Safe Driver
Application Form

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

Indicate if this is: ☐ a new application form ☐ a reinstatement OR
☐ an additional coverage to existing contract

Contract No. Leave this blank if this is a new application form

1 POLICYHOLDER/INSURED'S INFORMATION

Language of correspondence ☐ English ☐ French	Sex ☐ Male ☐ Female	Last name	First name

Last name at birth (if different)	Age[1]	Date of birth[1] Year Month Day

Address (No., street)	Apt.

City	Province	Postal code	Home tel.

☐ Cell tel. ☐ Work tel. (extension)	Email address

Occupation	Height ______ cm / ______ ft. ______ in.	Weight ______ kg / ______ lbs.

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

2 VERIFICATION OF POLICYHOLDER/INSURED'S IDENTITY

ID (Original documents only) ☐ Passport ☐ Driver's licence ☐ Health Insurance card (except Ont., Man., P.E.I.) ☐ Other photo ID issued by a federal or provincial government: ______	Document No.

Expiry date (if available) Year Month	Jurisdiction of issue	Province or country of issue

3 ELIGIBILITY

To be eligible for Safe Driver, the policyholder/insured needs to be able to answer *NO* to questions 1, 2, 3 and 4.

Question	Answer
1. In the last 3 years, have you been convicted of driving while intoxicated or been charged with careless/dangerous driving?	☐ Yes ☐ No
2. Are you a driver of an ambulance, city bus, taxi or transportation service such as, but not limited to, Uber, Lyft, limo or tow truck as your current occupation? Or are you a paramedic, fire fighter, or a police officer?	☐ Yes ☐ No
3. Are you currently disabled or receiving disability benefits?	☐ Yes ☐ No
4. Do you engage in competition, racing or speed contests?	☐ Yes ☐ No
5. Do you already have Safe Driver coverage or do you have an application pending for such coverage?	☐ Yes ☐ No

Note 1: The policyholder/insured must be age 16 to 80 inclusive.

4 BENEFICIARY INFORMATION (for the Accidental Death benefit)

A beneficiary is not designated: If a beneficiary is not designated, any benefits 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 named. 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). Any amount payable to a beneficiary who has reached the age of majority is payable directly to this person. 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.

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

5 PREMIUM RATE TABLE (including policy fees) AND CHOICE OF COVERAGE

SAFE DRIVER

Number of units	Coverages: Total disability (monthly benefit)	Hospitalization (daily benefit)	Accidental death	Total permanent disability benefits	Premium: Annual	Monthly
1	$200	$50	$2,500	$20,000	$72.06	$6.49
2	$400	$100	$5,000	$40,000	$114.12	$10.27
3	$600	$150	$7,500	$60,000	$156.18	$14.06
4	$800	$200	$10,000	$80,000	$198.24	$17.84
5	$1,000	$250	$12,500	$100,000	$240.30	$21.63
6	$1,200	$300	$15,000	$120,000	$282.36	$25.41
7	$1,400	$350	$17,500	$140,000	$324.42	$29.20
8	$1,600	$400	$20,000	$160,000	$366.48	$32.98

ALL ACCIDENT RIDER[2]

Monthly benefit	Annual premium	Monthly premium
$100	$62.07	$5.59
$200	$104.14	$9.37
$300	$146.21	$13.16
$400	$188.28	$16.95
$500	$230.35	$20.73
$600	$272.42	$24.52
$700	$314.49	$28.30
$800	$356.56	$32.09
$900	$398.63	$35.88
$1,000	$440.70	$39.66
$1,100	$482.77	$43.45
$1,200	$524.84	$47.24
$1,300	$566.91	$51.02
$1,400	$608.98	$54.81
$1,500	$651.05	$58.59
$1,600	$693.12	$62.38
$1,700	$735.19	$66.17
$1,800	$777.26	$69.95
$1,900	$819.33	$73.74
$2,000	$861.40	$77.53

CHOICE OF COVERAGE

Coverage	Monthly benefit		Annual premium	OR	Monthly premium
☐ Safe Driver	$	+	$	+	$
☐ All Accident Rider (Must complete Sections 6 and 7)	$		$		$
			Total annual premium		Total monthly premium
		=	$	=	$

2. If the policyholder/insured is retired, a student or a homemaker, the maximum monthly benefit is $600.

IMPORTANT: SECTIONS 6, 7, AND 8 CONCERN ONLY THE ALL ACCIDENT RIDER

6 EMPLOYMENT AND INCOME INFORMATION

6.1 Is the policyholder/insured retired, a student or a homemaker?

☐ Yes **IF YES**, proceed directly to Section 7 (non-medical Information)

☐ No **IF NO**, complete Section 6.2 before proceeding to Section 7 (non-medical Information)

THE POLICYHOLDER/INSURED MUST WORK IN AN INSURABLE OCCUPATION ACCORDING TO LA CAPITALE'S CRITERIA

6.2 **SALARIED EMPLOYEE**

Occupation: ______________________

Duties: ______________________

Employer's name: ______________________

Employer's address: ______________________

____

Number of years with current employer: __________

Number of hours worked per week: __________

Number of months worked per year: __________

Gross annual income: $ ______________

SELF-EMPLOYED AND BUSINESS OWNER

Occupation: ______________________

Duties: ______________________

Business name: ______________________

Business address: ______________________

____

Number of years in business: __________

Number of years of related experience: __________

Number of hours worked per week: __________

If less than 30 hours worked per week, provide explanation:

____

____

Number of months worked per year: __________

Net annual income: $ ______________

7 NON-MEDICAL INFORMATION

If any of the questions are answered "Yes" (except questions 1 and 5), complete the appropriate section of the additional questionnaire available in the illustration software or on lacapitale.com.

