

This application form is to be completed for Flexible Term, Mortgage Term, Freedom Plan, Business Options and Inheritance Tax cases. Please take care to complete all relevant sections as incomplete forms will delay the processing of your application

**To be completed by Broker/Agent (a copy of this application form is available on request).**

Proposal No.	<input type="text"/>	IFSRA Ref No.	<input type="text"/>	Commencement Date	<input type="text"/>
Broker/Agent	<input type="text"/> %	Agency Code	<input type="text"/>		
Broker/Agent	<input type="text"/> %	Agency Code	<input type="text"/>		
E-Mail Address	<input type="text"/>	New Client	<input type="checkbox"/>	Existing Client	<input type="checkbox"/>

**Other Instructions** \_\_\_\_\_

### A Personal Details

Please complete in block capitals. For questions marked \* delete as applicable

#### First Life Details

Mr/Mrs/Ms/Other\*

First Name

Surname

Previous name (if different)

Date of Birth

Age next birthday   Male  Female

Contact address

Contact Tel. No.

Email Address

Country of Birth

#### Second Life Details (if applicable)

Mr/Mrs/Ms/Other\*

First Name

Surname

Previous name (if different)

Date of Birth

Age next birthday   Male  Female

Contact address

Contact Tel. No.

Email Address

Country of Birth

Precise Occupation and Duties\*\*

Precise Occupation and Duties\*\*

\*\*In order to speedily process your application, please provide as much detail as possible concerning your occupation.

Marital Status

Marital Status

Tobacco smoker\*  Yes  No

Tobacco smoker\*  Yes  No

+A non-smoker is a person who has not smoked tobacco in any form over the last 12 months and has no intention of smoking in the future.

Please state relationship to the First Life

Nature of insurable interest

### Special Instructions

Hold for Risk Commencement Date

Yes  No

If no commencement date is given, then we will assume the 1st of the following month. For Mortgage cases please ensure you provide the Risk Commencement Date.

### B Applicant Details (life of another)

Name in full (surname first)  Mr/Mrs/Ms/Other \*

Please state relationship to life assured or nature of insurable interest

Where the application is being made by a person or persons other than the life assured, then this section should be completed.

### C Correspondence Address

To be completed if correspondence concerning this application is to be sent to an address other than that listed overleaf.

Address

Tel. No.

### D Purpose of Policy

Does this policy replace an existing policy, in whole or in part?  Yes  No

If yes, what is the purpose of the replacement?

If Yes, please quote number of policy being replaced (if a Canada Life policy)

**Protection Policies Please indicate the choice of policy (Tick appropriate boxes)**

**Whole of life Policies**  Freedom  Business Options\*  Inheritance Tax

**Term Policies**  Flexible Term  Mortgage Protection\*

\* Where Life and Serious Illness Cover are applied for they must be written on an Accelerated Basis

### E Plan Details

Premium  € per \*month/quarter/year/half year (\*delete as applicable)

Term (years)

Payment method  Direct debit  Cash  Payroll (Cash payments are accepted for annual premiums only)

#### Inflation Protector

Flexible Term Yes  No  (benefits inflate at 5% p.a.)

Freedom Yes  No  If Yes Fixed  Variable

Funds (applicable to Freedom) Name  %

Name  %

Conversion option+ Yes  No  (see note)

Freedom Premium Guarantee (please tick) 0 years  5 years

**Life Cover** **Serious Illness Cover** **Type of Cover\*\*** (see note) Please indicate whether Accelerated or Double Payout

**First Life**  €  € Accelerated  Double Payout

**Second Life**  €  € Accelerated  Double Payout

For full details on all features in Section E please refer to the relevant product brochure.

+ Conversion option applies to life and serious illness cover on a flexible term plan

\*\* If Life and Serious Illness Cover are selected, the types of cover available are Double Payout and Accelerated. You should state the type of cover you require in the space provided. Mortgage Term plans are only available on an accelerated basis

^ The maximum Personal Accident Benefit payable shall not exceed the lesser of €400 per person per week in respect of all policies held, or 50% of gross weekly earnings.

o The maximum Income Protection Benefit payable shall not exceed the lesser of €950 per person per week in respect of all policies held, or 67% of gross weekly earnings.

++ Premium Protection, where chosen, can only apply to either the first or the second life.

