GENERAL INFORMATION

☐ **NEW APPLICATION or**
☐ **ADDING/CHANGING EXISTING - EXISTING POLICY #:**________________

APPLICANT NAME First ________ Last ________

PREVIOUS NAME (if applicable) First ________ Last ________

PLACE OF BIRTH Country ________

DATE OF BIRTH (YYYY/MM/DD) ________ AGE ____ ☐ MALE ☐ FEMALE

ADDRESS Street ________ Suite/Apt. ________

City/Town ________ Prov. ________ Postal Code ________

PHONE ________

EMAIL ________

EMPLOYER/COMPANY NAME ________

ADDRESS Street ________ Suite/Apt. ________

City/Town ________ Prov. ________ Postal Code ________

PHONE ________

AD&D / FRACTURE: BENEFICIARY INFORMATION

Insured by ACE INA Life Insurance

Where no beneficiary is indicated benefits will be payable to the estate of the insured. The beneficiary will be the Applicant in the event of death of a spouse and/or dependent child(ren), where Couple or Family coverage is in force (where applicable).

APPLICANT BENEFICIARY First ________ Last ________

RELATIONSHIP ________

SPOUSE BENEFICIARY First ________ Last ________

RELATIONSHIP ________

TRUSTEE: for minor beneficiaries First ________ Last ________

RELATIONSHIP of trustee to beneficiary ________

Quebec residents: If you designate your spouse as your beneficiary, this designation is irrevocable unless you check the "Revocable" circle ☐ REVOCABLE

PHYSICIAN INFORMATION

Complete this section only if applying for Illness coverage *Insured by Co-operators Life Insurance Company*

DOCTOR'S NAME: First ________ Last ________

DATE CONSULTED: (YYYY/MM/DD) ________

ADDRESS ________

____

PHONE: ________

Provide details of last consultation, including reason, diagnosis, treatment given or medication prescribed:

____

____

NOTES SECTION:

Please provide details of any **"YES"** answers given in the ILLNESS QUESTIONNAIRE. If you are providing details regarding a history of elevated blood pressure, high cholesterol, or diabetes, please provide the most recent readings and dates completed.

Question No.: ______ Please provide details including diagnosis, date, type of treatment (including medication) and results/outcome: ________

____

____

DATE fully recovered with no residuals or limitations: (YYYY/MM/DD) ________

Dr. Information: First ________ Last ________

Street ________ Suite/Apt. ________

City/Town ________ Prov. ________ Postal Code ________

Question No.: ______ Please provide details including diagnosis, date, type of treatment (including medication) and results/outcome: ________

____

____

DATE fully recovered with no residuals or limitations: (YYYY/MM/DD) ________

Dr. Information: First ________ Last ________

Street ________ Suite/Apt. ________

City/Town ________ Prov. ________ Postal Code ________

Question No.: ______ Please provide details including diagnosis, date, type of treatment (including medication) and results/outcome: ________

____

____

DATE fully recovered with no residuals or limitations: (YYYY/MM/DD) ________

Dr. Information: First ________ Last ________

Street ________ Suite/Apt. ________

City/Town ________ Prov. ________ Postal Code ________

The EDGE Plans are administered by The Edge Benefits Inc ® Registered Trademark of the Edge Benefits Inc.
1 EDGE Loss of Income/Roadside EDGE Loss of Income and Business Overhead Expense Benefits (Injury and Illness) insured by Co-operators Life Insurance Company.
2 Accidental Death & Dismemberment, Guaranteed Issue Critical Illness, Final Expense Benefit, and Fracture Accident Benefit insured by ACE INA Life Insurance.
3 Health & Dental Plan provided by Green Shield Canada.
4 Travel Emergency Medical Coverage insured by Allianz Global Assistance.

the EDGE™ Benefits

APPLICATION FOR INSURANCE

COVERAGE BEING APPLIED FOR:

If you wish to postpone coverage until a later meeting, please initial in the space provided.

