

# Conversion Application

This application is to be used for full or partial conversions only.

To apply for a conversion with a face increase or a change of risk class (eg. smoker to non-smoker), use the Policy Change Application form (LP386).

**DETACH AND LEAVE THIS PAGE WITH THE OWNER**

APPLICATION NO.

## Notice of Disclosures

Thank you for continuing to do business with *ivari*.

Before submitting this request to change your policy, please ensure that you have carefully read each of the notices on this page and all other pages of this application. Once we receive your application we will assess the eligibility of each Insured for the insurance requested. We base this eligibility on the information that is provided in this application and any other declaration made in connection to this application, and the information previously submitted by you in relation to the insurance you already have or have had with *ivari*. Factors that we may consider when reviewing an application to convert a policy include, but are not limited to, information concerning an Insured's smoking habits. Questions? Please contact your Independent Insurance Advisor or write to our Client Services Department, *ivari*, 500-5000 Yonge Street, Toronto, Ontario, M2N 7J8.

### **NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

*ivari* collects, uses and discloses your personal information. In addition, we collect personal information about you from this application, any supplementary forms and questionnaires and from the following sources:

- Independent Insurance Advisors, including the Independent Advisor's Report section of your application; and *ivari*'s affiliates.

The information collected from these sources are used for the following purposes:

- Evaluating, assessing and investigating this application, our insurance risks and any claims you submit; evaluating your insurance and financial needs; administering and servicing the insurance and/or financial products we provide; and reporting information to the Canada Revenue Agency in accordance with federal legislation.

If you provide your Social Insurance Number (SIN), it will be used for the following purposes only: tax reporting, record keeping and identification, when needed. The use of your SIN for identification purposes is optional. You may withdraw consent for use of your SIN for identification purposes at any time by contacting *ivari*'s Client Services Department using the contact number listed on your policy. Please note that certain transactions requested under a universal life policy may require you to provide the SIN before processing. You have the option to provide your SIN now to avoid any future delays.

Your personal information may be shared with the entities and persons identified in this disclosure for the purposes of obtaining the information required. It may also be shared with or disclosed to managing general agencies, distributors and market intermediaries and their employees and agents and your Independent Advisors for purposes identified above. Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit payments. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

Your information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. For example, personal information may be disclosed in response to demands or requests from government authorities, courts or law enforcement in these countries.

**From time to time we may use your personal information to determine which other insurance and financial products and services may meet your needs and to offer them to you. We may disclose your personal information to our affiliated companies for their own use for such purposes. However, we will not disclose your health information to our affiliates for such purposes.**

**By signing and submitting this application on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this application.**

Upon receiving your application, *ivari* will add your personal information to your existing file, which is accessible at our Head Office. Your file will be accessible to only those employees and authorized representatives of *ivari* responsible for administering your file, and other persons authorized by you or by law. Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Officer, *ivari*, 500-5000 Yonge Street, Toronto, Ontario, M2N 7J8. Your personal information will be collected, used, disclosed, shared and treated as described herein, or as otherwise described at or before the time of collection, use or disclosure, or as otherwise permitted by law. To review our privacy policy, visit [www.ivari.ca](http://www.ivari.ca).

### **DISCLOSURE OF COMPENSATION**

The insurance product you are being offered is supplied by *ivari*, a company licensed to conduct business in all provinces and territories of Canada. The Independent Insurance Advisor/Distributor soliciting this insurance application is a licensed insurance Advisor representing *ivari* and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with *ivari*, the Advisor/Distributor or any other person or entity as a condition of this application.

