Application for Insurance Under the Randstad Advantage Plan

In this application *you* and *your* refer to the person applying for insurance. *We* and *the Company* refer to Canadian Premier Life Insurance Company ("Securian Canada").

Clear

1. General information

Information about you

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
Residence address (street number and name)			Apartment or suite
City	Province (insurance coverage is available across Canada, except Quebec)		Postal code
Preferred contact telephone number	Email address		

☐ Non-smoker
☐ Smoker

Non-smoker means that you have not used any tobacco or tobacco cessation products in the last 12 consecutive months.

Do you have any functional impairments or restrictions that prevent you from performing all the usual duties of your occupation or activities of daily living and are you on claim for life waiver of premium, long term or short term disability or have you been paid a critical illness claim or have a claim pending or have you ever been declined in the past for life or critical illness insurance?

☐ Yes ☐ No

Are you enrolled in your provincial health plan? ☐ Yes ☐ No	Employment start date (dd-mm-yyyy)

Information about your spouse (if applying)

First name	Middle initial	Last name	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Place of birth (province)	Place of birth (country)
Preferred contact telephone number	Email address		

☐ Non-smoker
☐ Smoker

Non-smoker means that you have not used any tobacco or tobacco cessation products in the last 12 consecutive months.

Do you have any functional impairments or restrictions that prevent you from performing all the usual duties of your occupation or activities of daily living and are you on claim for life waiver of premium, long term or short term disability or have you been paid a critical illness claim or have a claim pending or have you ever been declined in the past for life or critical illness insurance?

☐ Yes ☐ No

Are you enrolled in your provincial health plan?

☐ Yes ☐ No

Coverage applying for (Please see brochure for benefit details and ensure you have reviewed the rates)

Coverage applied for without proof of good health: (You must be under 60 to apply)

☐ $50,000 Term Life (TL) and Basic Extended Health Care (EHC)
☐ $50,000 Term Life (TL) and Basic Extended Health Care (EHC) + Basic Dental

Who are you covering?

☐ Yourself
☐ Your spouse
☐ Your dependent(s) How many?_____

Coverage applying for (Please see brochure for benefit details and ensure you have reviewed the rates) (continued)

Information about your dependent

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No

Coverage applied for with proof of good health:

☐ Term Life (TL)
☐ Accidental Death (AD)
☐ Critical Illness (CI)

☐ Extended Health Care (EHC) Basic
☐ Extended Health Care (EHC) Basic + Basic Dental
☐ Extended Health Care (EHC) Standard (includes Dental)
☐ Extended Health Care (EHC) Enhanced (includes Dental)

Term Life (TL) insurance

Who are you covering?

☐ Yourself ☐ Your spouse

Minimum $50,000 Maximum $250,000 in units of $25,000

Term Life (TL) insurance

Amount of insurance applying for at this time
$

Minimum $50,000 Maximum $250,000 in units of $25,000

Spousal Term Life (TL) insurance

Amount of insurance applying for at this time
$

In the event of your death, the proceeds of this insurance will be paid to your estate, unless there is a signed beneficiary designation in our file. At the time of the certificate issue and delivery, you will have the opportunity to appoint a named beneficiary by providing us with a duly completed and signed 'Beneficiary' form that will be included in your welcome package.

Accidental Death (AD) insurance

Who are you covering?

☐ Yourself ☐ Your spouse

Minimum $50,000 Maximum $250,000 in units of $25,000
The amount of AD insurance cannot exceed the amount of Life insurance.

Accidental Death (AD) insurance (If you are applying for Term Life insurance you have the option of adding Accidental Death insurance to your coverage.)

Amount of insurance applying for at this time
$

Minimum $50,000 Maximum $250,000 in units of $25,000
The amount of AD insurance cannot exceed the amount of Life insurance.

Spousal Accidental Death (AD) insurance

Amount of insurance applying for at this time
$

In the event of your death, the proceeds of this insurance will be paid to your estate, unless there is a signed beneficiary designation in our file. At the time of the certificate issue and delivery, you will have the opportunity to appoint a named beneficiary by providing us with a duly completed and signed 'Beneficiary' form that will be included in your welcome package.

Coverage applying for (Please see brochure for benefit details and ensure you have reviewed the rates) (continued)

Critical Illness (CI) insurance

Who are you covering?

☐ Yourself ☐ Your spouse

Minimum $20,000 Maximum $250,000 in units of $10,000

Critical Illness (CI) insurance

Amount of insurance applying for at this time
$

Minimum $20,000 Maximum $250,000 in units of $10,000

Spousal Critical Illness (CI) insurance

Amount of insurance applying for at this time
$

Extended Health Care (EHC) Basic

Who are you covering?

☐ Yourself ☐ Your spouse ☐ Your dependent(s) How many?_____

Information about your dependent

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No

Extended Health Care (EHC) Basic + Basic Dental

Who are you covering?