LOSS OF INCOME INJURY COVERAGE ☐ 24 Hour ☐ Non-Occupational **Benefit Period** ☐ 5 Year ☐ to age 70 **Elimination Period** ☐ 0 day ☐ 30 day ☐ 120 day
Insured by Co-operators Life Insurance Company

Monthly Benefit Amount ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000 **AA & Exec ONLY** $_____ (A) ____

LOSS OF INCOME ILLNESS COVERAGE *(Must be purchased in conjunction with Injury. Height & Weight, AND Gateway Questions must be satisfied. Illness amount must be less than or equal to the Injury amount.)*
Insured by Co-operators Life Insurance Company

Benefit Period *cannot be greater than Injury* ☐ 5 Year ☐ to age 70 **Elimination Period** *cannot be shorter than Injury* ☐ 30 day ☐ 120 day

Monthly Benefit Amount ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000 **AA & Exec ONLY** $_____ (B) ____

BUSINESS OVERHEAD EXPENSE INJURY COVERAGE
Insured by Co-operators Life Insurance Company

Monthly Benefit Amount ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000 **AA & Exec ONLY** $_____ (C) ____

BUSINESS OVERHEAD EXPENSE ILLNESS COVERAGE *(Must be purchased in conjunction with Injury BOE. Height & Weight, AND Gateway Questions must be satisfied. Illness BOE amount must be less than or equal to the Injury BOE amount.)*
Insured by Co-operators Life Insurance Company

Monthly Benefit Amount ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000 **AA & Exec ONLY** $_____ (D) ____

☐ INJURY Coverage NOW, *ILLNESS when approved and premium received*
☐ INJURY & ILLNESS Coverage, *effective when both are approved and premium received* ← *If selected DO NOT collect premium with application, "VOID Cheque" only.*

CRITICAL ILLNESS BENEFIT AMOUNT:
Insured by ACE INA Life Insurance

Applicant ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 $_____ (E) ____
Spouse ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 $_____ (F) ____

ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE
Insured by ACE INA Life Insurance

BASIC: ☐ $100,000 ☐ $200,000 ☐ $300,000 $_____ (G) ____
ENHANCED*: ☐ $300,000* ☐ $500,000* ☐ Single ☐ Family $_____ (H) ____
**includes $100,000 Accident Medical Reimbursement Benefits only if you are an EDGE Loss of Income Policyholder*

FINAL EXPENSE BENEFIT AMOUNT:
Insured by ACE INA Life Insurance

Applicant ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 $_____ (I) ____
Spouse ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 $_____ (J) ____

Spouse's name only required if applying for Critical Illness or Final Expense coverage.

SPOUSE NAME First _____ Last _____ DATE OF BIRTH YYYY/MM/DD _____ AGE_____ ☐ Male ☐ Female

TRAVEL MEDICAL EMERGENCY COVERAGE ☐ Single ☐ Family $_____ (K) ____
Insured by Allianz Global Assistance

FRACTURE ACCIDENT BENEFIT ☐ BASE PLAN ☐ STANDARD PLAN ☐ MASTER PLAN ☐ Single ☐ Couple ☐ Family $_____ (L) ____
Insured by ACE INA Life Insurance

HEALTH & DENTAL
Provided by Green Shield Canada

Coverage available to applicants and their spouse from ages 18 to 64 who are covered by a provincial health plan.
Dependent children are covered up to age 21, or 25 if enrolled as a student full-time. Please provide documentation.

PLAN TYPE: ☐ BASE PLAN ☐ DELUXE PLAN ☐ PLATINUM PLAN ☐ HEALTH ONLY ☐ HEALTH & DENTAL ☐ Single ☐ Couple ☐ Family

If Applicant currently holds any other coverages offered through the EDGE Plans (Policy No._____)
or is applying for any other EDGE Plans at the time of this Health & Dental application, you may use EDGE Discounted Premium rates noted in the Rate Guide. $_____ (M) ____

Are you replacing any other insurance with the coverage being applied for? ☐ YES ☐ NO
*If **yes**, your advisor must provide you with the applicable replacement disclosure form and submit a copy along with this application.*

AMOUNT TO COLLECT: (A + C) and (E thru M) *Do not collect B + D premium → $_____

TOTAL MONTHLY PREMIUM: (A thru M) → $_____

LOSS OF INCOME (INJURY): QUALIFYING QUESTIONS

MUST BE COMPLETED IF APPLYING FOR LOSS OF INCOME INJURY COVERAGE

Insured by Co-operators Life Insurance Company

OCCUPATIONAL RATING: ☐EXEC ☐AA ☐A ☐B ☐BB

OCCUPATION*_____

**Please use the exact wording as stated in the Rate Guide. If the occupation is not listed, please go to our web site for more options.*