# Conversion Application

Policy No. \_\_\_\_\_

Full Conversion    Partial Conversion

**IF APPLYING FOR A CONVERSION WITH A CHANGE OF RISK CLASS OR A CONVERSION WITH AN INCREASE IN THE FACE AMOUNT, COMPLETE POLICY CHANGE APPLICATION FORM LP386.**

**Note: The conversion will be effective on the policy's monthly anniversary date closest to the date of the request.**

Current Policy Number: \_\_\_\_\_ New Policy Number: \_\_\_\_\_

**MAIN PURPOSE OF INSURANCE: MANDATORY FOR UNIVERSAL LIFE POLICIES**

- Buy and Sell       Key Person Insurance       Retirement Planning       Critical Illness Protection
- Estate Planning       Life Protection       Partnership       Other \_\_\_\_\_

**1 Current Insured 1 PLEASE PRINT IN BLOCK LETTERS**

Mr.    Mrs.    Ms.    Miss    Other \_\_\_\_\_

First Name _____	Middle Initial _____	Last Name _____
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MANDATORY FOR UNIVERSAL LIFE POLICIES		
Identification Document*	Identification Document Number*	Issuing Jurisdiction*
<small>*Please refer to an original, non-expired passport, birth certificate, driver's license, Canadian citizenship, age of majority or Canadian Armed Forces identification (preferably photo I.D.).            Complete only for a Universal Life policy if the Insured is the Owner:            Are you a U.S. resident for tax purposes (which includes a U.S. citizen)?   <input type="radio"/> Yes   <input type="radio"/> No            If <b>"Yes"</b>; provide a United States Taxpayer Identification Number (TIN): _____</small>		

**2** Date of Birth: DD / MM / YYYY      Principal Business or Occupation \_\_\_\_\_  
 SIN: \_\_\_\_\_ - \_\_\_\_\_ (Optional: complete only if you are the Owner and applying for a Universal Life policy)

**3** Current address: (number and street name) \_\_\_\_\_ Apt./Suite: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home or Mobile telephone: \_\_\_\_\_ Business telephone: \_\_\_\_\_

**4 Current Insured 2 PLEASE PRINT IN BLOCK LETTERS**

Mr.    Mrs.    Ms.    Miss    Other \_\_\_\_\_

First Name _____	Middle Initial _____	Last Name _____
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MANDATORY FOR UNIVERSAL LIFE POLICIES		
Identification Document*	Identification Document Number*	Issuing Jurisdiction*
<small>*Please refer to an original, non-expired passport, birth certificate, driver's license, Canadian citizenship, age of majority or Canadian Armed Forces identification (preferably photo I.D.).            Complete only for a Universal Life policy if the Insured is the Owner:            Are you a U.S. resident for tax purposes (which includes a U.S. citizen)?   <input type="radio"/> Yes   <input type="radio"/> No            If <b>"Yes"</b>; provide a United States Taxpayer Identification Number (TIN): _____</small>		

**5** Date of Birth: DD / MM / YYYY      Principal Business or Occupation \_\_\_\_\_  
 SIN: \_\_\_\_\_ - \_\_\_\_\_ (Optional: complete only if you are the Owner and applying for a Universal Life policy)

**6** Current address: (number and street name) \_\_\_\_\_ Apt./Suite: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home or Mobile telephone: \_\_\_\_\_ Business telephone: \_\_\_\_\_

**Note: If this is a conversion of a Children's rider, the owner(s) will automatically be the child converting unless indicated otherwise in the Owner(s) section of this application. The beneficiary will be the current beneficiary unless a Change of Beneficiary form (PS367) is submitted.**

# Conversion Application

## 7 Owner

The Owner(s) must sign the Declaration on page 7.

**FOR A UNIVERSAL LIFE POLICY WHERE THE OWNER IS A CORPORATION, NON-CORPORATE ENTITY OR TRUST YOU MUST COMPLETE PAGES 5 & 6 INCLUDING THE INTERNATIONAL TAX CLASSIFICATION FOR AN ENTITY SECTION 6 OR FORM IP-LP1601 FOR TRUSTS.**

**CURRENT OWNER 1 THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNER(S) (TO CHANGE THE OWNER(S) COMPLETE THE TRANSFER OF OWNERSHIP FORM PS371)**

Mr.  Mrs.  Ms.  Miss  Other \_\_\_\_\_

Legal Name (first, middle initial, last and/or Legal company/entity name)

Date of Birth DD / MM / YYYY	Relationship to Insured	Principal Business or Occupation	SIN (Optional: complete only if you are applying for a Universal Life policy)	
Current Address (number and street name)				Apt./Suite
City	Province	Postal code	Phone Number	

**MANDATORY FOR UNIVERSAL LIFE POLICIES**

Identification Document*	Identification Document Number*	Issuing Jurisdiction*
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\*Please refer to an original, non-expired passport, birth certificate, driver's license, Canadian citizenship, age of majority or Canadian Armed Forces identification (preferably photo I.D).

