July 2018 version

Pillar Series

Income Protection

Application

F002 (07-2018)

Application No.: 11665271

In this application, "the Insurer" means La Capitale Financial Security Insurance Company.

Contract No.: Leave this blank

1 BASIC INFORMATION

1.1 Language of correspondence: ☐ English ☐ French

1.2 Indicate if this is: ☐ a new application OR ☐ additional coverage to existing contract No.: ____________

1.3 Should any contract resulting from this application be issued at the same time as another contract? ☐ Yes ☐ No

If so, indicate the number of the other application: ____________

1.4 **REASON FOR APPLICATION**

☐ External replacement ⚠ **Complete and attach the prior notice of replacement.**

☐ Internal replacement Contract numbers being replaced: ____________

⚠ **Complete and attach the prior notice of replacement and a request to cancel the existing insurance.**

2 GENERAL INFORMATION

2.1. POLICYHOLDER/INSURED'S INFORMATION

Last name ____________ First name ____________ Last name at birth (if different) ____________

Gender: ☐ Male ☐ Female Date of birth: Year Month Day S.I.N.:

Marital status ____________ Country of birth ____________ In Canada since: Year Month

Status: ☐ Canadian citizen ☐ Permanent resident ☐ Temporary resident ☐ Other: ____________

Address (No., street) ____________ Apt. ____________

City ____________ Province ____________ Postal code ____________

Country ____________ Email address ____________

Home tel. ____________ Work tel. ____________ (extension) ____________ Cell tel. ____________

2.2 VERIFICATION OF POLICYHOLDER/INSURED'S IDENTITY

Health insurance cards cannot be used in the following provinces: Ontario, Manitoba and Prince Edward Island. In Quebec, health insurance cards cannot be required for identification purposes but if a policyholder/insured chooses to present one, it can be accepted.

ID Use original documents only.

☐ Driver's licence ☐ Passport ☐ Health Insurance card

☐ Other photo ID issued by a federal or provincial government: ____________

Document No.: ____________ Province or country of issue: ____________

Expiry date (if available): Year Month Jurisdiction of issue: ____________

3 CHOICE OF COVERAGE (This section must always be completed)

3.1 Indicate the same coverage as in the Illustration: ☐ Disability ☐ Safe Driver ☐ Hospital Care

3.2 Indicate the annual payment for all coverage and riders mentioned in the Illustration: $ ____________

The premium may be subject to a provincial sales tax, if applicable.

I, the policyholder/insured, acknowledge that I have read the document entitled Illustration and agree to its contents. I confirm that the annual payment mentioned above corresponds to the annual payment mentioned in the Illustration.

Signed at ____________ on this ______ day of ____________ 20 ______.

POLICYHOLDER/INSURED'S SIGNATURE

✗ ____________

Policyholder/insured's signature

ADVISOR'S SIGNATURE

✗ ____________

Advisor's signature

⚠ **THE ILLUSTRATION THAT THE POLICYHOLDER/INSURED CONFIRMS HAVING READ MUST BE ATTACHED TO THE APPLICATION SENT TO THE INSURER.**

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4 BENEFICIARY INFORMATION (For the **Accidental Death** rider or **Safe Driver** coverage)

A beneficiary is not designated: If a beneficiary is not designated, any benefit will be paid to the policyholder/insured's estate.

Revocable and irrevocable beneficiaries: A beneficiary designation is revocable unless otherwise indicated. However, in Quebec if the named beneficiary is the person to whom the policyholder/insured is married or civilly united, this designation is considered irrevocable unless the policyholder/insured indicates that he or she wishes for the designation to be REVOCABLE.

Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, or carry out certain changes or transactions, the beneficiary's consent must be obtained. A minor irrevocable beneficiary cannot consent to a change or transaction, and the minor irrevocable beneficiary's parents and legal guardian are also unable to sign a document in that regard on his or her behalf.

Minor beneficiary: Outside Quebec, if a minor is the designated beneficiary, it is recommended that a trustee also be designated. By naming a trustee, the benefit is payable to the trustee who will hold it in trust for the minor beneficiary until he or she is of legal age (not applicable in Quebec). In Quebec, the minor beneficiary's legal guardian will receive the payable benefit unless an official trustee has been named.