1. Have you ever had any injury(ies) or other condition which currently restricts your bodily movement or that limits you in performing any daily activities? *If YES, coverage is NOT AVAILABLE* ☐YES ☐NO

2. Are you currently working at least 20 hours per week and 35 weeks per year? *If NO, coverage is NOT AVAILABLE* ☐YES ☐NO

If you have satisfied the qualifying questions above, continue

3. Do you understand English and/or French? *If NO, please submit the appropriate "statement of understanding" in your language.* ☐YES ☐NO

4. Are you covered by any workers' compensation plan? *If No, only 24 hour coverage is available. If Yes, you can still purchase 24 hour coverage but benefits will be integrated. You may wish to consider non-occupational coverage.* ☐YES ☐NO

5. Are you covered by Employment Insurance? *If Yes, 120 Day Elimination Period coverage is available.* ☐YES ☐NO

6. Do you work in any occupation other than the occupation noted above? ☐YES ☐NO

*If Yes; Occupation(s):*_____ *percentage of time spent in this Occupation(s):* _____

If this occupation is a different class than the primary occupation and more than 15% of time is spent, please use the lowest of the Occupational Classes for rating purposes.

LOSS OF INCOME BENEFIT CALCULATOR

THIS SECTION MUST BE COMPLETED FOR COVERAGE TO BE ISSUED

Insured by Co-operators Life Insurance Company

Self Employed	*Enter the HIGHEST of OPTION 1 or 2 from the calculator on the right*	*$ (A)*
Employees	*Enter annual Employment Income*	*$ (A)*
Qualifying Insurable Monthly Earnings (see chart in overview)		*$ (B)*
Less: monthly amount of existing coverage remaining in force (provide details below)		*- $ (C)*
Final Qualifying Insurable Monthly Earnings		*$ (D)*

Maximum Monthly Benefit Amount. (up to $5,000 for Classes A,B, and BB and up to $6,000 for Class AA and Exec).

SELF EMPLOYED ONLY

INCOME- CHOOSE the highest of:

Option 1: *GROSS REVENUE Formula*

Enter Gross Business Revenue $ _____

Less Cost of Goods - $ _____

*Less Employee Wages** - $ _____

SubTotal $ _____

Subtract 50% -$ _____

GROSS REVENUE - ***Enter in Box A:*** ***$*** _____

**Do not include income splitting amounts*

OR ***Option 2*** *EARNED INCOME FORMULA*

Enter Your Share of Profit before Tax

EARNED INCOME - ***Enter in Box A:*** ***$*** _____

Provide details of existing coverage remaining in force. Failure to disclose may result in cancellation of coverage, or a reduction in benefits provided under this policy.

Type: _____ (DI Injury, DI Illness, BOE etc.) Amount_____ Company_____ EP:_____ BP:_____

Type: _____ (DI Injury, DI Illness, BOE etc.) Amount_____ Company_____ EP:_____ BP:_____

BUSINESS OVERHEAD EXPENSES

*Lease:*_____ *Rent:*_____ *Utilities:*_____ *Insurance:*_____ *Prof/Accounting Fees:*_____

*List Other:*_____ ***TOTAL MONTHLY EXPENSES: $*** _____

AD&D/HEALTH & DENTAL/FRACTURE: DEPENDENT INFORMATION

Accidental Death & Dismemberment and Fracture Accident Coverage provided by ACE INA: Health & Dental provided by Green Shield Canada

Only required if: Family coverage *is selected for AD&D,* ***Couple or Family*** *coverage is selected for Fracture or Health & Dental*

If listing a dependent between the ages of 22 - 25, proof of full time student enrollment not required with application, but may be requested at time of claim.
Dependent children are covered up to age 21, or 25 if enrolled as a student full-time. Please provide documentation.

Name	Relationship to Applicant	Gender (M/ F)	Date of Birth (YYYY/MM/DD)

LOSS OF INCOME - ILLNESS : GATEWAY QUESTIONS

Insured by Co-operators Life Insurance Company

COMPLETE THIS SECTION ONLY IF APPLYING FOR ILLNESS COVERAGE

1. What is your current Height:_____ ☐ feet/inches ☐ cm Weight:_____ ☐ lbs ☐ kg
   Check against the Height & Weight Qualifying for Illness Chart in the Occupational Rate Guide. If outside the limits, Illness Coverage is NOT available.

