STANDARD LIFE

GROUP LIFE & HEALTH

Evidence of Insurability

ADMINISTRATION DEPARTMENT

TORONTO
P.O. BOX 4105, POSTAL STATION A
TORONTO, ONTARIO M5W 2P4

MONTRÉAL
P.O. BOX 4002, POSTAL STATION B
MONTRÉAL, QUÉBEC H3B 4M2

I Administrative information *(please print)*

Policyholder name	Policy no.	Division no.
THE HINCKS-DELLCREST CENTRE	014032	

Participant surname	Given name	Initial	Certificate no.

1. Why are you submitting evidence of insurability?

❑ Increase in insurance coverage in excess of maximum without evidence of insurability

❑ Application for optional life insurance
Total amount:
Participant $ ______
Spouse $ ______
Children $ ______

❑ Application for optional accidental death and dismemberment insurance
Total amount:
Participant $ ______
Spouse $ ______
Children $ ______

❑ Late application for participation in group plan
Date of permanent full-time employment with present employer *(YYYY/MM/DD)*

❑ Late application for dependent coverage
Were your spouse and/or dependent children, if any, covered under another employer's group plan? ❑ YES ❑ NO If so, please provide:
Name of previous employer ______
Name of insurer ______
Date of termination of coverage *(YYYY/MM/DD)*

2. Are you actively at work and capable of performing each and every duty of your employment?

❑ YES ❑ NO If not, please provide a brief explanation

Important: If this section is not completed, Standard Life will process this form on the assumption that you are actively at work and capable of performing each and every duty of your employment.

II Participant statement - Information on persons to be insured

Complete only for persons to be insured

❑ PARTICIPANT Height ft.in. ❑ m ❑ Weight lbs. ❑ kg ❑ Gender M ❑ F ❑

Place of birth	Date of birth *(YYYY/MM/DD)*
Number of years in Canada *(if place of birth is outside the country)*	
Occupation	
Main residence address *(no., street)*	Apt.
City	Province	Postal code
Telephone no. *(day)*	Telephone no. *(evening)*

❑ SPOUSE Height ft.in. ❑ m ❑ Weight lbs. ❑ kg ❑ Gender M ❑ F ❑

Surname or maiden name *(if different)*	
Given name	
Place of birth	Date of birth *(YYYY/MM/DD)*
Number of years in Canada *(if place of birth is outside the country)*	
Occupation	

❑ CHILDREN

Surname and given name			
Height ft.in. ❑ m ❑	Weight lbs. ❑ kg ❑	Gender M ❑ F ❑	Date of birth *(YYYY/MM/DD)*
Surname and given name			
Height ft.in. ❑ m ❑	Weight lbs. ❑ kg ❑	Gender M ❑ F ❑	Date of birth *(YYYY/MM/DD)*
Surname and given name			
Height ft.in. ❑ m ❑	Weight lbs. ❑ kg ❑	Gender M ❑ F ❑	Date of birth *(YYYY/MM/DD)*
Surname and given name			
Height ft.in. ❑ m ❑	Weight lbs. ❑ kg ❑	Gender M ❑ F ❑	Date of birth *(YYYY/MM/DD)*
Surname and given name			
Height ft.in. ❑ m ❑	Weight lbs. ❑ kg ❑	Gender M ❑ F ❑	Date of birth *(YYYY/MM/DD)*

III Authorization to provide information

STANDARD LIFE

A photocopy of this authorization will be as valid as the original.

***I HEREBY AUTHORIZE** any physician, practitioner, hospital, medical or paramedical clinic, insurance company, MIB or any other organization, institution or person having any information about me or my children concerning our health or our insurability, to provide such information to The Standard Life Assurance Company of Canada or its reinsurers in order to evaluate my eligibility and insurability or that of my spouse and my dependents, if any, under this plan. I agree that an investigation report regarding myself, my spouse and my children may be requested.*

Participant signature *(if to be insured)*	Spouse signature *(if to be insured)*	Children over 18 signature *(if to be insured)*	Date *(YYYY/MM/DD)*
			2005/04/28

G1053J-01-2005 GL

IMPORTANT: Please complete and sign both sides of this form.

The participant should detach and keep this section of the form.