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)?  Yes  No

If "Yes"; provide a United States Taxpayer Identification Number (TIN): \_\_\_\_\_

**CURRENT OWNER 2 THE ADVISOR MUST VERIFY IDENTITY OF ALL OWNER(S) (TO CHANGE THE OWNER(S) COMPLETE THE TRANSFER OF OWNERSHIP FORM PS371)**

Mr.  Mrs.  Ms.  Miss  Other \_\_\_\_\_

Legal Name (first, middle initial, last and/or Legal company/entity name)

Date of Birth DD / MM / YYYY	Relationship to Insured	Principal Business or Occupation	SIN (Optional: complete only if you are applying for a Universal Life policy)	
Current Address (number and street name)				Apt./Suite
City	Province	Postal code	Phone Number	

**MANDATORY FOR UNIVERSAL LIFE POLICIES**

Identification Document*	Identification Document Number*	Issuing Jurisdiction*
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\*Please refer to an original, non-expired passport, birth certificate, driver's license, Canadian citizenship, age of majority or Canadian Armed Forces identification (preferably photo I.D).

Are you a U.S. resident for tax purposes (which includes a U.S. citizen)?  Yes  No

If "Yes"; provide a United States Taxpayer Identification Number (TIN): \_\_\_\_\_

## 8 Politically Exposed Foreign Person MANDATORY FOR UNIVERSAL LIFE POLICIES

	OWNER 1 YES NO	OWNER 2 YES NO
a) Is a premium and/or lump sum payment equal to or greater than \$100,000 being made or to be made? ... If the answer is "Yes", each Owner must complete question b).	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
b) Do you, the Owner(s), or any person to whom you are related by blood or marriage (including your common-law partner), hold, or have held in the past, any of the following positions in a country other than Canada: head of state, member of the executive council of government or member of the legislature, deputy minister (or equivalent), ambassador or ambassador's attaché or counsellor, military general (or higher rank), president of state-owned company or bank, judge or leader or president of a political party in a legislature? .....	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

**Each Owner who answers "Yes" to 8 b) must complete the Politically Exposed Foreign Person form (IP-LP1165) and submit it along with the application.**

**NOTE ON BENEFICIARY DESIGNATIONS**

**For Life and Critical Insurance Policies:** The beneficiary on your current policy will be carried over to the new policy unless a Change of Beneficiary form (PS367) is submitted.

**For Critical Illness Riders converting to a Critical Illness Policy:** If you named a specific beneficiary on your original Critical Illness Rider, it will be carried over to the new policy only if the legislation in your province allows you to name a beneficiary on a Critical Illness Policy (per Accident and Sickness Insurance Legislation). Otherwise the Critical Illness Benefit and Early Detention Benefit beneficiary for the new policy will be the insured. If the insured is a minor, the beneficiary will be the owner, if living, or the owner’s estate, if deceased. Return of Premium on Death proceeds on the new policy will be payable to the owner, if living, or the owner’s estate, if deceased.

**9 Insurance** **NOTE: FOR UNIVERSAL LIFE POLICIES, SUBMIT A SIGNED ILLUSTRATION AND SUPPLEMENT TO THE INSURANCE APPLICATION.**

<b>INSURED 1</b>	Current	New	
Current Plan to be converted	Face Amount/Benefit	Face Amount/Benefit	New Plan Name
<input type="checkbox"/> Base plan	\$ _____	\$ _____	_____
<input type="checkbox"/> Additional rider/coverage	\$ _____	\$ _____	_____
<b>INSURED 2</b>	Current	New	
Current Plan to be converted	Face Amount/Benefit	Face Amount/Benefit	New Plan Name
<input type="checkbox"/> Base plan	\$ _____	\$ _____	_____
<input type="checkbox"/> Additional rider/coverage	\$ _____	\$ _____	_____