2a) Have you ever had any consultation, advice or treatment for heart attack, stroke, disease/disorder of the blood vessels of the heart or brain, Parkinson's disease, multiple sclerosis, emphysema, lupus, liver cirrhosis, alcoholic pancreatitis, AIDS, HIV positive or any subtypes, any disease or disorder of the immune system, paralysis or any brain or nervous system disease/ disorder, cerebral palsy, Lou Gehrig's disease (amyotrophic lateral sclerosis-ALS), Huntington's Chorea, muscular dystrophy, Alzheimer's disease, cystic fibrosis, or schizophrenia? ☐ YES ☐ NO

2b) **Within the last 5 years,** have you had any consultation, advice or treatment for any type of cancer (other than basal cell or squamous cell carcinoma)? ☐ YES ☐ NO

Provided the answers to 1, 2a, & 2b are acceptable, ***proceed with the next section.***

If the answer is YES to 2a or 2b, Illness Coverage is NOT available, however you may purchase Critical Illness coverage.

LOSS OF INCOME - ILLNESS: MEDICAL QUESTIONNAIRE

Insured by Co-operators Life Insurance Company

CIRCLE ANY SPECIFIC CONDITION AND PROVIDE DETAILS IN THE NOTES SECTION

Complete this section only if applying for Illness coverage, after qualifying the Illness Gateway Questions in the previous section

Have you ever had any known indication or symptom of, seen a doctor for, or been treated for:

1. Heart, circulatory problem, TIA (transient ischemic attack), high blood pressure, elevated cholesterol, angina, varicose veins, chest pain, palpitations, heart murmur, rheumatic fever or other heart disorder? ☐ YES ☐ NO
2. Cancer, leukemia, tumor, abnormal growth or cyst, or unusual skin lesion? ☐ YES ☐ NO
3. Diabetes, sugar in the urine, elevated sugar in the blood, disorder of the thyroid, pituitary or other glands? ☐ YES ☐ NO
4. Asthma, bronchitis, tuberculosis, persistent or chronic cough, shortness of breath or any disorder of the lungs or respiratory system? ☐ YES ☐ NO
5. Dizziness, seizures, fainting, chronic headaches, migraines, epilepsy, loss of consciousness, sleep apnea or, other sleep disorder? ☐ YES ☐ NO
6. Any disease or disorder of the reproductive organs, breast, or prostate? ☐ YES ☐ NO
7. Protein or blood in the urine, kidney stone, or other disorder of the bladder or kidneys? ☐ YES ☐ NO
8. Hepatitis B or C, anemia, hemophilia or any other disorder or abnormality of the blood? ☐ YES ☐ NO
9. Internal bleeding, jaundice, colitis, crohn's, ulcer, hernia, chronic diarrhea or other disease, condition or disorder of the stomach, intestines, liver, gall bladder or pancreas? ☐ YES ☐ NO
10. Amputation, deformities, numbness, tingling of the limbs, arthritis, osteoporosis, or connective tissue disease? ☐ YES ☐ NO
11. Any disease, disorder or impairment of the eyes or ears? ☐ YES ☐ NO
12. Any disease or disorder of the back, neck, or spinal discomfort including pain, sprain, strain, sciatica or disc disease? ☐ YES ☐ NO
13. Any disease or disorder of the knees, ankles, feet, hips, wrists, hands, elbows, shoulders or any other joints? If YES, please indicate specific joint ☐ YES ☐ NO
14. Have your parents or siblings ever had polycystic kidney disease, Huntington's chorea, dystonia or other hereditary disease? ☐ YES ☐ NO
15. **Within the past 5 years,** have you been advised about or treated for use or abuse of alcohol or drugs (prescription or non-prescription), or have you been convicted of any criminal offense or are charges currently pending against you? ☐ YES ☐ NO
16. **Within the past 5 years,** have you had any undiagnosed or untreated condition for which tests or examination are as yet to be completed or are ongoing? ☐ YES ☐ NO
17. **Within the past 5 years** have you had any illness or injury that resulted in missing more than 10 consecutive days of work? ☐ YES ☐ NO
18. Are you presently under investigation, observation or treatment therapy, counselling or taking medication? ☐ YES ☐ NO