	Freedom Plan		Flexible Term Plan	
	First Life	Second Life	First Life	Second Life
Accidental Death Benefit	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Surgical Cash	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Long Term Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital Cash	<input type="text"/> € per day	<input type="text"/> € per day	<input type="text"/> € per day	<input type="text"/> € per day
Personal Accident Benefit <sup>^</sup> (see note)	<input type="text"/> € per week	<input type="text"/> € per week	<input type="text"/> € per week	<input type="text"/> € per week
Income Protection <sup>o</sup> (see note)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Permanent & Total Disability "Own" or "Any" occupation	Own <input type="checkbox"/> Any <input type="checkbox"/>	Own <input type="checkbox"/> Any <input type="checkbox"/>		
Premium Protection <sup>++</sup> (see note)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Additional Single Premium	<input type="text"/> €			

**E Plan Details continued**
**Income Protection**
(only available on Freedom)

	First Life	Second Life
Income Protection benefit	€ <input type="text"/> per week	€ <input type="text"/> per week
Current Salary	€ <input type="text"/> per annum	€ <input type="text"/> per annum
Cessation age	55 <input type="checkbox"/> 60 <input type="checkbox"/> 65 <input type="checkbox"/>	55 <input type="checkbox"/> 60 <input type="checkbox"/> 65 <input type="checkbox"/>
Deferred Period	13 <input type="checkbox"/> 26 <input type="checkbox"/> weeks	13 <input type="checkbox"/> 26 <input type="checkbox"/> weeks
Escalation in Payment at	0% <input type="checkbox"/> 3% <input type="checkbox"/>	0% <input type="checkbox"/> 3% <input type="checkbox"/>
Occupation Class	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>

**Further information (Only to be completed when purchasing Income Protection)**

	First Life	Second Life
1. Have you ever been incapacitated for more than 4 weeks at a time from carrying out your occupation? If so please state nature and date of such incapacity in Section I.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever claimed sickness, accident or Social Welfare Benefit for a period of more than 26 weeks? If so please give details in Section I.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Would you expect to receive income during incapacity from a source other than this policy? If yes, please state how long and to what extent, in Section I.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you have, or are you applying for PHI, Income Protection or Disability Insurance cover with any other office? If so please supply full details in Section I.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Are you entitled to Social Welfare Benefits? If so, are you individually or jointly assessed for tax purposes? Individually/Jointly (delete as applicable)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Individually/Jointly	Individually/Jointly

**Mortgage Repayment Benefit (This benefit is only available on Mortgage Protection)**

	First Life	Yes	Second Life	Yes
Occupation Class	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	
Mortgage Repayment Amount	€ <input type="text"/> per month		€ <input type="text"/> per month	
Please state the name of lender	<input type="text"/>			

Are you currently availing of a Mortgage Repayment Benefit from your mortgage provider? Yes  No   
The mortgage repayment benefit amount cannot exceed 50% of gross salary or 50% of combined gross salary for joint life applications.

**F Additional Questions for 'Own' Occupation PTD, Income Protection, Mortgage Repayment Benefit, Personal Accident Benefit and Premium Protection**

Only complete this section if you are applying for Own Occupation PTD, Income Protection, Mortgage Repayment Benefit, Personal Accident Benefit and Premium Protection.

Do any of the following form an essential part of your occupation ? Yes  No

	First Life			Second Life		
	Yes	No	% of time	Yes	No	% of time
1. Manual or physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %
2. Use of machinery or tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %
3. Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %
			<input type="text"/> Miles per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> Miles per week
4. Working at heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> %
			<input type="text"/> Average height(ft)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> Average height(ft)

## G Health Questionnaire

### Material Facts:

A material fact is one that will influence whether and upon what terms Canada Life accepts this application. All material facts must be disclosed to Canada Life at the time of application. Failure to give complete and true answers and disclose all material facts could result in the contract(s) being void. If there is any doubt whether a certain fact is material it must be disclosed. Please note exemption in relation to Genetic Tests outlined below.

You should inform Canada Life of any change to any Material Fact occurring after you have completed this application but before the policy commences. Failure to do so may result in the proposed contract becoming void.

### Material Facts Exemption in Relation to Genetic Tests

In accordance with the Provisions of the Disability Act 2005, Canada Life will not ask, and you do not need to tell us, about any genetic test which you may have had. If you do disclose the results of such tests, we are not permitted to take these into account when assessing your application.