Estate, successors and legal heirs: The terms "estate", "successors" or "legal heirs" refer to the policyholder/insured's estate, successors or legal heirs.

BENEFICIARY

Last name	First name	Date of birth (Year / Month / Day)	Relationship to the policyholder/insured	Check one: Revocable	Check one: Irrevocable	Share % Total: 100%
				☐	☐	
				☐	☐	

5 PERSONAL INFORMATION

5.1 OTHER INSURANCE IN FORCE OR PENDING

Do you currently hold life, critical illness or accident or sickness disability insurance (including group or union insurance) or have a pending application for any of these types of insurance? ☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

Company name	Year and month issued (check if pending): Year	Month	Pending	Life Insurance and Critical Illness Insurance: Insured amount	Accidental Death: Yes	No	DISABILITY: Monthly benefit	Elimination period: Accident	Elimination period: Sickness	Benefit period: Accident	Benefit period: Sickness	Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required.
			☐	$	☐	☐	$					☐ Yes ☐ No
			☐	$	☐	☐	$					☐ Yes ☐ No

5.2 PREVIOUS INSURANCE COVERAGE

Have you ever had a life (**LIFE**), critical illness (**CI**) or accident or sickness disability (**DI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium? ☐ Yes ☐ No **If so**, provide details of these applications.

Year	Month	LIFE	CI	DI	Company name	Decision	Reason
		☐	☐	☐			
		☐	☐	☐			

5.3 PREVIOUS INSURANCE COVERAGE WITH LA CAPITALE FINANCIAL SECURITY INSURANCE COMPANY

Have you ever been insured by La Capitale Financial Security Insurance Company? ☐ Yes ☐ No

5.4. TOBACCO USE

In the last 12 months, have you smoked cigarettes, cigarillos, cigars, a pipe, a bong, a hookah or used betel nut, snuff or marijuana (cannabis) containing any tobacco or nicotine product or used any other form of tobacco or a substitute such as gum, nicotine patch or electronic cigarette? ☐ Yes ☐ No **If so**:

Type	Quantity	Frequency

If you quit smoking in the last 12 months, indicate the date: Year Month

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6 EMPLOYMENT AND INCOME INFORMATION

6.1 EMPLOYMENT INFORMATION

Fill the *Occupation and Income Questionnaire (IND175E)* for any additional occupation.

SALARIED EMPLOYEE

6.1.1 Occupation: ____________________

6.1.2 Duties: ____________________

6.1.3 Employer's name: ____________________

6.1.4 Employer's address: ____________________

____

6.1.5 Number of years with current employer: ________

6.1.6 Number of years of related experience: ________

6.1.7 Number of hours worked per week: ________

6.1.8 Number of months worked per year: ________

6.1.9 What percentage of your work is:

- Driving ________%
- Supervision ________%
- Office or administrative work ________%
- Manual work ________%
- Other: ____________________ ________%

6.1.10 What percentage of your work is done:

- At home ________%
- Away from home ________%

6.1.11 Gross annual income in the current year: $ ____________

6.1.12 Do you pay Employment Insurance premiums? ☐ Yes ☐ No

6.1.13 a) Have you declared bankruptcy in the last 5 years? ☐ Yes ☐ No

b) **If so**, indicate the date you were discharged from bankruptcy: Year Month Day

6.1.14 Request for guaranteed benefit? ☐ Yes ☐ No

If so, provide your income tax declarations for the last 2 years and go to Section 7.

If not, go to Section 6.2.

SELF-EMPLOYED AND BUSINESS OWNER

6.1.1 Occupation: ____________________

6.1.2 Duties: ____________________

6.1.3 Business name: ____________________

6.1.4 Business address: ____________________

____

6.1.5 Number of years in business: ________

6.1.6 Number of years of related experience: ________

6.1.7 Type of business: ☐ Sole owner ☐ Corporation ☐ Partnership

6.1.8 Number of employees:
Full-time: ______ Part-time: ______ Seasonal: ______

6.1.9 Number of hours worked per week: ________

6.1.10 Number of months worked per year: ________

6.1.11 What percentage of your work is:

- Driving ________%
- Supervision ________%
- Office or administrative work ________%
- Manual work ________%
- Other: ____________________ ________%

6.1.12 What percentage of your work is done:

- At home ________%
- Away from home ________%

6.1.13 What is the percentage of the policyholder/insured's interest in the company? ________%

6.1.14 Do you pay Employment Insurance premiums? ☐ Yes ☐ No

6.1.15 a) Have you (you or your business) declared bankruptcy in the last 5 years? ☐ Yes ☐ No

b) **If so**, indicate the date you were discharged from bankruptcy: Year Month Day

6.1.16 Request for guaranteed benefit? ☐ Yes ☐ No

If so, provide T1 General income tax forms and business financial statements for the last 2 years or the company's Statement of Business or Professional Activities, as applicable, and go to Section 7.