HEALTH & DENTAL: MEDICATIONS

Provided by Green Shield Canada

(Please Print Clearly) Complete this section if applying for Health & Dental coverage. *This section is not required for Quebec residents; prescription drugs are not available.*

Please list all medications you, your spouse/partner or any listed dependent children have taken in the last 3 months, including those for which refills are currently authorized or any medications expected to be used in the near future. If additional space is required, please attach a separate sheet. *Note: Prescription drugs include oral medications, injectables, creams, drops or serum.*

	Patient Name	Medication	Dosage	Frequency	Monthly Cost	Nature of illness/injury or condition
EXAMPLE:	John Smith	Adalat xl	30 mg 1 tab	2 X/day	$50.00	Hypertension

How long is medication expected to be taken? (indicate for each medication)_____

_____

PRE-AUTHORIZED DEBIT (PAD) *Please attach a cheque marked "VOID"*

I hereby request/authorize The Edge Benefits Inc. ("the Administrator") to debit my account, shown on the attached VOID cheque, pursuant to the Pre-Authorized Debit Agreement outlined on the attached product overview, for each month's premium payable to the Administrator and its successors or assigns. The Administrator's treatment of each payment shall be as if it were a cheque drawn on my account, and signed personally by me. **Under this premium payment method, the Administrator shall not be required to give notice of premiums due.** The expression "cheque" used in this request includes magnetic or computer produced paper tape that is or purports to be a direction to credit any amount to the Administrator and debits such amount to the account described. **If a pre-authorized cheque is returned due to non-sufficient funds, the Administrator is authorized to redeposit the cheque or add the appropriate amount to the next cheque. A $25.00 service fee will be applied to all NSF cheques. If you are applying for Health & Dental coverage, Premiums will be withdrawn on the 1st of each month. For all other products:**

Your PAD WITHDRAWAL DATE is the Effective Date of Coverage, or select a date _____ (1st to 28th) *the withdrawal date selected must be within 15 days from the premium due date.*

If your application is submitted without a cheque representing the first month's premium, we will use this PAD information to withdraw the first premium upon receipt of your application.

Name of Bank: _____ Transit #:_____ Institution #:_____ Account #:_____

Date _____ Signature of Payor _____ (as it appears on bank records) Print name of Payor _____

Date _____ Signature of Second Payor_____ (if required for joint account) Print name of Second Payor _____

AGREEMENT, DECLARATION & UNDERSTANDING SIGNATURE

I have reviewed this application for benefits, and it is to the best of my knowledge and belief true, complete and correctly recorded and together with any other forms signed by me in connection with this application form the basis for any policy issued. I understand that any coverage arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application. I hereby confirm that I understand, agree and consent as outlined herein.