You are required to disclose a diagnosis of a genetic disease if you are experiencing symptoms of a genetic disease or receiving treatment for a genetic disease. It is also necessary for you to disclose any family history of a genetic disease.

	<b>First Life</b>	<b>Second Life</b>								
<b>1. Name and address of your doctor</b> <i>(if registered less than 6 months please give details of your previous doctor also)</i>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>2. What is your height/weight?</b>	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;"><b>Height</b></td> <td style="text-align: center;"><b>Weight</b></td> </tr> <tr> <td style="text-align: center;">ft ins</td> <td style="text-align: center;">st lbs</td> </tr> </table>	<b>Height</b>	<b>Weight</b>	ft ins	st lbs	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;"><b>Height</b></td> <td style="text-align: center;"><b>Weight</b></td> </tr> <tr> <td style="text-align: center;">ft ins</td> <td style="text-align: center;">st lbs</td> </tr> </table>	<b>Height</b>	<b>Weight</b>	ft ins	st lbs
<b>Height</b>	<b>Weight</b>									
ft ins	st lbs									
<b>Height</b>	<b>Weight</b>									
ft ins	st lbs									
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>3.a. What is your average weekly consumption of alcohol (in units)?</b>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>b. Has your weekly alcohol consumption varied from this in the past?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>								
If so, please give full details.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>c. What is your average tobacco consumption per day?</b>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>d. If you currently smoke has your consumption always been as stated above?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>								
If not please state your maximum previous consumption.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>								
<b>e. If you are currently a non-smoker have you ever smoked in the past?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>								
If so when did you cease smoking and	Date <input style="width: 100%;" type="text"/>	Date <input style="width: 100%;" type="text"/>								
what was your daily consumption?	Amount <input style="width: 100%;" type="text"/>	Amount <input style="width: 100%;" type="text"/>								

Non-smokers may be requested to undergo a saliva-based cotinine test.

**4. Please answer each question below 'yes' or 'no' as appropriate. If you have answered 'yes' please ensure that you provide full details in Section I (eg. nature of illness/accident, date, duration, doctor or hospital and extent of recovery).**

**Have you ever suffered from or received medical advice or treatment or are you currently awaiting medical consultations or intending to consult a medical professional for any of the following:**

	<b>First Life</b>		<b>Second Life</b>	
(i) Any disorder of the heart or circulation, chest pain, stroke or mini-stroke, raised blood pressure or raised cholesterol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(ii) Any stomach, liver, kidney, bladder or bowel complaint?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iii) Diabetes mellitus, any blood disorder, alcohol or drug abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(iv) Any form of mental illness, anxiety, depression, stress, chronic fatigue or tiredness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(v) Any back, neck or joint pain, arthritis, slipped disc, recurrent or disabling muscular pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(vi) Any growth, tumour or cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## G Health Questionnaire continued

- |   |                              |                             |                              |                             |
|---|------------------------------|-----------------------------|------------------------------|-----------------------------|
| (vii) Any neurological disorder or disorder of the brain, multiple sclerosis, epilepsy, paralysis or movement disorder?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (viii) Visual disturbance, numbness, pins and needles, tremor, dizziness, hearing impairment or visual impairment?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ix) Any respiratory disorder or skin disorder?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (x) Have you ever suffered from any physical or mental complaint or injury not mentioned above?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Have you in the last five years sought medical advice or been medically examined or medically treated or had medical investigations?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Are you currently unwell, taking any medication or being prescribed any tablets or under any medical care?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Have you tested positive for HIV/AIDS or Hepatitis B or C or have you been tested/ treated for any other sexually transmitted diseases or are you awaiting the results of any such tests? If yes, please provide details – for confidentiality purposes these may be sent directly to the Chief Medical Officer at Canada Life House, Temple Road, Blackrock.  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Have your natural parents, or your brothers or sisters, living or dead, suffered from diabetes, heart disease, cancer, polycystic kidneys, Huntington's Chorea, familial polyposis of the colon, multiple sclerosis, cardiomyopathy or any other hereditary disorder before the age of 65. If yes, please give full details in Section I. <i>Also please give details of age when diagnosed with illness and site of any cancer.</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

