APPLICATION FOR ENHANCED WHOLE LIFE, EWL 20-PAY, T70, T10 AND GUARANTEED ISSUE

ORANGE BENEFIT FUND
505 CONSUMERS ROAD SUITE 706
TORONTO, ON M2J 4V8
1-800-565-6248

PROPOSED INSURED

FORM RESET BUTTON

Insured only ☐ Insured and Policy owner ☐

First name Last Name Middle Initial

Name _____ ☐ **Male** ☐ **Female** Mr. ☐ Mrs. ☐ Ms. ☐

No. Street Apt. City Province Postal Code

Address _____

Month Day Year Current

Phone _____ **Mobile** _____ **D.O.B** _____ **Age** _____ **SIN #** _____

☐ **Canadian Citizen**
☐ **Permanent Resident**
☐ **Work Permit** (< $30,000)
☐ **Super Visa** (< $30,000)

Driver's License (or Gov't Issued Photo ID# and Type) _____
Number (and type) Province/Territory of Issue Expiry Date (MM/DD/YY)

Are You an Orange Association Member?
☐ Yes ☐ No, applying for Associate Membership

Email _____

Beneficiary Name*	Relationship to Insured (to owner in QC)	Phone	Date of Birth MM/DD/YYYY	% Share	Primary (P) Contingent(C)	Revocable (R) Irrevocable (I)
					☐ P ☐ C	☐ R ☐ I
					☐ P ☐ C	☐ R ☐ I
					☐ P ☐ C	☐ R ☐ I
					☐ P ☐ C	☐ R ☐ I

* if the beneficiary is a minor: In all provinces except Quebec, a trustee should be named to receive funds on the minor's behalf. Please indicate the trustee's full name and their relationship to the policy owner above.

POLICY OWNER (If not the insured)

First Name Last Name Middle Initial

Name _____ ☐ **Male** ☐ **Female** Mr. ☐ Mrs. ☐ Ms. ☐

Same address as insured ☐ No. Street Apt. City Province Postal Code

Address _____

Month Day Year Current

Phone _____ **Email** _____ **D.O.B** _____ **Age** _____ **SIN #** _____

Number (and type) Province/Territory of Issue Expiry Date (MM/DD/YY)

Driver's License (or Gov't Issued Photo ID# and Type) _____

CONTINGENT OWNER

Full Legal Name Phone number Relationship to Owner

Name _____

EMERGENCY CONTACT

Full Legal Name Phone number Relationship to Owner

Name _____

TOBACCO USE (of proposed insured)

Within the past 12 months, have you used by any means, a substance or product containing tobacco or nicotine (excluding cigars) ☐ **Yes** ☐ **No** (If YES, smoker rates apply)

Within the past 12 months, have you smoked (including electronic vaporizer or "vaping") marijuana more than four times a week? ☐ **Yes** ☐ **No** (If YES, smoker rates apply)

REQUESTED COVERAGE

☐ **Enhanced Whole Life**
☐ **EWL 20-Pay**
☐ **Guaranteed Issue**
☐ **T70**
☐ **T10**

WHOLE LIFE
Benefit Amount
$ _____
Premium
$ _____

TERM LIFE
Benefit Amount
$ _____
Premium
$ _____

PAYMENT AND PREMIUM

☐ **Monthly**
☐ **Semi-annual**
☐ **Annual**
☐ **PAC 1st**
☐ **PAC 15th**

Total Premium
$ _____

First Payment:
☐ PAC withdrawal
☐ 1st month premium included

Will this application cause any other insurance or annuity to be replaced totally or partially? ☐ No ☐ Yes (if yes, details _____
Is any other application for insurance pending or being contemplated in any company? ☐ No ☐ Yes (if yes, details _____

PRE-AUTHORIZED PAYMENT AGREEMENT - AUTHORITY TO HONOUR CHEQUES DRAWN BY AND PAYABLE TO THE ORANGE BENEFIT FUND

Bank Name _____ **Transit #** _____ **Institution #** _____ **Account #** _____

Signature X _____ Date (MM/DD/YYYY) _____

Your treatment of each payment shall be the same as if I/we had personally issued a cheque authorizing you to pay as indicated and to debit the amount specified to my/our account. This authorization may be cancelled at any time upon written notice by me/us. Any delivery of this authorization to you constitutes delivery by me/us. Furthermore, I fully understand that your responsibility does not extend beyond the honouring of such drafts, and that you are not liable for lapse of insurance caused by non-payment of premium. NOTE: NSF charges may apply.