	<u>INSURED 1</u>		<u>INSURED 2</u>	
	YES	NO	YES	NO
a) If the above indicated face amount/benefit to be converted is less than the current face amount/ benefit, is the amount remaining under the current policy to be terminated? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If <b>“Yes”</b> , balance will be terminated on the date the new policy becomes effective				
If <b>“No”</b> , what amount will remain in force under the current policy? (must meet current plan minimum)				
<b>INSURED 1</b> \$ _____				
<b>INSURED 2</b> \$ _____				
b) If you are less than 55 years of age, do you wish to carry over any of the following riders to the new policy (if applicable):				
Accidental Death & Dismemberment (AD&D) .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Waiver of Premium .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If <b>“Yes”</b> , are you able to perform all the duties of your normal occupation? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>(Note: Accidental Death Benefit (ADB) riders cannot be carried over)</b>				
c) If you are less than 65 years of age, do you wish to carry over the Children’s Insurance Rider to the new policy (if applicable)? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) If converting from a children’s insurance rider or term policy with an undifferentiated class answer the following question: In the last 12 months, have you smoked cigarettes, cigarillos (small cigars), electronic cigarettes, traditional large cigars, pipe, shisha/hookah (water pipe) or used chewing tobacco, a nicotine patch, Nicorette chewing gum, marijuana, hashish (joints), betel nuts, snuff, used any other smoking cessation products, or used tobacco in any other form? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date last used: <b>INSURED 1</b> <u>DD / MM / YYYY</u> <b>INSURED 2</b> <u>DD / MM / YYYY</u>				

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### 10 Payment Details

Premium Quoted: \$ \_\_\_\_\_

a) Initial Premium/Deposit of \$ \_\_\_\_\_ to be paid by:

Cheque made payable to *ivari* attached

or

Withdraw from current bank account on existing authorization for Pre-Authorized Debit (PAD)\*

b) Future Premiums/Deposits to be paid by:

**Pre-Authorized Debit:**  Monthly  Quarterly  Use bank account on existing policy  Establish a new PAD account\*

The date of withdrawal will be the same as the Policy Effective date. If you wish a different withdrawal date please indicate

Preferred Date of Withdrawal (days 1-28 only) \_\_\_\_\_

For *Universal Life* policies; if you select a withdrawal date that is after your Policy Date, we will automatically set the withdrawal date to match the Policy Date.

**Direct Bill:**  Annual  Semi-Annual  Quarterly

\*Note: For new banking information complete the Request for Pre-Authorized Debit form (PS375) and submit a VOID cheque, pre-printed with payor's name or bank Letter of Direction.

c) For *Universal Life* policies:

Provide source of Premium/Deposit (where is the premium/deposit coming?): \_\_\_\_\_

d) If the Payor is other than the Insured, Owner or Beneficiary complete the Third Party Payor Determination information below:

Name of Third Party: \_\_\_\_\_

Relationship of Third Party to Owner: \_\_\_\_\_

Address of Third Party: \_\_\_\_\_

Date of Birth of Third Party: DD / MM / YYYY Occupation of Third Party: \_\_\_\_\_

If a Corporation provide incorporation #: \_\_\_\_\_

Place of Registration if Third Party is a Corporate Entity: \_\_\_\_\_

### 11 Policy Owner's Consent to Receive E-mails

**Canada's Anti-Spam Legislation** regulates the distribution of commercial electronic messages (e.g. e-mails) to consumers. To comply with this law, *ivari* is required to obtain your consent for the purposes of sending you commercial electronic messages regarding your policy, product information and marketing material.

By providing your e-mail address below, you are consenting to receiving commercial electronic messages as outlined above from *ivari*.

