FOR PROPOSED INSURED # 3 AND ALL QUESTIONS ARE CORRECTLY ANSWERED "NO")

The Company agrees to provide Conditional Insurance on the Proposed Insured # 3 on the following terms:

EFFECTIVE DATE AND COVERAGE

1. This coverage will become effective on the date the Proposed Owner completes the Application, but only if:
   (a) The minimum premium deposit (at least 10% of the aggregate yearly premium for the amount of the Proposed Insured # 3 Basic Plan, or one month's premium for monthly premium mode) is provided at the time the Application is completed and is received by the Company with the Application;
   (b) The Proposed Owner's premium deposit cheque is immediately negotiable and honoured on presentation;
   (c) The Proposed Owner has correctly answered the Conditional Insurance Application questions "no" on the same date he/she completes the Application for Critical Illness Insurance policy on Proposed Insured # 3;
   (d) The total amount of Critical Illness coverage pending or in force with other companies is: (i) less than $25,000 for Proposed Insureds age 2-4 or (ii) less than $100,000 for Proposed Insureds age 5-17;
2. Subject to the terms of this Agreement, the Critical Illness coverage provided by this Conditional Insurance Agreement will be for a single occurrence of the same specifically defined Critical Illnesses (excluding Cancer) which are contained in the Company's standard policy wording in effect at the time of the application, and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 3 were to be approved.
3. Subject to the Waiting Period, the Conditional Insurance benefit, in the amount stated below, will be paid to the Proposed Owner if the Proposed Insured # 3 is correctly Diagnosed, in the manner required, while this coverage is in force, with one of the covered Critical Illnesses.
4. Waiting Period: The Conditional Insurance Benefit will only be paid if the Proposed Insured # 3 meets the waiting period as specifically defined in the Company's standard Critical Illness policy wording in effect at the time of the Application and which would be issued if the Proposed Owner's Application for a policy on the Proposed Insured # 3 were to be approved.

(continued on reverse)

CONDITIONS

1. The amount of the Conditional Insurance benefit shall be limited to the LESSER of:
   a) The total amount of Critical Illness insurance applied for in the Application for Proposed Insured # 3, and either (b) or (c) below;
   b) $25,000 for Proposed Insureds age 2-4, less the amount of any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company or
   c) $100,000 for Proposed Insureds age 5-17, less any Critical Illness coverage already in force with the Company and/or any Critical Illness coverage in force or pending with any other company.
2. Insurance under only one Conditional Insurance Agreement can be in effect on Proposed Insured # 3. If more than one Application for Conditional Insurance is submitted on Proposed Insured # 3, effect will be given only to the one with the higher face amount that meets all of the provisions as set forth herein.

LIMITATIONS AND EXCLUSIONS

1. There is no coverage for, and no payment will be made under this Agreement for any type of cancer or any Critical Illness resulting from any type of cancer.
2. If the Proposed Insured # 3 suffers a covered Critical Illness as a result of an act of self-destruction, the Company's liability is limited to a refund of the payment made. An act of self-destruction occurs when the Proposed Insured, whether sane or insane, takes or attempts to take their own life or inflicts injuries on their own person, and the death or injury of the Proposed Insured results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.
3. There is no coverage under this Agreement if there is any material misrepresentation on the Proposed Insured #3 Critical Illness policy Application.

TERMINATION OF CONDITIONAL INSURANCE, occurs on the earlier of the following:

1. Conditional Insurance terminates automatically when a Policy providing insurance to Proposed Insured # 3 as a result of this Application becomes effective.
2. The Company may terminate this Conditional Insurance Agreement, and the coverage under it, by mailing a notice to that effect addressed to the Proposed Owner (termination being effective on the date the Company sends the notice), in which event any deposits paid on Proposed Insured # 3 will be refunded. Termination shall take place notwithstanding that such refund has not yet been received by the Proposed Owner.
3. In any event, Conditional Insurance will terminate automatically on the expiration of ninety days from the date of this Agreement.
4. Termination of this Conditional Insurance Agreement will not prejudice a claim, where the Proposed Insured # 3 commenced a Waiting Period while this coverage was in force.

It is acknowledged that the sum of $_________________was paid to the Company at the time of the completion of this Application.

Date ________________________ Signature of Producer **X** ____

20203859 ©2004, Moore Wallace Incorporated. All rights reserved. - 9355

Detach and give to Proposed Owner

CONSUMER FACT SHEET

PRE-NOTICE

Information regarding the insurability and claims of the Proposed Insured(s) will be treated as confidential. The Company or our reinsurers may, however, make a brief report thereon to Medical Information Bureau (MIB) Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If insurance on the life of one of the Proposed Insureds is applied for with another MIB member company, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it its file. Upon receipt of a request from the Proposed Insured's parent or legal guardian, MIB will arrange disclosure of any information it may have on the particular Proposed Insured. If the parent or legal guardian questions the accuracy of the information in the MIB file, they may contact MIB and seek a correction.

The address of MIB's information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7. Telephone No: 416-597-0590. We may also release information in our files to our reinsurers and/or other life insurance companies to whom any of the Proposed Insureds apply or to whom a claim for benefits may be submitted.

Confidential History Interview

As part of the underwriting process, You may be asked to respond to a telephone interview. Specially trained interviewers conduct this confidential interview. The interview will take approximately five to ten minutes. Since we want to conduct the interview at a time most convenient to You, Your sales representative will ask You on the Application whether You wish to be contacted at home or at work and the best time to call.

The questions asked by the interviewer amplify the information on Your Application for insurance of the Proposed Insureds. These questions relate to personal, financial and medical aspects of insurability. We also use the interview process to gather information that may have been omitted or only partially explained. Because of the nature of the information obtained, the interview will only be conducted with You.

Any information obtained during the interview will be kept strictly confidential and will not be released to anyone without Your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide You with the best quality underwriting.

RBC Life Insurance Company

1122 International Boulevard, P.O. Box 5044, Burlington, Ontario L7R 4C1 • 905-319-9501

™ Trademark of Royal Bank of Canada.
RBC Insurance is a registered trademark of Royal Bank of Canada. Used under license.