

HEALTH POLICY CHANGE APPLICATION

Throughout this form, "Empire Life" means the Empire Life Insurance Company.

Use this form to make a change on Adjusting Income in Disability policies, Office Overhead policies, Income Replacement policies and policies where Monthly Income Benefits are included.

Do not use this form to apply for reinstatement. Use C-0048 - Policy Change and/or Reinstatement Application.

Please print clearly.

Policy number	Name of Life Insured
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1. Change Details (complete applicable sections only)

- Increase Monthly Benefit (only available under Future Insurability Option) to: \$ _____
- Extend Maturity Date for one year under the Conditionally Renewable Period Option (only available at policy Maturity Date)

For the above changes, please submit the following documentation with this application:

- proof of full time employment and proof of employment income (current pay stub)
- **if your policy is an Office Overhead policy**, also provide proof of business expenses and proof of % of company ownership.
- **if your policy is an Adjusting Income in Disability policy** and you are self employed or a shareholder, also provide net business income, any employment income claimed on personal tax return, Corporate Income and Expense Statement, and % of company ownership.

And please provide the following information:

- a) Number of hours you currently work per week at your place of employment: _____
- b) Are these hours more or less than you have worked in the past year? yes no – if yes, provide your previous hours worked per week and the reason for the increase or decrease:
- c) Are you currently disabled due to injury or sickness? yes no – if yes, provide details:
- d) What were your average NET monthly employment earnings, including your NET business income, over the last 12 months?
\$ _____ (not including personal investment or rental income)
- e) Please provide full details of any other income or business expense replacement that you would receive during disability:
- f) Employer's name

Decrease Monthly Benefit to: \$ _____

Increase Waiting Period to: _____ days

Decrease Benefit Period to: _____ years

Delete the following Rider(s):

- Indexed Inflation Adjustment Lifetime Accident & Sickness First Day Hospital Lifetime Accident

2. Special Instructions

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3. Declaration, Acknowledgement, Authorization and Consent

I declare that:

- I am applying to have this policy changed;
- I have read and understood the meaning and importance of all the questions, answers and statements in this Health Policy Change Application;
- all statements and answers in all parts of this and related applications, including any supplementary questionnaires, forms or information sheets were accurately recorded and that they are complete and true to the best of my knowledge and belief;

I understand and agree that:

- Empire Life may change this policy as requested in this application. When I take delivery of the changed policy or any document endorsing the change I have requested, I agree to its terms, including any changes Empire Life has made to the terms;
- in the event of any material misrepresentation or non-disclosure of any material fact, and benefits are being added or increased, the added or increased benefits shall be void;
- the policy change shall not become effective until Empire Life has received this application and the full premium amount required, if any;
- if a new policy is issued by Empire Life as a result of this Health Policy Change Application, this new policy will be deemed to be based on the same statements, representations and warranties as the original application for insurance, including evidence submitted in this or any previous policy change application;
- premiums due as a result of this Health Policy Change Application may, at the discretion of Empire Life, be based on premium rates other than those in use by Empire Life at the effective date of this policy;
- by accepting this Health Policy Change Application Empire Life has not waived any current or future rights under the contract;
- Empire Life will maintain the information contained on this application and any related documents in my file. My file enables Empire Life and its employees, agents or representatives to assess this application, appraise the risk, assess any claim that I or my beneficiaries may make for benefits, administer my file, answer any questions I may have about this application or my file in general, and provide me with information about my file and Empire Life products and services;
- Empire Life will use personal information about me on a continuing basis for the purpose of my file. Empire Life may use third party service providers located outside of Canada to process and store my personal information. To access a copy of the most recent Empire Life Privacy Policy, please visit the Empire Life Web site at www.empire.ca. If I refuse to provide consent for this, Empire Life won't be able to assess my application or claim and issue or change any policy. If I am permitted by law to withdraw my consent, and do so, Empire Life will be unable to continue to administer the policy, neither I nor my estate will be able to exercise any rights under the policy and the policy may be cancelled at the discretion of Empire Life.

I acknowledge that:

- My Advisor may be paid on a commission basis.

I authorize:

- Empire Life to provide and exchange information (other than my medical information) regarding my file to my Advisor, his or her agency or other market intermediary as may be designated by me on an ongoing basis in order to provide me with ongoing service and advice related to my file;

A photocopy or an image of the signed Declaration, Acknowledgement, Authorization and Consent will be as valid as the original. By signing below I confirm that I have read, understood and agree to the statements in the Declaration, Acknowledgement, Authorization and Consent and consent to the use of my personal information as described.

Signature of person insured X	Print name of person insured
Signature of Owner(s) IF NOT THE PERSON INSURED — If Owner is a corporation, indicate its exact name. Two officers of the corporation must sign and provide their names and titles, or one officer of the corporation accompanied by the company seal. Persons signing must provide proof of authority to bind the corporation.	
Signature of Owner (or first authorized signature for corporate Owner) X	Print name of Owner (and title if signing for corporation)
<input type="radio"/> Only one corporate signing authority to bind corporation (copy of signing authority must be provided.) OR	
Second authorized signature for corporate Owner X	Print name of Owner (and title if signing for corporation)
Signature of witness to all signatures X	Name of witness (please print)
Signed at (city and province)	Date (dd/mmm/yy)