

<b>Insured Information</b> <small>(see page 2 for additional details)</small>			<b>Second Insured</b> <small>(applicable to joint policies)</small>		
Last Name	Given Name(s)	Last Name	Given Name(s)		
DOB (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F <small>Sex</small>	DOB (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F <small>Sex</small>		
Initial Underwriting Status: <input type="checkbox"/> Standard <input type="checkbox"/> Sub-Standard			Initial Underwriting Status: <input type="checkbox"/> Standard <input type="checkbox"/> Sub-Standard		
If Sub-Standard, what was the rating? _____			If Sub-Standard, what was the rating? _____		
Current Underwriting Status: <input type="checkbox"/> Standard <input type="checkbox"/> Sub-Standard			Current Underwriting Status: <input type="checkbox"/> Standard <input type="checkbox"/> Sub-Standard		
If Sub-Standard, assumed rating? _____			If Sub-Standard, assumed rating? _____		
Current Smoking Status: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker			Current Smoking Status: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker		
If Smoker, type and frequency: _____			If Smoker, type and frequency: _____		
<b>Purpose of Valuation</b>					
<input type="checkbox"/> Personal to Corporate Transfer <input type="checkbox"/> Matrimonial division of property <input type="checkbox"/> Charitable Donation <input type="checkbox"/> Corporate to Personal Transfer <input type="checkbox"/> Corporate to Corporate Transfer <input type="checkbox"/> Other: _____					
<b>Date of Valuation</b>					
Has the change of ownership already occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, date of change: _____ <small>(mm/dd/yyyy)</small>	
<b>Policy Information</b> <small>(see page 2)</small>					
Insurance Company	Policy Number	Issue Date (mm/dd/yyyy)	\$	\$	
\$	\$	\$	\$	\$	
Cash Value/Account Value	Surrender Charge	Cash Surrender Value	Adjusted Cost Base	Policy Loan	Date of values (mm/dd/yyyy)
<b>Type of Policy</b>			<b>Additional Documents Required</b> <small>(see page 2)</small>		
<input type="checkbox"/> Universal Life -Level Cost <input type="checkbox"/> Face + Funds <input type="checkbox"/> Face Only <input type="checkbox"/> Other: _____			<input type="checkbox"/> Account Statement <input type="checkbox"/> Policy summary or copy of original policy		
<input type="checkbox"/> Universal Life - Yearly Renewal Term <input type="checkbox"/> Face + Funds <input type="checkbox"/> Face Only <input type="checkbox"/> Other: _____			<input type="checkbox"/> Account statement <input type="checkbox"/> Cost schedule <input type="checkbox"/> In force illustration <input type="checkbox"/> Level cost convertibility information		
<input type="checkbox"/> Term to 100			<input type="checkbox"/> Policy summary or copy of original policy		
<input type="checkbox"/> Whole Life Non-Participating			<input type="checkbox"/> Policy summary or copy of original policy		
<input type="checkbox"/> Whole Life Participating			<input type="checkbox"/> Policy summary or copy of original policy <input type="checkbox"/> In force illustration		
<input type="checkbox"/> Term <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> Other: _____			<input type="checkbox"/> Policy summary or copy of original policy <input type="checkbox"/> Renewal premiums and expiration date <input type="checkbox"/> Convertibility illustration - Level cost UL <input type="checkbox"/> Convertibility illustration - Selected option: _____		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Policy summary or a copy of the original policy		
<b>Your Information</b> <small>(where should we send the estimate)</small>					
Name		Company		e-mail	
Phone		Fax		<input type="checkbox"/> e-mail <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Phone <small>Preferred Method to Receive Estimate</small>	
Address			City		Province
					Postal Code



## Instructions for Completing the Estimate Request Form

Return form to:  
[quotes@wallactuaries.ca](mailto:quotes@wallactuaries.ca)

### Insured Information

**Last Name and Given Name(s)** - Provide the names as they should appear on the final documents.

**Initial Underwriting Status** - If the policy being valued was rated sub-standard what was the rating? If it was a percentage rating, provide the total rating (200%), or the added rating (+100%). If the rating was a flat extra or age rating, please indicate the type and amount of the rating.

**Current Underwriting Status** - If the rating that would apply to a new policy is sub-standard the final valuation will require health records which will be reviewed by our underwriter. The collection of health information can be a lengthy process. To ensure a timely response Wall Actuaries can provide an initial estimate prior to submitting any health records. To do so, please provide an assumed rating, or provide a brief summary of any health concerns on the attached Health Information page. If the rating would be a decline, indicate **Decline** and provide a summary. A range may also be provided, and several estimates within that range will be completed.

Complete the medical release, or provide medical records. When the records are received Wall Actuaries will update the initial estimate using the actual medical information.

### Type of Policy - Additional Documents

**Account Statement** - For Universal Life policies, provide an account statement that shows the opening balance, the insurance and other charges during the period, and the closing balance.

**Policy summary or copy of original policy** - Any document that explains the policy details (death benefit, premiums, type of insurance policy, etc.).

**Cost Schedule** - For Universal Life Yearly Renewal Term policies, a schedule of the cost of insurance for all future years. This is generally found as an appendix in the original policy.

**Level cost convertibility information** - Provide an illustration of the option to convert to a level cost of insurance, if that option is available. The level cost option is generally based on the current age of the life insured and current premiums payable for a new policy issued by the insurance company.

A small number of these policies include convertibility based on premiums guaranteed at issue which are lower than premiums payable for a new policy. If so, the illustration should be based on this option.

**In force illustration** - Provide an in force illustration of the policy. This is provided on request by the insurance company.

**Renewal premiums and expiration date** - Provide the date and premium of each renewal, the expiry date of the conversion option, and the expiry date of the policy.

**Convertibility illustration - Level cost UL** - Provide an illustration of the option to convert the policy to Universal Life level cost of insurance.

**Convertibility illustration - Selected Option** - If the policy will be converted to a permanent option other than level cost UL, also provide an illustration of the permanent option that will be selected. If there are no plans to convert the policy from term please indicate **No Conversion**.

**Other** - Provide as much information as possible. After review more information may be requested.

## Health Information

Do not complete this form if there are no health concerns.

If the current underwriting status is sub-standard or unknown, health information will be required. In order to expedite the initial estimate an assumed rating may be used prior to collecting any health records. Please provide an assumed rating on page 1, or provide a brief description of health concerns here:

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After the initial estimate is provided, based on an assumed medical rating, you may decide to proceed with a new estimate using a rating based on medical records. A rating will be provided by a Wall Actuaries underwriter. Please complete the medical release below. The release may be left blank on the initial request and completed after receiving the initial estimate, or may be completed with the initial request.

## Medical Release

Doctor's Information			
Name	Company	e-mail	
( ) - Phone	( ) - Fax	<input type="checkbox"/> e-mail <input type="checkbox"/> Fax <input type="checkbox"/> Mail Preferred method to send release	
Address	City	Province	Postal Code
Patient Information			
Name	DOB (mm/dd/yyyy)		
Address	City	Province	Postal Code

I, \_\_\_\_\_ authorize the release of the medical records for the patient indicated  
Printed Name

above. This authorization shall be valid for a period of 180 days from the date of my signature.

## Signature

\_\_\_\_\_  
(Signature of Patient or Patient's Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
(if signed by someone other than the patient,  
state your relationship to the patient/authority)