P.O. Box 2305
Buffalo, NY 14240-2305

POLICY CHANGE APPLICATION

USE THIS FORM FOR THE FOLLOWING:	**Section**
ADD/REMOVE BENEFIT RIDER	2
CHANGE IN SMOKING STATUS	6
DIVIDEND OPTION CHANGE	4
INCREASE IN FACE/SPECIFIED AMOUNT	2
MISCELLANEOUS POLICY CHANGES	2
REINSTATEMENT	1
REVIEW OF EXTRA RATING	3
STATEMENT OF HEALTH	7, 8
TERM CONVERSION	9

PLEASE NOTE:

PART B – Smoking Questionnaire and Statement of Health – MUST BE COMPLETED for the following requests: Reinstatement, Review of Extra Rating, Non-Smoker Discount, Increase in Face Amount, Addition of Benefit/Rider, or any change that would result in additional risk to the Company.

INSTRUCTIONS:

- Mark the box for each change or service you are requesting.
- This form and all signatures should be in ink.
- SIGNATURE REQUIREMENTS: The owner's signature is required for all requests. If a Corporation is Owner, signatures and titles of two officers, or one officer under Corporate Seal, are required. Witness must be of majority age with no interest in the contract.
- For Addition of Child Rider, complete Form No. 59.
- For Child Policy, complete Form No. 17, Juvenile Non-Medical Form.

POLICY INFORMATION – Please Complete

Policy No. ______

OWNER INFORMATION:

Owner Information
Name
Address
Social Security or Tax I.D. No.

☐ Check here if new address

INSURED INFORMATION:

Insured Information	
Name	
Address	
Social Security Number	
Date of Birth	Place of Birth

☐ Check here if new address

PART A

1. REINSTATEMENT

☐ Please reinstate this policy according to its terms.

☐ Please reinstate the policy on the basis of changing the policy year's date so that the arrears of premium payable on reinstatement will be the minimum acceptable to the Company. A fee will be charged.

2. POLICY CHANGE/INCREASE

Request is hereby made to ☐ change or ☐ increase existing policy to that specified below:

For UNIVERSAL LIFE Plans Only

Change to Option: ☐ A (Increasing) ☐ B (Level) ☐ New Specified Amount: $ ______

New Billed Amount (or minimum required, if greater): $ ______ ☐ Lump Sum Amount: $ ______

Automatic Payment: $ ______ ☐ Add ☐ Remove ☐ Increase ☐ Remain the Same

For NON-UNIVERSAL LIFE Plans Only

New Face Amount (Base Policy Only): $ ______ ☐ ECO Face Amt. (or max. avail., if less): $ ______

ABR Annual Prem.: $ ______ ☐ Add ☐ Remove ☐ ABR Sgl Prem.: $ ______ ☐ Add ☐ Remove

Waiver of Premium: ☐ Add ☐ Remove

Please Add or Remove the Following Benefit(s)/Rider(s):

☐ Accidental Death Benefit: $ ______ ☐ Add ☐ Remove

☐ Term Rider (Specify Type): $ ______ ☐ Add ☐ Remove Type: ______

☐ Guaranteed Insurability Rider – No. of Units: ______ ☐ Add ☐ Remove

☐ Other Insured Rider / ☐ Spouse Rider to age ______ : $ ______ ☐ Add ☐ Remove

☐ Other (Please Specify): ______

Please change Premium Mode to: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC/EFT

☐ Add to existing PAC/EFT under Policy No. ______ ☐ New PAC/EFT Form Attached

3. REVIEW OF EXTRA RATING

☐ Please review the existing additional rating on this policy for possible reduction/removal.

4. DIVIDEND OPTION

Please ☐ change to or ☐ include the following dividend option:

☐ Paid-Up Additions ☐ Cash ☐ Reduce Premium (not avail with PAC/EFT)

☐ Accumulate at Interest ☐ Repay Policy Loan ☐ Purchase One-Yr. Term (bal. of div. to be ______)

☐ Other (Specify) ______

☐ Please apply existing dividend credits to this option. ☐ Withdraw existing dividend credits.

☐ Leave dividend credits under existing option. ☐ Other ______

5. REMARKS (Not applicable in West Virginia.)

PART B

6. SMOKING QUESTIONNAIRE (Specimen may be required)

A. Do you currently use tobacco? ☐ Yes ☐ No
If "YES", give type: ☐ Cigarettes; ☐ Cigar; ☐ Pipe; ☐ Other (Specify): ______
How long have you been using tobacco? ______ Quantity per day: ______

B. If you are not currently smoking cigarettes, have you ever smoked them? ☐ Yes ☐ No
If "YES", date on which you stopped smoking: ______
Length of time you smoked: ______ Why did you stop? ______