☐ Yourself ☐ Your spouse ☐ Your dependent(s) How many?_____

Information about your dependent

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No

Extended Health Care (EHC) Standard (includes Dental)

Who are you covering?

☐ Yourself ☐ Your spouse ☐ Your dependent(s) How many?_____

Information about your dependent

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No

Coverage applying for (Please see brochure for benefit details and ensure you have reviewed the rates) (continued)

Extended Health Care (EHC) Enhanced (includes Dental)

Who are you covering?

☐ Yourself ☐ Your spouse ☐ Your dependent(s) How many?_____

Information about your dependent

First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No
First name	Middle initial	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Student ☐ Yes ☐ No

Insurance information

Note: Do not cancel any existing coverage until the coverage you have applied for has been approved.

Do you have inforce or have you concurrently applied for any Term Life or Accidental Death or Critical Illness or Extended Health Care coverage?

☐ Yes ☐ No

Please provide amount and details below

Type of insurance	Amount $	Insuring company	
Status ☐ Inforce ☐ Pending	Date of issue (dd-mm-yyyy)	Will any insurance be discontinued if this application is approved? ☐ Yes ☐ No	Amount to be discontinued $

Medical information

Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. Do not tell us about genetic testing or genetic test results.

Information

Information about you

Date and reason for consulting with attending physician (if no attending physician, please state *none*)
Name of physician, diagnosis, treatment given, results, medications prescribed
If the physician named above does not have the most complete records of your medical history, please provide the full name and address of the physician who does have them

Information about your spouse

Date and reason for consulting with attending physician (if no attending physician, please state *none*)
Name of physician, diagnosis, treatment given, results, medications prescribed
If the physician named above does not have the most complete records of your medical history, please provide the full name and address of the physician who does have them

Medical information (continued)

Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

You	Your spouse	Your dependent children
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Medical information

Your

Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

Your spouse

Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

Your dependent's

First name	Middle initial	Last name
Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

First name	Middle initial	Last name
Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

First name	Middle initial	Last name
Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

First name	Middle initial	Last name
Height ft in m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months? ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		

Medical information (continued)

Have any of the persons to be insured ever:

	You	Your spouse	Your dependent children
a) had chest pain, angina, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, peripheral vascular disease, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had a stroke, transient ischemic attack (TIA or 'mini stroke'), phlebitis, paralysis, dizziness, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's, or any other disease or disorder of the brain or neurological system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) had diabetes, impaired fasting glucose, sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or abnormal pap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) had disorder of the breast including lumps, cysts, abnormal mammogram findings or biopsy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) had tumours, cancer, polyps, moles or other growth; disorder of the skin or lymph glands; blood or immune disorder, leukemia or any other form of malignant disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had sleep apnea or chronic lung or respiratory disorder; disease or disorder of the eyes (excluding near or far sightedness), ears, nose or throat or had loss of speech?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have any of the persons to be insured ever:

h) had any disorder of the colon, rectum, intestines (including Crohn's or colitis), ulcer, gallbladder, stomach or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; amputation; fibromyalgia or rheumatic/ arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) had any psychiatric disorder; depression, suicide attempts or ideations; anxiety state or panic attacks; eating disorder; other emotional disorders; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) had a disorder of the liver, tested positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepatitis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) had any other illness, disease, disorder, condition or injury not listed above; had any health symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Within the past five years, have any of the persons to be insured:

m) consulted a physician, chiropractor, psychologist, physiotherapist, psychiatrist, or any other health care professional, or been admitted to a hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) had any symptoms or adverse findings, or were advised to have further examinations, diagnostic tests, hospitalization or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) submitted to ECGs, blood tests, x-rays, a biopsy or any other diagnostic tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) had any surgical operation, treatment, ailment, abnormality or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) received any treatment or are currently taking any medication, over-the-counter medications, including any herbal supplements or remedies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
r) been advised to have any further examinations, diagnostic tests, hospitalization or surgery which has not been completed, or had any symptoms or complaints regarding your health for which a physician has not yet been consulted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

In the next six months, did any of the persons to be insured:

s) contemplate medical or surgical treatment, or a hospital stay?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Within the past 12 months:

t) have you, your spouse or dependent child(ren) been unable to work for more than five consecutive days or made a claim or received benefits, pension, or compensation for sickness or accident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical information (continued)

Additional information

You

a) Do you consume alcoholic beverages? ☐ Yes ☐ No

Please record the number of glasses in each category.

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

Your spouse

Do you consume alcoholic beverages? ☐ Yes ☐ No

Please record the number of glasses in each category.

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

	You	Your spouse	Your dependent children
Within the past 10 years, have any of the persons to be insured:			
b) consumed substantially more alcohol than outlined previously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) been charged with impaired driving or been arrested, due to the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had your driver's license suspended or revoked, or had three or more moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use and/or abuse of non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) had Life, Critical Illness, or Disability insurance declined, postponed rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years, have any of the persons to be insured:			
h) piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities such as skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do any of the persons to be insured:			
i) expect to change country of residence or expect to travel outside Canada or the USA within the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For female applicants only			
j) Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please indicate expected due date.	(mm-yyyy)	(mm-yyyy)	(mm-yyyy)
k) Have you had any previous complications of pregnancy such as miscarriage, preeclampsia, caesarean section, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical information (continued)

Please provide details below for any *yes* answers.