		Yes	No
Alcohol	1. Do you drink alcohol?	☐	☐
	If yes, current weekly consumption (number of glasses of beer, wine and/or spirits). ______		
	2. Has your consumption of alcohol changed in the last 5 years?	☐	☐
	3. Have you ever received treatment or counselling for alcoholism, alcohol abuse or have you been advised by a physician to reduce your alcohol consumption?	☐	☐
Bankruptcy	4. Have you declared bankruptcy in the past 5 years?	☐	☐
	If so, indicate the date you were discharged from bankruptcy: ______		
Criminal record	5. Have you ever been charged with or found guilty of any criminal offence or are you awaiting the outcome of proceedings for a criminal offence?	☐	☐
	If yes, specify the type, date, sentence and probation for each offence. ______		
Driving record	Within the last 3 years:		
	6. Has your driver's licence been suspended or revoked?	☐	☐
	7. Have you been found guilty of 3 or more violations of the Highway Safety Code?	☐	☐
Drug use	8. Do you take, or have you ever taken, drugs?	☐	☐
Hazardous sports	9. Do you plan to take part in or, in the last 5 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity?	☐	☐

8 MEDICAL INFORMATION

Medical information

Check YES or NO. Provide details for each YES answer in the "Explanations" section below.

	Yes	No
1. Are you currently taking any medication?	☐	☐
2. Within the last 5 years, have you been hospitalized?	☐	☐
3. Within the last 5 years, have you been advised to have a diagnostic test or undergo surgery that has not yet been done or has been done but the results not yet received?	☐	☐
4. Within the last 5 years, have you received disability benefits from any source whatsoever?	☐	☐

Explanations

To be completed for each of the YES answers in the previous section. If you need extra space, attach an extra sheet to this questionnaire and ensure it is signed and dated by the proposed insured.

Question No.	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited, name of medication, dose, reason for medication.

8 MEDICAL INFORMATION (CONT.)

Height and weight

Height: ☐ cm ☐ ft./in. ______ Weight: ☐ kg ☐ lb. ______

Have you lost 4.5 kg (10 lb.) or more in the last year? ☐ Yes ☐ No

If yes, number of kg (lb.) lost: ______ ☐ kg ☐ lb.

Reason: ______

Personal physician

Name of physician

Address

Tel. (extension)

Last physician consulted, if different

Date of last consultation: Year Month Day

Reason

Results (consultations or treatments recommended)

9 PAYMENT

9.1 SELECT PAYMENT METHOD

☐ Annual ☐ Preauthorized debit (PAD) Complete Section 11.

9.2 SELECT PAYMENT METHOD FOR THE INITIAL PAYMENT

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

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

☐ Credit card Complete Section 10. Note for the advisor: If the form is sent to the Insurer electronically, have Section 10 completed, but **do not include the card number**. A Customer Service agent will contact the policyholder/insured to obtain the number.

10 PAYMENT OF THE INITIAL PAYMENT BY CREDIT CARD

10.1 NOTICE

Section 10.2 below, which only contains information regarding the credit card used as the payment method for the initial payment, 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 10.2 does not constitute an alteration of this document of any kind whatsoever. The parties therefore agree that despite the deletion of Section 10.2, this document represents the entire and complete agreement between the parties with respect to its subject matter.

10.2 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

11 PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

☐ Policyholder/insured ☐ Other: ☐ Mr. ☐ Ms. ________ First name ________ Last name

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

________ Tel. Date of birth: ________ Year Month Day

☐ Business: ________ Company name ________ Tel.

________ Address (No., street, city, province) ________ Postal code

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

Branch number ________ Financial institution number ________ Account number ________

PAD TYPE: ☐ Personal ☐ Business

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

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. 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. 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. 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.

✗ ________ Signature of premium payor ________ Date

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

12 DECLARATIONS AND AUTHORIZATIONS

I hereby confirm that the information provided in this application form is true and complete, in the knowledge that the Insurer shall base its decision to approve or decline my application form on this information and I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled.

I understand that if I am eligible, the insurance shall become effective on the date on which the Insurer approves this application form, provided that the initial payment has been paid and there have been no changes in the nature of the insurable risk of the policyholder/insured since the date on which the application form was signed. I further agree that the applicable premiums shall be those that are in effect on the date on which the application form is received by the Insurer.

I agree that the suicide of the policyholder/insured during the first two years following the effective date of any life insurance benefit issued for the policyholder/insured shall cause the contract to be null and void with regard to that person and that the Insurer's only obligation shall be limited to the reimbursement of the premiums paid for this benefit.

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 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.

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.

A photocopy of this authorization shall be considered as valid as the original.

I acknowledge having read the leaflet or the illustration about Safe Driver, including guaranteed and non-guaranteed elements and any applicable exceptions and limitations. I acknowledge that my advisor has provided satisfactory explanations.

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

Policyholder/insured's signature

13 ADVISOR'S REPORT

13.1 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

13.2 COMMISSION STRUCTURE

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

☐ Level ☐ High-low

13.3 COMMISSION SPLIT

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

13.4 ADVISOR'S DECLARATIONS

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 have provided all information about Safe Driver, including guaranteed and non-guaranteed elements and any applicable exceptions and limitations.

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 form is complete, accurate, and up-to-date.

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

____
Advisor's signature

☐ Check here if you would like the insurance policy to be mailed directly to the policyholder.