CERTIFICATE OF SHORTENED LIFE EXPECTANCY

TO: The BMO Trust Company
(the Trustee)

AND TO: BMO InvestorLine Inc.
(the Agent)

This certificate is made with respect to

____ (the Patient)

INSERT FULL NAME OF PATIENT

Address of Patient

____

____

Birth Date of Patient ____________________________ (MM/DD/YYYY)

Plan Type ___________________

Governing Jurisdiction ___________________________

(LIF / LRIF / LIRA / LRSP)

NOTE: Where the governing jurisdiction is British Columbia, Alberta, Saskatchewan, Manitoba, Ontario or Newfoundland, the Patient must also obtain a spousal waiver before the locked-in funds are released.

I hereby certify the following:

1. I am a physician licensed to practice in the Province of ____________________ since ___________ (MM/YYYY).

I am licensed to practice the following types of medicine ____.

BMO InvestorLine®

2. The Patient has been my patient since ___________________________(MM/YYYY) and the extent of my treatment of the Patient has been sufficient to enable me to make the diagnosis contained in paragraph 3 of this Certificate.

3. Complete the appropriate paragraph a), b), c) or d) and cross out the paragraphs which do not apply.

a) IF THE FUNDS ARE GOVERNED BY LEGISLATION IN ANY PROVINCE OTHER THAN ALBERTA, BRITISH COLUMBIA, MANITOBA OR ONTARIO:

The Patient is suffering from the following disability ____________________________ (insert type of disability).

This is a significant _______________________(insert either physical or mental) disability, which considerably shortens the life expectancy of the Patient.

b) IF THE FUNDS ARE GOVERNED BY ALBERTA LEGISLATION:

The Patient is suffering from the following terminal illness

____

(insert type of terminal illness) OR

The Patient is suffering from the following disability _____________________________ (insert type of disability).

This is a significant _______________________(insert either .physical. or .mental.) disability, which considerably shortens the life expectancy of the Patient.

c) IF THE FUNDS ARE GOVERNED BY BRITISH COLUMBIA LEGISLATION:

The Patient is suffering from the following physical disability

____________________________________ (insert type of disability).

This is a significant physical disability, which considerably shortens the life expectancy of the Patient.

d) IF THE FUNDS ARE GOVERNED BY MANITOBA OR ONTARIO LEGISLATION:

The Patient is suffering from the following terminal illness

____________________________________ (insert type of terminal illness)

OR

The Patient is suffering from the following physical disability

_____________________________ (insert type of disability).

This is a significant physical disability, which is likely to shorten the life expectancy of the Patient to less than two years.

I understand that the Trustee and the Agent are relying upon this certificate in order to pay to the Patient locked in pension funds, which could not be paid without this certificate.

Dated this _____________ of _____________________________, ____________.

(DATE) (MONTH) (YEAR)

Signed in the Presence of:

______________________________ ________________________________

Signature of Witness — Signature of Physician

PRINT — PRINT

Name: __________________________ Name:______________________________

Address: ________________________ Address: _____________________________

__________________________ ______________________________