If on the advice of a physician, provide full name and address: ______

7. STATEMENT OF HEALTH (The Company may require additional Evidence of Insurability)

Proposed Insured:	Occupation:	Relationship to Owner:

Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female Height: ______ Weight: ______ lbs.
Weight Gain/Loss in last year? If "YES", how much? ______ lbs. Reason: ______

	Yes	No
A. During the last two years have you been absent from work for a continuous period of two weeks or more because of illness or injury? If "Yes", give details below.	☐	☐
B. Is any other application for insurance on your life pending at this time? If "Yes", give details below. INDICATE TOTAL LIFE and AD&D CURRENTLY IN FORCE.	☐	☐
C. Do you participate in any type of flying or gliding, other than as a fare-paying passenger? If "Yes", please complete an aviation questionnaire (Form 24).	☐	☐
D. Do you participate in sky or scuba diving, or racing of any kind? If "Yes", please complete an avocation questionnaire (Form 56).	☐	☐
E. Do you travel or have you made plans to travel outside the U.S.A. and Canada within the next year? If "Yes", where ______, how long ______, and why ______	☐	☐
F. Do you now or have you ever used alcohol? If "Yes", have you received treatment or belonged to an organization because of alcohol use? If "Yes", give details below. Alcohol Use: Amount per week: ______ Type: ______	☐	☐
G. Have you ever had your driver's license restricted, revoked or suspended in the last three years? If "Yes", give details below.	☐	☐
H. During the past 5 years, have you used heroin or other narcotics, hallucinogenic or other habit forming drugs, including cocaine and marijuana? If "Yes", give details below.	☐	☐
I. Have you ever had an application for life or disability insurance declined, postponed, rated, or modified? If "Yes", give details below.	☐	☐
J. To the best of your knowledge and belief, have you:		
1. Ever been diagnosed or treated by a medical professional for heart disorder, high blood pressure, stroke, cancer, diabetes, alcoholism, or liver or kidney disease?	☐	☐
2. Ever been diagnosed or treated by a medical professional for a respiratory disorder, gastrointestinal disorder, nervous disorder, sexually transmitted disease, elevated cholesterol or triglycerides, arthritis, or bone or joint disorders?	☐	☐
3. Ever been treated by a medical professional for significant weight loss, fever, night sweats, persistent diarrhea or swollen lymph nodes?	☐	☐
4. Ever been diagnosed as having or treated by a medical professional for any disease or disorder of the immune system?	☐	☐
5. Had medical or surgical treatment during the past five years for any ailment, injury or sickness not named in connection with your prior answers?	☐	☐

8. Details of "YES" Answers. Identify Question Number and Individual and Circle Applicable Items. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

AGREEMENT

The undersigned hereby declare(s) that to the best of his/her knowledge and belief the foregoing statements and answers are complete and true. I/We agree that this application and any evidence of insurability required by the Company in connection with the change requested shall be considered an amendment and supplement to the original application and shall form a part of the policy. I/We also agree that the change or reinstatement requested shall not take effect until it has been approved at the Home Office and any required premium has been paid while the facts concerning the insurability of the Proposed Insured are the same as described in this application. No agent can modify this agreement or waive any of the Company's rights or requirements. I have received a copy of: 1) the Medical Information Bureau Notice; and 2) the Notice required by the Federal Fair Credit Reporting Act.

AUTHORIZATION: I understand and authorize the following:

A. to determine eligibility for insurance for the Proposed Insured, I authorize the release of information concerning:
   1. the diagnosis, treatment or prognosis of any past or present physical, mental, drug, or alcohol condition; and
   2. any non-medical data which relates to insurability;
B. the parties authorized to release such information are:
   1. any physician or medical practitioner;
   2. any hospital, clinic, or other medically related facility;
   3. any insurance or reinsurance company;
   4. the Medical Information Bureau or any consumer reporting agency; and
   5. any employer of the Proposed Insured;
C. the information may be released to:
   1. the Canada Life Assurance Company (Canada Life);
   2. the reinsurers of Canada Life; and
   3. the legal representative of Canada Life; and
D. any data obtained will not be released by Canada Life to any person or organization except:
   1. to reinsuring companies;
   2. to the Medical Information Bureau;
   3. to persons performing business or legal services in connection with my application;
   4. to any physician named in my medical declarations (as required for my medical care);
   5. as required by law; or
   6. as I further authorize.

I agree that a photocopy of this authorization will be as valid as the original. I know that I may request a copy of this authorization. I agree that this authorization shall be valid for two and one-half years from the date shown below. I know that I may revoke this authorization at any time except to the extent that action is taken in reliance on it.

Signed at ______________ this __________ day of ______________, ________.