Notice concerning the MIB (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. The Standard Life Assurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB (Medical Information Bureau), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage, or to which a claim is submitted, MIB will supply such company with the information in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction. Address: MIB Inc., 330 University Avenue, Toronto, Ontario M5G 1R7. Telephone: (416) 597-0590.

The Standard Life Assurance Company of Canada may also release information from its files to other life insurance companies to which you may apply for life or health insurance or to which a claim may be submitted.

G1053J-01-2005 GL

IV Participant statement - Medical questionnaire

Have any of the persons to be insured (including your spouse and children, if any) -

	Participant		Spouse/ Children	
	YES	NO	YES	NO
1. had cancer, a tumor, diabetes, a heart, circulatory or blood disorder, or high blood pressure?	❑	❑	❑	❑
2. had a nervous disorder, a liver, lung or kidney disorder, an ulcer or an intestinal disorder, or any urine abnormality?	❑	❑	❑	❑
3. had arthritis, rheumatism, a disorder of the bones or joints, or backaches?	❑	❑	❑	❑
4. developed AIDS or an AIDS-related complex, or had a positive result from a test designed to reveal the presence of the virus that causes these diseases?	❑	❑	❑	❑
5. been absent from work for 10 days or more due to illness or injury in the past two years?	❑	❑	❑	❑
6. submitted to an electrocardiogram, an X-Ray (excluding dental X-Rays), a blood test or any other test for diagnostic purposes, or been advised to do so in the past five years?	❑	❑	❑	❑
7. used drugs without a physician's prescription, been advised to make a more moderate use of alcohol, or been treated for drug or alcohol abuse?	❑	❑	❑	❑
8. had an application for life or health insurance declined, rated or postponed?	❑	❑	❑	❑
9. been examined by a physician or received treatment in a hospital, clinic or sanatorium in the last five years, for any reason other than those mentioned above?	❑	❑	❑	❑
10. have a physical abnormality or deformity?	❑	❑	❑	❑
11. been following a diet, receiving medical care or treatment?	❑	❑	❑	❑
12. been expecting to receive medical treatment or to undergo an operation in the next twelve months?	❑	❑	❑	❑
13. presently taking any medication?	❑	❑	❑	❑
14. smoked cigarettes, small cigars (cigarillos), a pipe or used smoking cessation aid products during the past twelve months?[1]	❑	❑	❑	❑

[1] *Standard Life must be advised of any change in smoking status.*

If you answered "Yes" to any of the questions above, please provide details in the space below.

Question no.	Given name	Illness, injury, condition or reason	Tests, operations, treatments and results	Medication brand name(s)	Date of annual exam *(YYYY/MM/DD)*	Onset of illness/injury *(YYYY/MM/DD)*	Date of complete recovery *(YYYY/MM/DD)*	Full name and address of physicians and hospitals
								Name *Address* *Telephone no.*
								Name *Address* *Telephone no.*
								Name *Address* *Telephone no.*
								Name *Address* *Telephone no.*
								Name *Address* *Telephone no.*

Please date and sign any document(s) submitted with this form.

V Statement

I, THE UNDERSIGNED, HEREBY CERTIFY that the statements made in this document and in any document attached hereto are complete and true.

I AUTHORIZE the employer, the policyholder, the Plan Administrator, The Standard Life Assurance Company of Canada or their reinsurers, their respective agents and mandataries to give, receive and share any personal information in order to evaluate my eligibility and my insurability or that of my spouse and children, if any, under this plan.

I UNDERSTAND that coverage will only take effect when my application is accepted by the insurer.

I HAVE READ THE NOTICE ON THE REVERSE concerning the exchange of information with MIB (Medical Information Bureau) and other insurers.

I UNDERSTAND that my Social Insurance Number may be used as my Certificate number within my group plan, and that it is my responsibility to advise my Plan Administrator if I do not wish my Social Insurance Number to be used to identify me under the group plan.

Participant signature *(if to be insured)*	Spouse signature *(if to be insured)*	Children over 18 signature *(if to be insured)*	Date *(YYYY/MM/DD)*
			2005/04/28

IMPORTANT: Please complete and sign both sides of this form.
NOTE: An incomplete questionnaire will delay processing of the application for insurance.