If not, go to Section 6.2.

6.2 INCOME INFORMATION

SALARIED EMPLOYEE

	Year:	Year:
Gross annual income earned in the last 2 years:	$	$

SELF-EMPLOYED AND BUSINESS OWNER

Net annual income in the last 2 years:[1]

If applying for a monthly benefit of $3,000 or more, provide T1 General income tax forms and business financial statements for the last 2 years or the company's Statement of Business Activities, as applicable.

	Year:	Year:
Net business profit[2]	$	$
In the case of a corporation, the salary paid to the policyholder/insured by the company, if applicable	+ $	+ $
Net annual income	= $	= $

1. If less than 12 months' income earned, indicate number of months when income was earned: ______ months
2. Net business profit based on the policyholder/insured's shares = shares percentage × (business income before taxes − business expenses that are deductible for income tax purposes)

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7 QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE
(Answer these questions only if the **Sickness Disability** rider is being applied for.)

		POLICYHOLDER/ INSURED Yes	POLICYHOLDER/ INSURED No
7.1	Have you ever consulted for, been treated for or shown signs or symptoms of the following? Heart or blood vessel disease, heart attack, chest pain, diabetes, cancer or tumours, transient ischemic attacks, stroke (cerebrovascular accident) or chronic kidney, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, loss of speech, loss of limbs, coma, severe burns, AIDS or HIV infection.	☐	☐
7.2	In the last 2 years, have you had any symptoms of or treatment for any medical condition that resulted in hospitalization (for any reason other than a pregnancy or childbirth)?	☐	☐
7.3	Have you had an application for individual or group life, disability, critical illness or long-term care insurance declined, deferred, modified, cancelled or rated with a higher premium?	☐	☐
7.4	In the last 90 days, have you been admitted or been advised to be admitted to a hospital or other medical facility (for any reason other than a pregnancy or childbirth)?	☐	☐
7.5	In the last 2 years, have you: a) been treated for or had any symptoms of disease or disorder of the neck, back or spine?	☐	☐
	b) been treated or counselled for anxiety, stress, "burnout", depression, chronic fatigue or an emotional, behavioural, mental or nervous disorder?	☐	☐
	c) been absent from work for more than 15 consecutive days as a result of an injury or sickness?	☐	☐
7.6	Are you unable to perform any duties of your present occupation because of injury or sickness?	☐	☐

8 PREMIUM PAYMENT

8.1 PAYMENT METHOD SELECTION

☐ Annual ☐ Semi-annual ☐ Preauthorized debit (PAD) ⚠ **Complete Section 9.** ⚠ **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**

8.2. SELECT PAYMENT METHOD FOR THE INITIAL PAYMENT

☐ Cheque attached to this application $____________ Cheque must be made out to La Capitale Financial Security Insurance Company.

☐ Credit card ⚠ **Complete Section 8.3.**

☐ Cheque to be received on policy delivery. ⚠ **If this option is selected, the Conditional Certificate of Temporary Insurance does not apply.**

☐ Payable by PAD Available only if the selected method of premium payment is PAD.

8.3 INITIAL PAYMENT BY CREDIT CARD

8.3.1 Notice

Section 8.3.2 below, which only contains information regarding the credit card used as the initial payment method, will be voluntarily deleted from this document prior to being filed in the Insurer's records. This is done for purposes of confidentiality and compliance with applicable laws and rules. The deletion of Section 8.3.2 does not constitute an alteration of this document of any kind whatsoever. The parties therefore agree that despite the deletion of Section 8.3.2, this document represents the entire and complete agreement between the parties with respect to its subject matter.

