Producer #:_____

KEY PERSON CRITICAL ASSET PROTECTION APPLICATION FORM

Policy Owner/Beneficiary (Not the Insured): _____

Phone Number: _____ Email: _____

Address of Policy Owner: _____

_____

Type of Business: _____

Requested Benefit Amount: $_____ Disability Rider: ❑ Yes ❑ No

Proposed Insured Person Insurability

This section must be completed by the proposed insured person.

Name of Insured Person: _____

Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Occupation: _____ Daily Duties: _____

Period of Insurance: _____

If "Yes" is answered for any of the following questions, please provide full details in the space below. If there is not sufficient space, please attach your answers on a separate sheet.

1. Do you have any physical health problems or suffer from, been diagnosed with, received treatment for, or been prescribed treatment for any condition related to, or from a sickness of any kind? ❑ Yes ❑ No
2. Have you ever been diagnosed with a heart condition, high blood pressure, diabetes or cancer? ❑ Yes ❑ No
3. Have you at any time been physically or mentally unable to work during the last 12 months? ❑ Yes ❑ No
4. Have you ever been declined, postponed, or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
5. Do you intend to engage in hazardous sports or any activities that expose you to personal injury? ❑ Yes ❑ No
6. Any foreign travel planned during the proposed period of insurance? *If "Yes", please include location(s), anticipated length, and frequency of travel.* ❑ Yes ❑ No
7. Do you hold a valid pilot license? *If "Yes", please include average piloting hours and type(s) of aircraft to be flown.* ❑ Yes ❑ No
8. Have you ever had any criminal convictions? ❑ Yes ❑ No

Details to the answers above: _____

_____

FINANCIAL INSURABILITY

Please provide a breakdown of how you will suffer a financial loss in the event of death of the Key Person along with any supporting financial documentation:

1. **Loss of revenue:** $_____
2. **Costs which will be incurred to find a replacement:** $_____
3. **Cost of temporary replacement staff:** $_____
4. **Key person's share of ownership:** $_____ & _____%
5. **Loss of future accounts:** $_____
6. **Other (please provide additional detail):** $_____

Declaration (The Applicant must read this before signing) I am aware that the policy wording contains exclusions in coverage in respect of AIDS, HIV, suicide, alcohol and drugs. To the best of my knowledge and belief the information provided in connection with this application, whether in my own hand or not, is true and I have not withheld any material fact. I understand that non-disclosure or misrepresentation of a material fact will entitle underwriters to void this insurance. (A material fact is one likely to influence acceptance or assessment of this application by underwriters.

Insured's Name: _____ Signature: _____ Date: _____

Policy Owner's Name: _____ Title: _____

Signature: _____ Date: _____