Witness	Insured
Witness	Additional Insured, if any
Witness	Policy Owner, if other than Insured
Witness	Policy Owner, if other than Insured
Witness	Assignee or Irrevocable Beneficiary, if applicable
Witness	Other Signature, If Required

REQUEST FOR CONVERSION OF TERM INSURANCE

NOTE: If converting to a greater face amount than that currently in force, or adding benefits or riders, please complete Part B of this Policy Change Application. To qualify for the Non-Smoker's Discount, please complete Part B, #6.

RE: Policy Number ______ **On The Life Of** ______

I/We, the undersigned, hereby request that ☐ all, or ☐ $ ______ of the term insurance provided under the above numbered policy or ☐ the ______ provision of the above-numbered policy be converted into insurance under a new policy of life insurance on the life of the above-named person.

Any remaining term insurance under the Policy is to be:

☐ cancelled as of date of conversion. ☐ continued under original policy.

New Policy Hereby Applied For

New Plan: ______

Face Amount: $ ______

Smoker? ☐ Yes ☐ No

Date of Policy: ______

This date shall be equivalent to the most current monthly premium due date under the original policy(ies), or the date of conversion, which is only available for (a) special PAC/EFT withdrawal date or (b) backdating to save age.

Premiums To Be Paid: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC/EFT ☐ Add to existing PAC/EFT under Policy No. ______ ☐ New PAC/EFT Form attached

UNIVERSAL LIFE PLANS ONLY

Death Benefit: ☐ Option A (Increasing) ☐ Option B (Level)

Billed Amount (or minimum required, if greater): $ ______

Automatic Payment Benefit? ☐ Yes ☐ No ☐ APB Annual Amount $ ______

Additional Benefits/Riders: ______

NON-UNIVERSAL LIFE PLANS

Waiver of Premium? ☐ Yes ☐ No Automatic Premium Loan, if available? ☐ Yes ☐ No

Dividend Option: ☐ Paid-Up Additions ☐ Repay Policy Loan ☐ Accumulate at Interest

☐ Reduce Premium (not avail. with PAC/EFT) ☐ Other: ______

☐ Purchase One-Yr. Term (Balance of div. to be: ______) ☐ Cash

Additional Benefits/ Riders

☐ ECO Face Amt.: $ ______ (or maximum avail., if less) ☐ Waiver of Premium

☐ ABR-Ann. Prem.: $ ______ ☐ ABR-Sgl. Prem.: $ ______ ☐ Term Rider: $ ______

☐ Accidental Death: $ ______ ☐ Guaranteed Insurability – No. of Units: ______

☐ Other: ______

REMARKS: (Not Applicable in West Virginia)

IT IS HEREBY AGREED THAT:

(a) This application and such other material as may be required herewith shall form the basis of the contract evidenced by the new policy; and (b) Unless otherwise provided in the above-numbered policy, any additional benefits to be included in the new policy shall be subject to such evidence of insurability as the Company may require, in which event, the insurance under any such additional benefit will not take effect until the new policy has been approved at the Home Office and any required premium has been paid while the facts concerning the insurability of the Proposed Insured are the same as described in this application.

Dated at ______ this ______ day of ______, ______.

Witness ______ SS# or Tax I.D.# of Policy Owner ______ Policy Owner Signature ______

Witness ______ Insured Signature ______

Witness ______ Other Required Signature ______

Witness ______ Other Required Signature ______

FEDERAL FAIR CREDIT REPORTING ACT NOTIFICATION

THE FEDERAL FAIR CREDIT REPORTING ACT REQUIRES THAT YOU BE GIVEN A COPY OF THIS NOTICE

This is to inform you that as part of Canada Life's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your: character; general reputation; personal characteristics; and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Canada Life Assurance Co. or our reinsurers may, however, make a brief report thereon 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 Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a 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. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The Canada Life Assurance Co. or our reinsurers may also release information in our files 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.

CANADA LIFE ASSURANCE COMPANY INFORMATION PRACTICES

This notice is provided to give you a brief description of our information practices. If you would like a more detailed description, please write to us at the address shown below.

One of our important objectives is to see that our insurance coverages are priced in a way that is fair to all policyholders. To do this, we need personal information about you and your family members proposed for coverage under your policy. You are the prime source of that information, but we may also obtain information from other sources such as physicians, hospitals, the Medical Information Bureau and consumer reporting agencies. You may request to be interviewed in connection with the preparation of a consumer report and you are entitled to obtain a copy of the report on request.

The information about you which we obtain and keep in our files will not be disclosed to others without your authorization except to the extent necessary to conduct our business. For example, some may be disclosed for research study purposes, but no report of such studies would include identification of individuals.

You have a right of access to information we maintain in our files about you (medical information is normally disclosed only to a physician of your choice) and to request correction of any information you believe to be incorrect. Should you wish further details about your right of access or our information practices, write to: Underwriting Department, Canada Life Assurance Company, 6201 Powers Ferry Road, NW, Suite 600, Atlanta, Georgia 30339.