Owner 1 E-mail Address: \_\_\_\_\_

Owner 2 E-mail Address: \_\_\_\_\_

You may withdraw your consent at any time by contacting us at *ivari* as follows:

500-5000 Yonge Street

Toronto, ON M2N 7J8

Telephone: 1-800-846-5970

Fax: 416-883-5520 or 1-877-767-0477

# Corporate/Non-Corporate Entity/Trust Identification

**MANDATORY FOR UNIVERSAL LIFE POLICIES – COMPLETE THIS SECTION IF THE OWNER(S) IS A CORPORATION, NON-CORPORATE ENTITY OR TRUST – REFER TO SUMMARY TABLE BELOW FOR GUIDELINES**

## Summary Table

TYPE OF ENTITY	SECTIONS TO BE COMPLETED	ADDITIONAL INFORMATION MUST BE SUBMITTED
Corporation	Sections 1, 2, 3, 4 and 6	Certificate of Incumbency (submit your own or use our form IP-LP1572)
Non-Corporate Entity	Sections 1, 2, 3 and 6	Certificate of Incumbency (submit your own or use our form IP-LP1572) Include one of the following: <ul style="list-style-type: none"> <li>• Partnership Agreement</li> <li>• Articles of association</li> <li>• Other similar record that confirms the entity's existence</li> </ul>
Trust	Sections 1 and 5	Certificate of Incumbency (you may submit your own or use our form IP-LP1572) International Tax Classification for an Entity form (IP-LP1601) <b>DO NOT COMPLETE SECTION 6 on page 6.</b> Include one of the following: <ul style="list-style-type: none"> <li>• Trust Agreement</li> <li>• Trust Deed</li> <li>• Declaration of Trust</li> <li>• Other similar record that confirms the entity's existence</li> </ul>

1. Please provide the following information on the individual(s) submitting an application on behalf of a Corporation, Non-Corporate Entity or Trust.

NAME OF INDIVIDUAL	JOB TITLE	IDENTIFICATION DOCUMENT*	IDENTIFICATION DOCUMENT NUMBER*	ISSUING JURISDICTION*

*\*Please refer to an original non-expired passport, birth certificate, driver's license, Canadian citizenship, age of majority or Canadian Armed Forces identification (preferably photo ID).*

2. Information about the Entity that will own the policy:

- a) Type of Entity:     Corporation     Non-Corporate Entity
- b) Official Entity Name: \_\_\_\_\_
- c) Address: \_\_\_\_\_
- d) Business/Registration Number: \_\_\_\_\_
- e) Place of Federal or Provincial Incorporation/ Issuing Jurisdiction: \_\_\_\_\_

3. Names of all individuals who directly or indirectly own or control 25% or more of the shares of the Corporation or 25% or more of the Non-Corporate Entity.

Name of Individual	Occupation	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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4. Names of all Directors of a Corporate Entity (If necessary, attach listing of all directors).

Names of Directors

Occupation

_____	_____
_____	_____
_____	_____

5. Trust – Please provide Trust information.

Name of person who created the Trust (Settlor)      Address

_____	_____
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Name of Trustee      Address

_____	_____
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Name of Beneficiary      Address

_____	_____
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6. INTERNATIONAL TAX CLASSIFICATION FOR AN ENTITY

**MANDATORY FOR UNIVERSAL LIFE POLICIES IF THE OWNER IS A CORPORATION OR NON CORPORATE ENTITY**

Canada's Intergovernmental Agreement (IGA) with the U.S. requires Canadian financial institutions to identify and report specific types of accounts/policies held, directly or indirectly, by a U.S. Person. For information about the IGA, visit <http://www.fin.gc.ca/afc/faq/fatca-eng.asp>. We will use the information provided below to determine our tax reporting requirements. Depending on the entity's classification, we may report to the CRA.

**Instructions:** Answer the questions below to determine the entity's classification under the IGA. The terms used in this section are defined in the IGA. For more information, refer to the International Tax Classification for an Entity form (IP-LP1601), or consult the entity's tax or other advisor, or view CRA's [www.cra-arc.gc.ca/tx/nnrstdnts/nhncdrprtng/ntts-eng.htm](http://www.cra-arc.gc.ca/tx/nnrstdnts/nhncdrprtng/ntts-eng.htm).