For verification purposes, a picture or physical copy of your personal/void cheque, or a Pre-Authorized Payment form from your Financial Institution must accompany this application.

V20200414-1

GENERAL HEALTH QUESTIONS

a) Do you have, or are you contemplating, planning or receiving treatment for, any terminal illness, or have you been receiving radiation or chemotherapy for cancer (excluding basal cell carcinoma) during the past 2 years? ☐Yes ☐No

b) Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or tested positive for HIV? ☐Yes ☐No

c) Are you currently hospitalized in a hospital, or are you a resident of a nursing home or nursing facility because you are incapable of independently carrying out 2 or more of the basic activities of daily living such as getting up, walking, washing, toileting, dressing or feeding? ☐Yes ☐No

IF ANY OF THE QUESTIONS (a, b or c) ABOVE ARE ANSWERED "YES", DO NOT PROCEED WITH THIS APPLICATION

ENHANCED WHOLE LIFE, EWL 20-PAY, T70 OR T10 - DECLARATION OF INSURABILITY

IF "YES" TO ANY QUESTIONS 1- 4 BELOW, YOU ARE NOT ELIGIBLE FOR ENHANCED WHOLE LIFE, EWL 20-PAY, T70 OR T10, PLEASE PROCEED TO THE GUARANTEED ISSUE SECTION BELOW

1. Within the past 2 years, have you had any application for benefits denied or postponed because of a terminal illness? Or, have you been advised by a physician to have surgery, diagnostic testing, investigation or referral that has not been completed or the results are unknown? ☐Yes ☐No
2. Within the past 2 years, have you had, been told you have, or been treated for: Severe or Chronic Respiratory illness or use of oxygen for any respiratory conditions. Chronic kidney, hepatitis, cirrhosis, or liver disease? Diabetic coma or insulin shock? Life threatening illness, which includes blood related illness, vascular, congestive, or severe heart condition, cardiac arrest, Infarction, severe chest pain? Or within past 2 years been treated for a stroke, angina or resistant hypertension? Or have you been told you have a mental or nervous system disorder including: Parkinson's, Alzheimer's disease, multiple sclerosis or cerebral palsy? ☐Yes ☐No
3. Within the past 2 years, have you been diagnosed with, hospitalized for or undergone medical treatment (including Prescribed medication or surgery) for Malignant tumor, cancer (excluding basal cell carcinoma), leukemia, or organ transplant (other than cornea)? ☐Yes ☐No
4. Within the past 2 years, have you used narcotics or barbiturates (except as prescribed by a physician), heroin, psychoactive drugs, cocaine, crack or similar agents or been a resident of a drug or alcohol treatment facility? ☐Yes ☐No

IF APPLYING FOR ENHANCED WHOLE LIFE, EWL 20-PAY, T70 OR T10 WITH FACE AMOUNTS OVER $50,000, PLEASE CONTINUE TO ANSWER QUESTIONS 5-13 BELOW