8.3.2 Authorization

☐ Visa
☐ MasterCard
☐ American Express

Credit card number: ____________________ Expiry date: ____ Month Year

Authorization No. Reserved for the Administration

I authorize the Insurer to charge the initial payment of $____________ to the above-mentioned credit card. Upon receipt of this authorization, the Insurer will request the necessary authorization from the credit card issuer. If such authorization is obtained from the credit card issuer, the credit card will be charged. In the event the premium is increased after my application is reviewed, I authorize the Insurer to charge the additional amount to the credit card. In the event the initial premium is decreased, the Insurer will reimburse any excess by cheque.

✗ ____________________ ____________________ ____________________
Credit cardholder's signature | Credit cardholder's name | Date

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9 PREAUTHORIZED DEBIT (PAD) AGREEMENT

9.1 PREMIUM PAYOR INFORMATION

☐ Policyholder/insured ☐ Other: ☐ Mr. ☐ Ms. ______ First name (please print) ______ Last name (please print)

______ Address (No., street, apt., city, province) ______ Postal code

______ Tel. Date of birth: ______ Year Month Day

☐ Business: ______ Name of business ______ Tel.

______ Address (No., street, unit, city, province) ______ Postal code

9.2 BANK ACCOUNT INFORMATION: ☐ Cheque specimen attached to the application ☐ Bank account information provided below:

⑈243⑈ ⑆00005⑉123⑆ 12345⑉123456⑈

Branch number | Financial institution number | Account number

______ Branch number ______ Financial institution number ______ Account number

9.3 PAD TYPE: ☐ Personal ☐ Business

9.4 WITHDRAWAL DATE: The ______ of each month (between the 1st and 30th day of the month). If a date is not indicated, it will be selected by the Insurer.

9.5 WAIVER: I waive my right to receive advance notice of the amount and the date of the PAD and of any change to the amount and the date.

9.6 CANCELLATION: This agreement may be cancelled upon receipt by the Insurer of 10 days' written notice prior to the scheduled date of the next PAD. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement, contact your financial institution or visit www.cdnpay.ca.

9.7 RECOURSE AND REIMBURSEMENT: 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 about your recourse rights, contact your financial institution or visit www.cdnpay.ca.

9.8 AUTHORIZATION: I authorize the Insurer or its agent to debit the fixed monthly amounts required for payments due to the Insurer from the account indicated on the enclosed cheque specimen or from the account identified above.

Signed at ______ on this ______ day of ______ 20 ______.

SIGNATURE OF PREMIUM PAYOR

✗ ______
Signature of premium payor

La Capitale Insurance and Financial Services
625 Jacques-Parizeau St, Quebec QC G1R 2G5
Tel.: 418 528-2211 or 1 800 463-4433
Email: fim@lacapitale.com

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10 AUTHORIZATION TO DISCLOSE INFORMATION TO THE ADVISOR OR TO THE GENERAL AGENT

The policyholder/insured authorizes the Insurer to disclose to the advisor or to the general agent personal information collected in the application or during the underwriting process that may affect the premium rate or contract issuance. This information generally includes the results of medical or laboratory tests, medical, employment and alcohol or drug consumption history, criminal record, financial information or any other information considered when evaluating the application.

The Insurer may decide not to disclose this information to the advisor or the general agent even if this Authorization has been signed.

This Authorization will remain valid for 45 days after the contract is issued or a notice that the application was declined has been sent. This Authorization may be cancelled at any time by sending written notice to the Insurer.

Signed at ______________________________ on this ______ day of ______________________ 20 ______.

POLICYHOLDER/INSURED'S SIGNATURE

____
Policyholder/insured's signature

11 DECLARATIONS AND APPLICATION SIGNATURES

The policyholder/insured hereby declares that all of the answers and explanations given in this application and, where applicable, in any other related form including in any telephone or face-to-face interview, are true and complete, in the knowledge that the Insurer shall base any decision to issue the contract on this information.

Subject to the general conditions of the contract and the conditions of the Conditional Certificate of Temporary Insurance, if issued, the policyholder/insured agrees that all insurance shall become effective on the date on which the Insurer accepts this application, provided that it is accepted without modification, that the initial payment has been completed and that there have been no changes in the insurable risk of the policyholder/insured since the application was signed.