For Trusts, complete the International Tax Classification for an Entity form (IP-LP1601).

1) Are you a Corporation or partnership organized in Canada?

Yes – proceed to question #2

No – if the entity is a specified U.S. person provide the entity's TIN (U.S. Tax Identification Number): \_\_\_\_\_  
if not, no further action required.

2) Are more than 50% of the entity's earning revenue from **passive investments** (e.g. interest, dividends, rent, capital gains, etc.)

No – no further action required

Yes – proceed to # 3

3) Does any individual directly or indirectly own or control 25% or more of the entity?

No – no further action required

Yes – if **"Yes"**, are any controlling persons a U.S. resident for tax purposes (which includes a U.S. citizen)?

No – if **"No"**, no further action required

Yes – if **"Yes"**, provide information about each of these individuals below:

Name & Address: \_\_\_\_\_ U.S. TIN \_\_\_\_\_

Name & Address: \_\_\_\_\_ U.S. TIN \_\_\_\_\_

Name & Address: \_\_\_\_\_ U.S. TIN \_\_\_\_\_

Name & Address: \_\_\_\_\_ U.S. TIN \_\_\_\_\_



# Declaration

I/We have read all of the questions and answers in this application and I/we understand the meaning and importance of them. **THE STATEMENTS AND ANSWERS GIVEN IN THIS APPLICATION ARE TRUE, COMPLETE, AND CORRECTLY RECORDED TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.**

## ACKNOWLEDGEMENT AND AGREEMENT

I/We acknowledge and agree that:

- a) This application consists of pages i and 1 – 7, any supplement to it (if applicable) and any other declaration made in connection to this application. Together all of this information will form the basis for any policy/coverage (“policy”) issued.
- b) No information acquired by any representative of *ivari* will be binding on *ivari* unless set out in writing in this application.
- c) Any policy, amendment or endorsement issued on this application will not take effect unless all of the following conditions are satisfied:
  - i) any premium required for the conversion is received by *ivari* during the lifetime of all Insured(s) under the policy;
  - ii) the policy, amendment or endorsement is delivered to the Owner(s) during the lifetime of all Insured(s) under the policy; and
  - iii) all statements and answers given in this application continue to be true and complete on the date of delivery of the policy, amendment or endorsement;
- d) Only the President together with a Vice-President or Secretary of *ivari* has the authority to bind *ivari* or to make any change in this application or any policy, amendment or endorsement issued. *ivari* will not be bound by any promise or representation made by any other person. No advisor or distributor is authorized to waive, amend or modify any of the terms or provisions in this application or any policy, amendment or endorsement issued. The Owner(s) accepting delivery of the

policy constitutes approval of its provisions and ratifications of any additions, endorsements or amendments.

- e) **If the answer to any question(s) in this application is misstated, including the Tobacco/Nicotine Use Question or if any other material misrepresentation or fraudulent statement is made in this application, any policy, amendment or endorsement issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.**
- f) All premium payments must be made payable to *ivari*.
- g) I/We have received and fully understand the contents of the Disclosure of Compensation, where applicable.
- h) If the Owner is an Entity, I/we certify that the information provided on pages 5 & 6 is a complete and accurate disclosure in respect of the Entity. I/We have the authority to sign on behalf of the Entity.

## PERSONAL INFORMATION AUTHORIZATION

I/We have read and fully understand the contents of the Notices regarding Use and Disclosure of Personal Information (collectively, the “Notices”) and acknowledge and consent to the collection, use and disclosure of my/our personal information by *ivari* and its affiliates for the purposes identified in those Notices.