1. I confirm that I live permanently in Canada and am a Canadian Citizen or a Permanent Resident (landed immigrant) of Canada, and I am not contemplating living permanently outside of Canada within the next 24 months. I understand that if I am not a Canadian Citizen or a Permanent Resident of Canada my coverage will not be valid.
2. I hereby consent to and authorize the disclosure of any records or information received or known by the insurers and/or The Edge Benefits Inc. to any insurance company which reinsures a group of policies which includes my policy number.
3. I understand that all benefits payable are subject to the general terms, conditions, definitions, exclusions and limitations outlined in The Policy Booklets for the applicable coverages.
4. I consent to the use of my personal information for the purposes outlined in the Privacy Statement located in the Lifestyle Protection Planner©. I understand that my consent to the use of any information to offer me products and services is optional, and that if I wish to discontinue such use I may call or write to The Edge Benefits Inc. (or their insurers) at the telephone number or address shown on the Lifestyle Protection Planner ©
5. I understand that The Edge Benefits Inc. and/or their Insurers will create and maintain a file for the purposes of the Application and any subsequent claim. Only the employees, mandatories or agents responsible for such purposes will have access to this file. I am entitled to consult the personal information contained in this file and where applicable have it rectified, by formulating a written request to The Edge Benefits and/or their Insurers.
6. EFFECTIVE DATE OF COVERAGE: I hereby understand that Coverage becomes effective on the later of, the date of this application, the date of the cheque for the first month's premium if submitted with this application, or the Effective Date specified on the Schedule of Benefits issued by The Edge Benefits Inc. Coverage will not become effective if the cheque submitted as payment is not honoured on presentation. If Benefits are being added to a current policy, or age conservation applies, coverage will become effective when received and approved by the insurer, and premiums have been debited from my account. I authorize The Edge Benefits Inc. to debit my account for any additional benefits purchased.
7. If a third party or my employer (herein after referred to as "the Payor") is paying premiums on my behalf, I hereby authorize The Edge Benefits Inc. to receive and accept premium payments, pay any premium refunds, and send any premium or lapse notices to the Payor, and I understand and agree that for purposes set out herein, that the Payor shall be my agent, and the payment of premium refunds or the sending of notices referred to herein to the Payor, shall be deemed to be sufficient notice to me. In addition, I authorize the Payor to have access to my personal information, as supplied in the application form, for the purposes of forwarding it on my behalf to The Edge Benefits Inc. for determining coverage and for the administration of my policy. I also authorize the Payor to receive the policy contract from The Edge Benefits Inc. on my behalf, for delivery to me.
8. INCONTESTABILITY: The statements made in this application, in any subsequent application, or in any application for reinstatement, except for fraudulent misstatements and statements erroneous as to age or sex, shall be incontestable after the policy has been in effect for two years from the later of applicable effective date, or the effective date of an endorsement or amendment to the policy or from the effective date of the last reinstatement.
9. I acknowledge having received, and have been advised to read the accompanying Lifestyle Protection Planner ©, which contains some key exclusions and limitations applicable to the coverage and the Privacy Statement outlining certain privacy practices regarding collection, use and disclosure of my personal information. I have further been advised to review my Policy Booklet when issued for complete understanding of the terms, conditions, definitions, exclusions and limitations outlined in the policy.

With respect to Loss of Income - Illness Coverage:

10. I hereby authorize any physician, health care professional, hospital, clinic, or any other medically related facility, any provincial or federal tax authority, the Medical Information Bureau (MIB) or any other organization, institution or company that has any records or knowledge of me to provide such information to Co-operators Life Insurance Company, The Edge Benefits Inc., or any other party providing or administering benefits under this plan, for the assessment of this application for insurance. I also authorize Co-operators Life Insurance Company to make a brief report of my personal health information to MIB. A facsimile, photocopy, scan or other electronically imaged copy of this authorization is as valid as the original and this authorization shall continue to be in effect so long as I maintain insurance with Co-operators Life Insurance Company.

With respect to Health & Dental, Green Shield Canada reserves the right to perform a claim audit from time to time to verify the accuracy of the medical information provided.

11. I hereby authorize any licensed physician or other medical practitioner, medical or medically related facility, that has any records or knowledge of me or my health, or that of my spouse/partner or any listed dependents, to exchange any such information as is needed to administer benefit claims and/or confirm the accuracy of the information with The Edge Benefits Inc. and Green Shield Canada. I may request and receive a copy of any medical information obtained with this authorization. A photographic copy of this authorization shall be as valid as the original.
12. I declare that I, my spouse/partner and all listed dependents are residents of Canada who are covered by a provincial government health plan.
13. I understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and or listed dependents could result in denial of a claim and the cancellation or modification of the coverage.
14. I am authorized to release information concerning my spouse/partner and my dependent child(ren) for the purposes of determining their eligibility for benefits.
15. I hereby understand that the coverage applied for shall be effective on the 1st of the month following notification of approval. I understand that it is my obligation to inform The Edge Benefits Inc. of a change in my health or that of my listed dependents due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.
16. I declare that I am able to read and/or speak English or French and acknowledge having read this notice.

With respect to Critical Illness

17. I understand that a critical illness benefit will not be payable if I am diagnosed with an Insured Condition within the first 24 months immediately following the later of the effective date or the latest reinstatement date of critical illness insurance coverage, which results directly or indirectly from a Pre-existing Medical Condition. "Pre-existing Medical Condition" means any medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to the effective date of insurance, or latest reinstatement date.

It is the express wish of the parties that this application for insurance and any related documents be drawn up in English *Il est la volonté expresse des parties que cette demande d'assurance et tous les documents y afférents soient rédigés en anglais.*

Date _____ Signed at _____ Signature of Applicant _____

ADVISOR INFORMATION

Advisor Signature: _____ Print Name Here: _____ Tel.: _____

Email: _____ Advisor Code: _____ MGA: _____ if applicable