## H General Information

- | <b>Please provide full details in Section I.</b>  | <b>First Life</b>            |                             | <b>Second Life</b>           |                             |
|---|------------------------------|-----------------------------|------------------------------|-----------------------------|
| 1. a. Are you effecting, or have you effected within the last 12 months assurance cover with any other company? If 'yes' please give details of the cover and the name of the company involved.   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Do you have any existing Serious Illness Insurance in force? If so, please give details.   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Do you have any existing permanent health insurance, sickness or personal accident insurance in force? If so, give details.  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. a. Have you any prospect or intention of residing or travelling abroad, or have you done so in the past, other than on normal holidays? If yes please provide full details.  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Have you resided anywhere outside of the Republic of Ireland for more than 2 months within the past 5 years? If so please give details including the duration of your stay and the country visited   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Does the amount of total cover (Life and Serious Illness) that you already hold, including any cover that is currently proposed or contemplated, exceed an amount of €15 million? Types of cover include, but are not limited to, any personal cover, mortgage cover (commercial or personal), business cover and death in service cover. If yes, please give full details of existing, pending and contemplated cover. Any cover under this application will be subject to Canada Life obtaining cover in the reinsurance market. | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Has any proposal for life assurance, serious illness, sickness, personal accident or permanent health insurance on your life ever been declined, postponed or accepted on special terms?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Do you or are you likely to engage in an occupation or any activity (such as aviation or motor racing) which could be considered hazardous?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Have you ever previously applied for Insurance to Canada Life. If yes, please quote Policy No.   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Have you ever attempted (successfully or unsuccessfully) to claim under any benefit covered by a Canada Life policy? If so please give full details including policy number, date of claim, nature of illness and benefit claimed under in Section I.  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**You should inform Canada Life of any change to any Material Fact occurring after you have completed this application but before the policy commences. Failure to do so may result in the proposed contract becoming void.**

I Space for further information if required

**First Life**

**Second Life**

*Please note - if you answered yes to any of the questions in Section G Health Questionnaire or Section H General Information, please supply full details in this section.*

## J Tele-Interviews

### What is a Tele-Interview?

Tele-Interviewing is the use of a telephone interview as the primary means of gathering information to assess a customer's application for life assurance.

Experienced nurses carry out the interviews, on Canada Life's behalf. All interviews are recorded and the information gathered will form part of the application process.

The interviews can be done in lieu of obtaining a report from a doctor or to clarify some details disclosed on the application form.

These interviews evolved in the US where it is now established business practice with over one million Tele-Interviews being performed every year.

### How long do Tele-Interviews take?

Typically a Tele-Interview can take 20 - 30 minutes.

### When will the Tele-Interview be made?

The nurse will normally contact you within a few days of receiving your application. You should provide all available phone numbers, indicate the best time to call, and times or dates when you are not available.

### Is any preparation required for the interview?

While it is not essential, a little preparation will help speed up the interview and generally makes it more productive. It is recommended therefore that you should familiarize yourself with:

- Any medication you are taking, or have taken; that is, it would be helpful if you had the name of the medication, the dose and why you are taking it
- Details of any past or present medical conditions suffered, (other than very minor ailments such as a common cold), this should include any visits to a doctor, the reason for the visit and what medication you received.
- Names and addresses of doctors and specialists
- Any family history of medical conditions
- You will also be asked to confirm your height and weight, so if you do not know your weight accurately, you should try and weigh yourself prior to the interview.

### Duty of Disclosure

You are under the same obligation to disclose all known facts during the Tele-Interview process as you are when completing the application form. The nurse will carefully explain how the process works. The Tele-Interviewers are trained professionals and will explain in clear and simple terms what information needs to be given and why.

### Material Facts Exemption in Relation to Genetic Tests

In accordance with the Provisions of the Disability Act 2005, Canada Life will not ask, and you do not need to tell us, about any genetic test which you may have had. If you do disclose the results of such tests, we are not permitted to take these into account when assessing your application.

You are required to disclose a diagnosis of a genetic disease if you are experiencing symptoms of a genetic disease or receiving treatment for a genetic disease. It is also necessary for you to disclose any family history of a genetic disease.