The policyholder/insured acknowledges having read and having receive a copy of the illustration containing information about the coverage applied for, including guaranteed and non-guaranteed elements and any applicable restrictions, reductions and exclusions. The policyholder/insured acknowledges that his or her advisor has provided satisfactory explanations.

If the Conditional Certificate of Temporary Insurance was issued, the policyholder/insured acknowledges having read and understood it.

The policyholder/insured acknowledges having received and read the MIB, Inc. notice, the notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews and the Personal Information Protection Notice.

Signed at ______________________________ on this ______ day of ______________________ 20 ______.

POLICYHOLDER/INSURED'S SIGNATURE

____
Policyholder/insured's signature

ADVISOR'S SIGNATURE

____
Advisor's signature

Contract No.: Leave this blank

12 AUTHORIZATION

1. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of determining my insurability, managing my file and considering my claims. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., for such purposes.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
3. In case of death, I expressly authorize the beneficiary, the heirs or the liquidator of my estate to provide the Insurer or its assigns, when required, with any information or authorizations needed to process my file.
4. A photocopy of this authorization shall be considered as valid as the original.

Signed at ______________________________ on this ______ day of ______________________ 20 ______.

POLICYHOLDER/INSURED'S SIGNATURE

____
Policyholder/insured's signature

ADVISOR'S SIGNATURE

____
Advisor's signature

La Capitale Financial Security Insurance Company (the Insurer)

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7150 Derrycrest Drive
Mississauga ON L5W 0E5

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13 CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE

To be given to the policyholder/insured

The Conditional Certificate of Temporary Insurance (the Certificate) guarantees limited insurance coverage while the insurance application identified by the number at the bottom of this page is being reviewed by the Insurer. Being covered by the Certificate does not guarantee that the application will be accepted.

Effective date of the Certificate

The Certificate shall be effective when the following conditions are met:

– for the **sickness disability rider,** the policyholder/insured must have answered No to the questions for the Conditional Certificate of Temporary Insurance;

– the answers and explanations given in this application, any other form and interview must be complete and accurate;

– the first annual or semi-annual payment has been made or the Preauthorized Debit (PAD) Agreement has been duly completed and signed; and

– the policyholder/insured must not have asked that the contract's effective date be set for a specific subsequent date.

Subject to the above-mentioned terms and conditions, the Certificate shall be effective **on the later of the following dates**:

– the signature date of the duly completed application; or

– the date of completion of the last test, exam or telephone interview or declaration or form required prior to reviewing the application.

Termination of Certificate

The temporary coverage provided under this Certificate shall be terminated **on the earliest of the following events**:

– the effective date of the requested contract;

– the date a counteroffer is sent by the Insurer to the advisor;

– the date a notice is sent by the Insurer to the policyholder/insured declining the requested contract;

– the date a notice is sent by the Insurer to the advisor or to the policyholder/insured regarding its decision to terminate this Certificate;

– the date on which the policyholder/insured requests cancellation of the application; or

– the 60th day following the effective date of the Certificate.

Terms and exclusions

The Certificate does not apply to the following benefits and riders: Hospital Care, Safe Driver, Accident Hospitalization, Sickness Hospitalization, Accidental Death and Dismemberment, Accidental Fracture and the Future Insurability Option.

If the policyholder/insured enters a state of total disability while the Certificate is in force, the Insurer shall review his or her file according to its usual underwriting criteria without considering any changes in the nature of the policyholder/insured's insurable risk which may have occurred following the effective date of the Certificate. Therefore, in the event that, on the effective date of the Certificate, the Insurer would have issued a benefit covered by this Certificate, without any restrictions, exclusions or changes, the benefit shall be issued in accordance with the application.

If a benefit is issued pursuant to this Certificate, it shall be issued under the same terms and exclusions as the requested coverage, including the elimination period, subject to the terms and exclusions of the Certificate, with the latter taking precedence.

If the policyholder/insured does not enter a state of total disability while the Certificate is in force, any changes in the nature of the insurable risk regarding the policyholder/insured which may have occurred following the signature of the application shall be taken into consideration in order to determine if a benefit covered by this Certificate will be issued and, if so, under what terms.

No benefits shall be payable under the Certificate if the policyholder/insured is under age 18 or over age 59 on the date the application is signed.

No benefits shall be payable under the Certificate in the event of misrepresentation, omission, concealment or fraud in the application or any other related document.