5. Have you taken part in any hazardous sports, such as parachuting, scuba diving, bungee jumping, hang gliding, gliding, flying ultra light aircraft, ballooning, rodeos as a participant, automobile racing, motorcycle racing or motor-cross racing ☐Yes ☐No
6. Flown as a pilot, student pilot or crewmember and is any such activity planned? ☐Yes ☐No
7. Have you used drugs, narcotics, steroids or any other controlled substance or drug other than prescribed by medical practitioner? ☐Yes ☐No
8. Within the past 5 (five) years, have you been advised to have any such lab or diagnostic test, hospitalization or surgery, which was not completed? ☐Yes ☐No
9. Have you had or been treated for chronic fatigue? ☐Yes ☐No
10. Have you had or been treated for Hepatitis, Convulsions, Seizures or Tuberculosis? ☐Yes ☐No
11. Have you had or been treated for Paralysis? ☐Yes ☐No
12. Have you had or been treated for any disorder of the Lungs (excluding asthma), Respiratory System or Lymph Gland ☐Yes ☐No
13. Within the past 2 (two) years, have you had or been treated for any disorder of the Brain, Kidney or Liver? ☐Yes ☐No

IF "YES" TO ANY QUESTIONS 5 -13, YOU ARE NOT ELIGIBLE FOR MORE THAN $50,000 OF ENHANCED WHOLE LIFE, EWL 20-PAY, T70 OR T10 COVERAGE.

GUARANTEED ISSUE - DECLARATION OF INSURABILITY (maximum $30,000)

IF ANY QUESTIONS FROM 1 - 4 ABOVE ARE ANSWERED "YES" YOU MAY STILL QUALIFY FOR GUARANTEED ISSUE BENEFITS PROVIDING THE ANSWERS TO QUESTIONS a, b, and c IN THE "GENERAL HEALTH SECTION" ARE ALL "NO" AND THE FOLLOWING CONDITIONS ARE MET:

I the undersigned certify that I understand if death, other than accidental, occurs within the first two (2) years the contract is in force, the benefit paid will be limited to the premiums paid plus interest.

I ACKNOWLEDGE THAT I AM NOT ELIGIBLE FOR ENHANCED WHOLE LIFE, EWL 20-PAY, T70 or T10 COVERAGE AND HEREBY APPLY FOR THE GUARANTEED ISSUE BENEFIT.

Print Name _____ **Signature X** _____

NOTES / MEDICATIONS / REQUESTS

_____

_____

_____

SIGNATURES

We, the proposed insured and or the applicant, declare that all answers and explanations given in this application or in any other questionnaire in connection herewith are true and complete. We agree that the insurance/benefit takes effect as of the acceptance of the application by the Orange Benefit Fund / Orange Insurance / Grand Orange Lodge of British America, inasmuch as the latter has been accepted without modification, the first premium has been paid and no change has taken place in the insurability of the proposed insured's since the signing of the application. We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or 3rd party agencies and any public body holding information concerning ourselves or our family, particularly medical information, to supply this information to Orange Benefit Fund and or its reinsurers for the risk assessment or the investigation necessary for the study of any claim. We also authorize our insurer, or its reinsurers, to exchange the personal information contained in this application with other insurers, or financial institutions, and to inquire of them for the appraisal of the risk or in the event of a claim. In case of death or disability, the beneficiary, the heir or the liquidator of my estate, is expressly authorized to supply the Orange Benefit Fund, when required by the latter, with all information and authorizations necessary to study the claim and obtain the required justification. Furthermore, we agree that a photocopy of this authorization shall be as valid as the original. It is further understood that the health of the applicant and or co-applicant be in the same insurable state of health as when the application for benefits was taken, a period of 21 days commencing from the issue date as stipulated by the policy. It has been explained to me/us that the acceptance and validity of the proposed insurance is dependent on the truth and accuracy of the answers given to the questions above, this prerequisite (needed as a prior condition) shall remain in effect for the life of the policy. The Orange Benefit Fund Privacy Code is based on the Model Code for the Protection of Personal Information, and the Federal Personal Information Protection and Electronic Documents Act, PIPEDA.

Signed at: _____ **this** _____ **day of** _____ **, 20** _____ **(Rec'd H/O** _____**)**
City or Town

Insured (signature) **X** _____ **Policy Owner** (signature) **X** _____

Agent (print) _____ **Agent / Witness** (signature) **X** _____
Name

Agent Code _____ **Agency #** _____