**Your application may be selected for the Tele-Interview process, so please indicate the following preferred contact times and all appropriate telephone numbers.**

	Life 1
Name	<input type="text"/>
Date of Birth	<input type="text"/>
Home Phone No.	<input type="text"/>
Mobile Phone No.	<input type="text"/>
Work No.	<input type="text"/>

	Life 2
Name	<input type="text"/>
Date of Birth	<input type="text"/>
Home Phone No.	<input type="text"/>
Mobile Phone No.	<input type="text"/>
Work No.	<input type="text"/>

### Please state your preferred contact time (tick as appropriate)

	Life 1	
Office Hours	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Early Evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Early Morning	Yes <input type="checkbox"/>	No <input type="checkbox"/>

	Life 2	
Office Hours	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Early Evening	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Early Morning	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I will not be available on the following dates

I will not be available on the following dates

I am not available at the following times

I am not available at the following times

## K Direct Debiting Mandate

### Instructions to your Bank/Building Society to pay Direct Debit

Please complete parts 1 to 5 in BLOCK CAPITALS (except signatures) to instruct your bank/building society to make payments directly from your account. **Please return to: Canada Life, Canada Life House, Temple Road, Blackrock, Co. Dublin.**

1. Please write the full postal address of your bank/building society branch in the box below.

To: The Manager

2. Name of account holder(s)

3. Type of Account \*

\*Some Account types are not acceptable for Direct Debit. If you are not operating the Debit from a Current Account you should confirm with the bank/building society prior to submitting the mandate.

4. Account Number

5. Sort Code

#### For Office Use Only

Sent by

Date

Canada Life DD Number

Originator Code 

9 9 2 9 7 1

Premium Due Date

Policy No(s)

I/We instruct you to pay direct debits from my/our account at the request of Canada Life Assurance (Ireland) Limited. The amounts are variable and may be debited on various dates. I/We understand that Canada Life may change the amounts and dates only after giving me/us prior notice. I/We will inform the bank/building society in writing if I/we wish to cancel this instruction. I/We will understand that if any direct debit is paid which breaks the terms of this instruction, the bank/building society will make a refund.

**These are your instructions to the bank/building society, please read them carefully.**

Signature

Date

Signature

Date

## L Canada Life Payroll Moneymanager – Where premiums are to be paid by ‘Payroll MoneyManager’ please complete this Authority Form.

**Please note: This option applies to qualifying schemes only**

Name of employer

Scheme No.

Policy No.

Employee/Registered. No.

How paid?  Weekly  Fortnightly  Monthly

Office from which paid

Please deduct from the remuneration payable to me the installment of premiums as set out on the Application form and as will be set out in the adjoining box and remit the amount so deducted to Canada Life. This also permits the deduction of further additional amounts in respect of any future index linking of my policy. Details of each amount will be notified to me by Canada Life.

I recognise that these deductions will be made solely for my convenience and may be discontinued by you at any time.

I also recognise that the ultimate responsibility for ensuring that the deductions have in fact been made rests with me and that apart from ensuring that such deductions are paid to Canada Life you have no further responsibility in the matter.

Signature

Date

Employee Name in full  (block letters please)

Address

Section/Group No.

Occupation

Station/Depot/Office/District at which employed

Deduction details (Office use only)

The above figures will be confirmed at Canada Life Head Office.

**M Declaration by the Applicant**

I/We have read through the replies to all questions in this application and declare that to the best of my/our knowledge and belief all the information given, including any not filled in myself/ourselves in my/our handwriting are true and complete.

Where in doubt about whether certain facts are relevant, I/we have disclosed them. A non-smoker is a person who has not smoked tobacco in any form over the last 12 months and has no intention of smoking in the future. Canada Life reserves the right to test declared non-smokers for cotinine.

I/We agree that this proposal form shall form the basis of the contract(s) between me/us and Canada Life. I/We understand that failure to give true and complete answers to all questions may be grounds for rejecting a claim. I/We have read and understand the Material Facts Exemption in relation to Genetic Tests.

I/We consent to Canada Life seeking medical information from any doctor who at any time has attended me/us concerning anything which affects my/our physical or mental health or seeking information from any insurance office to which a proposal has been made on my/our lives and I/we authorise the giving of such information. I consent to the passing of personal and medical information to reinsurance companies, with whom Canada Life has a relationship, for the purposes of assessment of my application.

I/we have received an illustration in writing which complies with the Life Assurance (Provision of Information) Regulations, 2001 and understand that a copy of the policy conditions/completed application form is available on request. I/we have read through the illustration and fully understand its contents and I am/we are fully satisfied that this policy suits my/our particular needs.