The monthly total disability benefit payable under the Certificate, or any other certificate in force with the Insurer, corresponds to the lesser of:

– the monthly benefit amount requested MINUS any portion of the monthly benefit amount requested as a result of replacement of contracts in force with the Insurer; or

– $2,000 per month.

No advisor may amend the terms of this Certificate.

In the event of a claim, the Insurer shall validate the eligibility of the policyholder/insured.

Signed at ______________________ on this ______ day of ______________ 20 ______.

ADVISOR'S SIGNATURE

✗ ______________________

Advisor's signature

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La Capitale Financial Security Insurance Company (the Insurer)

14 NOTICE

To be given to the policyholder/insured

14.1 – MIB, Inc. Notice

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including the Insurer, work with an organization called the MIB, Inc. (MIB).

Any information regarding your insurability will be treated as confidential. However, the Insurer and its reinsurers may forward a summary of such information to MIB, a not-for-profit organization formed by life insurance companies. This organization enables information to be exchanged among member companies.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB will, upon request, supply such company with information in its files.

The Insurer, or its reinsurers, may also disclose the information held in its files to other life insurance companies to which you may submit an application for life or health insurance, or to which a claim may be submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the US Fair Credit Reporting Act. MIB's address is:

MIB, Inc.
330 University Ave, Suite 501
Toronto ON M5G 1R7
Tel.: 416 597-0590
www.mib.com

MIB receives personal information, and the collection, use and communication of such information are governed by the *Personal Information Protection and Electronic Documents Act* and other provincial legislation. Consequently, MIB safeguards personal information in a manner consistent with standard corporate privacy practices and in accordance with applicable legislation, and information may only be disclosed in accordance with the provisions of the legislation. If you have any questions about how MIB safeguards and protects the confidentiality of your personal information, you can contact MIB's privacy department at privacy@mib.com

14.2 – Notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews

In order to examine your application for insurance, the Insurer may wish to obtain some additional information.

Investigation: A representative from an investigation company may contact you to ask you for some personal and financial information.

Medical examination and tests: A physician or nurse from a paramedical company may ask you to undergo a medical examination, an electrocardiogram, chest X-ray or other diagnostic tests. Blood, urine or saliva samples may be taken. These samples may be analyzed to check for the presence of HIV antibodies, also known as the AIDS virus, determine your cholesterol level and screen for liver or kidney disorders, diabetes or the presence of nicotine, narcotics or prescription drugs.

You must give written consent before any samples are taken.

Your cooperation in ensuring any medical appointments are scheduled without delay is greatly appreciated.

Telephone or face-to-face interview: A telephone or face-to-face interview may be necessary to complete your application for insurance. If so, an evaluator working on behalf of La Capitale will contact you to schedule an appointment for a telephone or face-to-face interview, using the information given in the application. The interview will take from 20 to 30 minutes and you will be asked questions concerning your medical history (complete contact information of physicians you consulted in the last five years, a list of your medications, your height and weight, etc.), your pastimes and lifestyle habits. Please have this information handy. The evaluator will not be able to let you know if you are eligible or not after the interview. The information obtained in the interview will be included with that stated in the application as well as any received from your physician.

14.3 – Notice Concerning the Protection of Personal Information

At La Capitale, we respect your privacy, because we know how important it is to keep your personal information confidential and secure. That is why we have adopted a Personal Information Protection Policy and implemented safeguards to protect your personal information. We collect and use your personal information to manage your Insurance, Annuity, and Credit Financial Services or Related Services insurance file. Your personal information is stored at our offices and protected by high security measures in accordance with the laws and regulations applicable to the protection of personal information. Only our employees, mandataries, distribution partners (such as agents and their firms) and service providers may access your personal information, and solely when such access is required to perform their duties, carry out their mandate or fulfil their service contract. La Capitale may do business with service providers based outside of Canada. It is therefore possible that some of your personal information held by La Capitale may be stored outside of Canada and governed by the laws of foreign countries or states.

If you would like to access your file or make a correction to it, make your request in writing to the following address:

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive
Mississauga ON L5W 0E5

15 TELEPHONE INTERVIEW OR MEDICAL REQUIREMENT ORDERS

15.1. TELEPHONE INTERVIEW ORDER

Indicate the best time of day to reach the policyholder/insured.