Include the results of all physical examinations and check-ups.

Please do not tell us about genetic testing or genetic tests results.

If you need more space, please complete on separate sheet of paper and sign and date it.

Question	Name of person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results

Premium payments

☐ **Credit card payment**
(charge my premium to my VISA or MasterCard)

Payment frequency: ☐ Monthly ☐ Annually

Once we have processed your application, you will be contacted by a Securian Canada call centre representative to obtain your credit card information.

Terms and conditions
In connection with you required premium under this benefit plan, you authorize us to: charge your credit card for the insurance premium owing, cancel this authorization 10 days after you have provided written notice to us, and to automatically cancel this agreement if we are unable to charge your credit card.

☐ **Pre-authorized debit (PAD)**
(collect my premium directly from my bank account)

Are you the bank account holder? ☐ Yes ☐ No

Monthly Pre-authorized Debit (PAD)

Financial institution name
Financial Institution address (street number and name)

Premium payments (continued)

Bank account information

Transit number	Bank/institution number	Account number

This sample cheque shows the information that you need to provide.

Notes:

Branch/Transit numbers are normally 4-5 digits

Bank/Institution numbers are always 3 digits long:

BMO 001

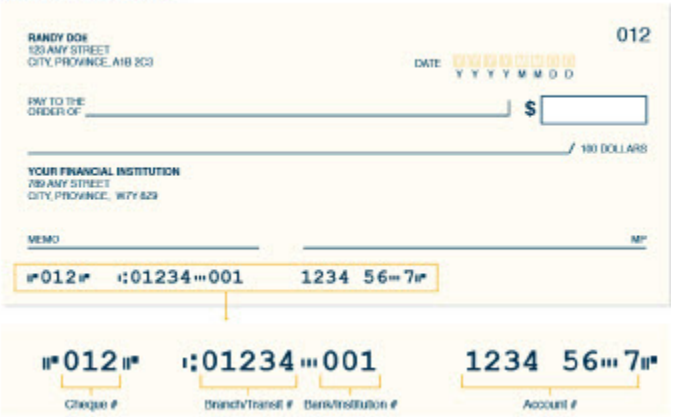
Scotiabank 002

RBC 003

TD 004

CIBC 010

Account numbers can be up to 12 digits long



Terms and conditions

You authorize Canadian Premier Life Insurance Company ("Securian Canada") to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. You agree to waive the requirements that Securian Canada notify you of any payments after the first payment whether the amount of the monthly premium is changed or not. You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Securian Canada is unable to make a withdrawal from your account.

This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting *www.payments.ca.*

Securian Canada may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit *www.payments.ca*.

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

Telephone number: 1-877-363-2773
Email: association.newbusinesssupport@securiancanada.ca

☐ I acknowledge and certify that I have read, understood and agree with the contents of the terms and conditions outlined above.

Date of agreement (dd-mm-yyyy)

Declaration and authorization

If my spouse and/or dependent(s) are being insured by this plan, I am authorized by them to provide the following authorizations on their behalf.

I declare that all my answers in this application are true and complete. If applicable, I have provided answers on behalf of my spouse and/or dependent(s) as directed by them and they confirm their answers are true and complete. I understand, and if applicable confirm my spouse/dependent(s) understand, that concealment, misrepresentation and false declaration concerning this Application will cause the insurance to be void.

I and, if applicable, my spouse and/or dependent(s) authorize Canadian Premier Life Insurance Company ("Securian Canada"), and its agents and service providers to collect, use and disclose information about me and, if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this insurance plan with any person or organization who has relevant information about me/us including any health professionals, institutions, investigative agencies, insurers and reinsurers.

My spouse/dependent(s), if applicable, authorize Securian Canada to disclose information about them to me for the purpose of assessing this Application and managing the plan.

This Authorization is as valid as a signed document and shall continue to have effect throughout the duration of my coverage under this plan, unless withdrawn in writing.

☐ I acknowledge and certify that I have read, understood and agree with the contents of the declaration and authorization outlined above.

Agreed at (city)	Agreed at (province)	Date of agreement (dd-mm-yyyy)

Medical Information Bureau notice

In the course of underwriting your application, Securian Canada may disclose information about you and your spouse to its reinsurers. Securian Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you and your spouse may apply for life or health insurance or to whom a claim for benefits may be submitted.

Securian Canada or its reinsurers may also submit a brief report of our findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you and your spouse also apply for insurance coverage or submit a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You and your spouse may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

To learn more about MIB, you and your spouse may visit the website at www.mib.com, call 416-597-0590 or write to them at:

Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *http://www.securiancanada.ca/privacy-statement*.