I/We understand that the Company will not assume risk, until the earlier of issue by the Company of the Policy Document(s) relating to this application or issue by the Company of its formal notification of acceptance and that pending assumption of risk any payment made will be provisional only. If the initial premium cheque or debit instrument is not met or payroll deductions are not implemented I/we acknowledge that the Company will not be on risk notwithstanding the happening of either of the events referred to in the previous sentence.

I/We understand that Hospital Cash charges and Permanent and Total Disability charges are dependant on age, sex and occupation. I/We understand that Personal Accident Benefit charges are based on occupation. **I/We declare that I/we will inform the Company of any change to any material fact occurring before the commencement date of the policy shown in the policy schedule and understand that failure to do so may result in the proposed contract becoming void.**

I understand that information given to either of the companies The Canada Life Assurance Company or Canada Life Assurance (Ireland) Limited (herein collectively called "Canada Life" ) will be deemed to be given to each and every one of the two. I understand that, if my/our proposal is declined or if I am/we are offered insurance on special terms then, whether or not my application proceeds, this fact will be noted on a central registry, administered by the Irish Insurance Federation, and may be shared with other insurance companies as a protection against non-disclosure of material facts. I understand that in the event of my application not proceeding, information provided in connection with my application will be retained by Canada Life for a period of six years to facilitate any future application by me and as a protection against non-disclosure of material facts.

I/We acknowledge that Canada Life incurs fees, costs and expenses in setting up policies and administering the voiding of policies in cases of non-disclosure of material facts. I/we declare that I/we agree and consent that Canada Life shall be able at its discretion to deduct and set-off any such fees, costs and expenses incurred by it from premiums refunded or owing to me/us in the case of any policy becoming void.

**Material Facts:**

**A material fact is one that will influence whether and upon what terms Canada Life accepts this application. All material facts must be disclosed to Canada Life at the time of application. Failure to give complete and true answers and disclose all material facts could result in the contract(s) being void. If there is any doubt whether a certain fact is material it must be disclosed. Please note exemption in relation to Genetic Tests outlined in Section G.**

**Data Protection Acts 1988 and 2003 - Consent**

I/we consent to Canada Life (meaning in this context Canada Life Assurance (Ireland) Limited, the Canada Life Assurance Company and any other companies forming part of the worldwide Canada Life group) and organisations with whom it has a relationship (including its reinsurer(s)) receiving and processing my/our personal data, including medical information, for the following purposes: to decide upon my/our application for life assurance, the administration of any policy taken out by me/us with Canada Life, administration, risk assessment, research, statistical analysis and marketing. I/we consent to Canada Life using my/our data to inform me/us of other products and services offered by it unless the following box is ticked. I/we do not wish to be contacted in this way

I/we consent to Canada Life processing sensitive personal data about me/us including: my/our racial or ethnic origin; my/our physical or mental health; and my/our sexual life. I/we consent to Canada Life transferring my/our personal data within the Canada Life Group where necessary and appropriate and I/we understand that this may involve the transfer of my/our personal data, including sensitive personal data, to countries outside of the European Economic Area. I/We am/are aware that I/we have a right to apply for a copy of the information held by Canada Life about me/us (for which a small charge may be made) and that I/we have the right to have any inaccuracies corrected. I/We am/are aware that Canada Life will take all reasonable measures to ensure the security and integrity of my/our personal information.

**IMPORTANT: PLEASE READ THE DECLARATION BEFORE SIGNING**

Signature of First Life Assured

Signature of Second Life Assured

Signature of Applicant (if different from Life Assured)\*

Date

\*For keyman policies applications require a signatory for and on behalf of the company and their title/position noted

**Warning:** If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this please contact your insurer or insurance intermediary.

**Declaration of Insurer or Insurance Intermediary**

I hereby declare that in accordance with Regulation 6(1) of the Life assurance (Provision of Information) Regulations 2001\*

\*(insert names and addresses)

has/have been provided with information specified in Schedule 1 to those regulations and that I have advised the client(s) as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction, and of possible financial loss as a result of such a replacement.

Signature of insurer or insurance intermediary

Date

**Declaration of Client**

Declaration of client(s): I/We confirm that I/we have received in writing the information specified in the above declaration.

Signature(s) of client(s)

Date



Date