	1ST CHOICE	2ND CHOICE
Day of the week:		
Time of day:	☐ morning ☐ afternoon ☐ evening	☐ morning ☐ afternoon ☐ evening
	Tel. (extension)	Tel. (extension)

☐ **Telephone interview to be ordered by the Insurer**

☐ **Telephone interview ordered from Dynacare by the advisor** To order a telephone interview from Dynacare, please dial 1 800 361-3771.

Date ordered: Year Month Day Order confirmation No.:

15.2 MEDICAL REQUIREMENTS ORDER

☐ HIV urine ☐ Blood profile ☐ Vital signs

☐ **Medical requirements to be ordered by the Insurer**

☐ **Medical requirements ordered by the advisor**

Date ordered: Year Month Day Order confirmation No.:

Medical requirements ordered from: ☐ ExamOne ☐ Dynacare

☐ **Medical requirements ordered by another insurer** – Specify the other insurer:

16 ADVISOR'S REPORT

16.1 Who initiated the application process? ☐ Advisor ☐ Policyholder/insured ☐ Acquaintance ☐ Another advisor ☐ Other:

16.2 Does the policyholder/insured speak or read the application language? ☐ Yes ☐ No

If not, who explained the application content to the policyholder/insured?

In your opinion, did he or she understand the explanations? ☐ Yes ☐ No Provide any applicable details:

16.3 Did you complete this application in the presence of the policyholder/insured? ☐ Yes ☐ No

If not, explain:

16.4 Are you aware of any information that was not included in the application that could affect the underwriting process with regard to the policyholder/insured? ☐ Yes ☐ No **If so**, explain:

16.5 How long have you known the policyholder/insured?

16.6 What is the relationship between you and the policyholder/insured?

16.7 Have you completed and given the Conditional Certificate of Temporary Insurance to the policyholder/insured? ☐ Yes ☐ No

16.8. ADVISOR'S INFORMATION

Advisor's name | Advisor's code | General agent | General agent's code

Email address to be used by the Insurer to obtain any additional information

16.9 COMMISSION STRUCTURE

Does not apply if the general agent has chosen a specific commission structure.

☐ Level ☐ High-low

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16 ADVISOR'S REPORT (cont.)

16.10 COMMISSION SPLIT

Is the commission to be shared? ☐ Yes ☐ No **If so**, provide information on how the commission is to be shared.

Advisor's name	Advisor's code	Split	General agent	General agent's code
		%		
		%		
		%		
		%		

16.11 SPECIAL INSTRUCTIONS

16.12 ADVISOR'S DECLARATION

I hereby declare that the information provided in this section is true.

I hereby declare that the benefits and riders mentioned in the Illustration attached to this application are the ones selected by the policyholder/insured. I further declare that I have provided all necessary explanations to the policyholder/insured.

I hereby confirm that I have disclosed in writing the names of the companies that I represent, the fact that I am compensated by commission on the sale of insurance products and that I may receive additional compensation in the form of bonuses, convention participation or other incentives, as well as any potential conflicts of interest with regard to this sale.

I declare that I hold all necessary licences and certificates for selling the insurance being applied for in the province or territory where it is being purchased.

In signing, I confirm that to the best of my knowledge all the information provided in this insurance application is complete, accurate, and up-to-date.

Signed at ______________________ on this ______ day of ______________________ 20 ______.

ADVISOR'S SIGNATURE

X ______________________

Advisor's signature

INSTRUCTIONS FOR THE ADVISOR

- All required signatures must be entered.
- Any corrections or changes made to the application must be initialled by the policyholder/insured.
- Give the policyholder/insured the notices (section 14).
- Submit all of the application form pages except the pages that must be given to the policyholder/insured.

ATTACH THE FOLLOWING DOCUMENTS, AS APPLICABLE	
In all cases	☐ Illustration
Replacement	☐ Prior notice of replacement ☐ Request to cancel existing insurance
PAD method of payment	☐ Preauthorized Debit (PAD) Agreement (Section 9) ☐ Cheque specimen or bank information. ⚠ **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**
Annual or semi-annual method of payment	☐ Cheque made out to La Capitale Financial Security Insurance Company. ⚠ **If the cheque is received upon delivery of the policy, the Conditional Certificate of Temporary Insurance does not apply.**

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