La Capitale

REINSTATEMENT
INCOME PROTECTION, PILLAR SERIES

Policyholder/insured's last name

Policyholder/insured's first name

Date of birth: Year Month Day

Contract No.

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

INSTRUCTIONS

- To reinstate **Simplified Accident Insurance**, complete Sections 1 and 3.
- To reinstate **Disability Accident Only** or **Accident and Sickness Insurance**, complete Sections 2 and 3.
- To reinstate **Safe Driver Insurance with All Accident rider,** complete Sections 2 and 3. To reinstate **Safe Driver Insurance only**, do not complete this form and complete the "Safe Driver (IND105E)" application form and check the reinstatement option.

1 REINSTATEMENT OF SIMPLIFIED ACCIDENT INSURANCE

To be eligible, the policyholder/insured must be able to answer YES to Questions 1.1 and 1.2 and NO to Question 1.3 and complete the "Medical Authorization (IND178E)" form.

1.1 Do you currently work a minimum of 21 hours per week, 35 weeks per year? ○ Yes ○ No

1.2 Are you a Canadian citizen or has the Canadian government granted you permanent resident status (landed immigrant)? ○ Yes ○ No

1.3 Have you ever sustained an injury or have a current health problem that restricts your physical movements or prevents you from carrying out your daily duties? ○ Yes ○ No

2 REINSTATEMENT OF DISABILITY ACCIDENT ONLY OR ACCIDENT AND SICKNESS INSURANCE

Fill and enclose the Declaration of Insurability form required for the policy coverage type and answer questions 2.1 to 2.7 of this form.

2.1 Are you currently working full time? ○ Yes ○ No – **If No**, explain why: _____

2.2 Since the date of your last application, have you changed your occupation? ○ Yes ○ No – **If so,** provide details: _____

_____

2.3 Do you currently hold accident or sickness disability insurance (including group or union insurance) or have a pending application for this type 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	DISABILITY Monthly benefit	Elimination period Accident	Elimination period Sickness	Benefit period Accident	Benefit period Sickness	Are you applying for reinstatement to replace this insurance contract? Complete the prior notice of replacement, if required.
			☐	$					○ Yes ○ No
			☐	$					○ Yes ○ No

2.4 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
		☐	☐	☐			
		☐	☐	☐			

La Capitale Financial Security Insurance Company
625 Jacques-Parizeau St, Quebec QC G1R 2G5

IND137E (03-2018)

La Capitale

REINSTATEMENT
INCOME PROTECTION, PILLAR SERIES

2 REINSTATEMENT OF DISABILITY ACCIDENT ONLY OR ACCIDENT AND SICKNESS INSURANCE (cont.)

2.5 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

2.6 Do you pay Employment Insurance premiums? ○ Yes ○ No

2.7 **INCOME INFORMATION**

SALARIED EMPLOYEE

Gross annual income earned in the last 2 years:

Year: ____ $ _____ Year: ____ $ _____

SELF-EMPLOYED AND BUSINESS OWNER

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

	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	$ 0.00	$ 0.00

1. If less than 12 months' income earned, indicate number of months when income was earned: _____ months
2. Net business profit = business income before taxes − business expenses that are deductible for income tax purposes

3 DECLARATION AND AUTHORIZATION

- I request that the Insurer reinstate the above-mentioned policy and agree that this request is conditional on receipt by the Insurer of the duly completed declaration of insurability and on payment of the outstanding premiums and any other outstanding amount due.
- I certify that the information provided in these declarations is true.
- I agree that the reinstatement of this contract will not be effective until the date the Insurer confirms its approval of such in writing. In the event the request is declined, any amounts paid to such effect will be refunded.
- I acknowledge that the incontestability period begins anew as of the reinstatement date.
- I also acknowledge that the Insurer will only cover a loss that results from an injury sustained after the date of reinstatement or from a sickness that first manifests itself after the period provided for in the contractual clauses of any disability rider in the event of sickness attached to the policy.

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

X _____
Signature of policyholder/insured

La Capitale Financial Security Insurance Company
625 Jacques-Parizeau St, Quebec QC G1R 2G5

IND137E (03-2018)