**A photocopy of this authorization shall be as valid as the original. The consent you provided in the Notice Regarding Collection, Use and Disclosure of Personal Information relating to the use of your personal information to provide you with details about other insurance and financial services and products is optional.**

**If you do not wish your personal information to be used for this optional purpose, check here  or you can write to us at: *ivari*, 500-5000 Yonge Street, Toronto, Ontario, M2N 7J8, Attention: Privacy Officer.**

Signed at (city) \_\_\_\_\_ in the Province of \_\_\_\_\_ on DD / MM / YYYY

**IF INSURED IS A MINOR THE SIGNATURE OF A PARENT OR LEGAL GUARDIAN IS REQUIRED**

**Sign Here** \_\_\_\_\_  
INSURED 1

**Sign Here** \_\_\_\_\_  
INSURED 2

**Sign Here** \_\_\_\_\_  
Current Owner 1, if not an Insured

**Sign Here** \_\_\_\_\_  
Current Owner 2, if not an Insured

\_\_\_\_\_  
Print name of signing officer and title, if Corporation, Non-Corporate Entity or Trust

\_\_\_\_\_  
Print name of signing officer and title, if Corporation, Non-Corporate Entity or Trust

**Sign Here** \_\_\_\_\_  
Current Preferred/Irrevocable Beneficiary Signature (if applicable)

**Sign Here** \_\_\_\_\_  
Witness to signature(s)

**Sign Here** \_\_\_\_\_  
Assignee Signature (stamp required if Assignee is a financial institution)

**If the Owner is an Entity, the signature(s), name(s) and title(s) of the authorized signing officers thereof are required, as stated in the by-laws of the Entity.**

**Conversion Application**

**Independent Advisor's Report** **MUST BE COMPLETED IN ALL CASES**

1. Third Party Determination must be completed for all applications. Every reasonable effort must be made by you to determine if the Owner(s) is/are acting on behalf of a third party. The **Proceeds of Crime (Money Laundering) and Terrorist Financing Act** requires each Insured's identity to be verified by referring to certain documents. The law also requires the existence of third parties, if any, to be determined and recorded.

When asked whether the Owner(s) is/are acting on behalf of a third party, the individual submitting the application answered:

No  Yes; Complete and submit the **Identity and Third Party Determination form (IP-LP 782)**

Unable to determine; however, I have reasonable grounds to suspect there is a third party.

Reason (attach separate page if necessary):

\_\_\_\_\_

\_\_\_\_\_

2. Are you the Insured, Owner or Beneficiary on this policy? ..... 

<b>ADVISOR 1</b>	<b>ADVISOR 2</b>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

3. If you have a family relationship with the Insured, please specify: ..... \_\_\_\_\_

4. Did you meet with the Insured in person? ..... 

<b>INSURED 1</b>	<b>INSURED 2</b>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

5. By signing below, I/we acknowledge that I/we have disclosed, where applicable, the following items to the Owner of the policy resulting from this application:

- a) the company or companies I/we represent;
- b) that I/we will receive compensation (*such as commissions or a salary*);
- c) that I/we may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- d) that I/we have disclosed any conflicts of interest that I/we may have with respect to this transaction.

**Advisor's Notes:** Future effective date: DD / MM / YYYY If permitted, save age?  Yes \_\_\_\_\_  No \_\_\_\_\_

**NOTE: A conversion of a rider/coverage from a Universal Life policy will be effective on the closest monthly anniversary date of the policy. The new policy cannot be backdated.**

\_\_\_\_\_

\_\_\_\_\_

Advisor's e-mail address: \_\_\_\_\_

**I/We hereby declare** that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief, and that I am/we are not aware of additional information material to the Insured(s) except as stated in any Advisor's Notes. When applicable, I/we have verified the identity of the individuals who submitted the application by referring to the original, non-expired documents. I/We confirm that the information recorded was correctly copied from such document(s). Reasonable effort has also been exercised to determine if the Owner(s) is/are acting on behalf of a third party.

Signed at (city) \_\_\_\_\_ in the Province of \_\_\_\_\_ on DD / MM / YYYY

**Sign Here** \_\_\_\_\_  
Signature of Advisor Name of Advisor

**Sign Here** \_\_\_\_\_  
Signature of Advisor Name of Advisor

**Sign Here** \_\_\_\_\_  
Signature of Supervising Advisor (where required) Name of Supervising Advisor





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