

# Simplified Advantage Application Form



La Capitale

Note: The contract will be issued by La Capitale Civil Service Insurer Inc. (the Insurer).

Contract No.

Leave this blank

## 1 INSURED'S INFORMATION

### INSURED 1

<input type="checkbox"/> Male <input type="checkbox"/> Female	Last name	First name		
Last name at birth (if different)		Date of birth Year   Month   Day		Age at nearest birthday
S.I.N.				
Address (number and street)				
City		Province		Postal code
Telephone		Email address		Occupation (mandatory)

### INSURED 2 – Only complete the shaded sections if the address of Insured 2 differs from that of Insured 1.

<input type="checkbox"/> Male <input type="checkbox"/> Female	Last name	First name		
Last name at birth (if different)		Date of birth Year   Month   Day		Age at nearest birthday
S.I.N.				
Address (number and street)				
City		Province		Postal code
Telephone		Email address		Occupation (mandatory)

## 2 POLICYHOLDER'S INFORMATION

### Check only one box:

Insured 1 is the policyholder **OR**  Insured 2 is the policyholder

Policyholder's employer (current or past)

### VERIFICATION OF POLICYHOLDER'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 chooses to present one, it can be accepted.

**I.D.:** Use original documents only.  Driver's licence  Health insurance card  Passport  
 Other photo I.D. issued by a federal or provincial authority: \_\_\_\_\_

Document No.	Expiry date (if available) Year   Month	Issuing authority	Province or country of issue
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### VERIFICATION OF TAX CLASSIFICATION

#### Foreign Account Tax Compliance Act (FATCA)

Is the policyholder a U.S. citizen or a U.S. resident for U.S. tax purposes?  
 Yes  No **If so**, indicate policyholder's U.S. taxpayer identification number (U.S. TIN).

U.S. TIN
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#### Common Reporting Standard (CRS)

Is the policyholder a resident of a jurisdiction other than Canada or the United States for tax purposes?  Yes  No **If so**, enter policyholder's country and the foreign taxpayer identification number.

Country	Identification number
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### THIRD PARTY DETERMINATION

Is the policyholder acting in accordance with the instructions of another person (third party)?  Yes  No **If so**, complete the Third-Party Determination section of the Verification of an Individual's Identity form (IND121E).

### 3 ELIGIBILITY

You don't need to take a medical exam when applying. To be eligible, you need to be between age 40 and 80<sup>1</sup> inclusive, have a permanent Social Insurance Number (one not beginning with the figure 9) and be able to answer NO to all the questions below. If you answer YES to any of the following questions, you are not eligible for *Simplified Advantage*.

	INSURED 1	INSURED 2
1. a) During the last two years, have you had an application for life insurance declined or deferred? b) Do you currently have another life insurance application being assessed by La Capitale? c) During the next 12 months, do you intend to submit an application for another life insurance product with La Capitale?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been diagnosed or undergone treatments, including taking medication, for the following: HIV, Acquired Immunodeficiency Syndrome (AIDS) or any AIDS-related complex, amyotrophic lateral sclerosis (Lou Gehrig's disease), congestive heart failure, cystic fibrosis, Huntington's disease, organ or bone marrow transplant, Alzheimer's disease or dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been diagnosed or undergone treatments for an incurable condition that has reduced your life expectancy to less than 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you currently residing in a hospital, clinic, convalescent home or institution providing specialized care or are you confined to bed or a wheelchair, or have you been advised that this is required due to your present condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. During the last three years, have you been diagnosed, advised to undergo treatment or prescribed new medication or had the dosage of your medication changed, for angina, coronary bypass, myocardial infarction (heart attack), heart failure or cardiomyopathy, peripheral vascular disease, cerebrovascular accident (stroke), any blood disorder, other than iron-deficiency anemia, cancer (other than basal cell carcinoma), malignant tumor or leukemia, chronic kidney disease, a chronic respiratory condition requiring the administration of oxygen, liver disease (other than fatty liver), diabetic coma or insulin shock, multiple sclerosis or a primary immunodeficiency disease, attempted suicide, alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. During the last three years, have you suffered from high blood pressure (hypertension) not controlled by medication or monitored by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. With regard to the conditions mentioned in questions 2, 5 and 6, have you been investigated or have you undergone medical tests following which a diagnosis has not yet been made, or have you been advised to do so, or have you noted symptoms for which you have not consulted a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does your current weight exceed the maximum weight indicated in the table?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	HEIGHT		MALE		FEMALE	
	FEET	CM	LB	KG	LB	KG
4'10" – 4'11"		147 – 151	195	88	180	82
5'0" – 5'3"		152 – 160	208	94	191	87
5'4" – 5'6"		161 – 168	230	104	213	97
5'7" – 5'9"		169 – 175	250	113	229	104
5'10" – 6'0"		176 – 183	270	122	249	113
6'1" – 6'4"		184 – 193	291	132	274	124
> 6'4"		> 193	330	150	325	147

### 4 SMOKER STATUS

	INSURED 1	INSURED 2
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note 1: Age at nearest birthday

**5 INSURED AMOUNT SELECTION**

See the Table of Monthly Premiums for premium rates.

Select the insured amount desired from the following minimums and maximums:

- Insured age 40 to 70<sup>1</sup> when applying: \$5,000 to \$100,000
- Insured age 71 to 80<sup>1</sup> when applying: \$5,000 to \$50,000

If you are age 70<sup>1</sup> or less, the insured amount, combined with any insured amount already in force under an existing *Simplified Advantage* coverage, may not exceed \$100,000. If you are age 71<sup>1</sup> or more, the insured amount, combined with any insured amount already in force under an existing *Simplified Advantage* coverage, may not exceed \$50,000. If applicable, the portion of the premium corresponding to any amount in excess of the insurance coverage will be reimbursed.

The insured amount is doubled in the event of accidental death before age 85.<sup>1</sup>

	INSURED 1	INSURED 2
	\$ _____	\$ _____

**TABLE OF MONTHLY PREMIUMS (per \$1,000 of coverage)**

**IMPORTANT**

- Add a fixed monthly fee of \$5
- No additional fee applies when the Preauthorized Debit (PAD) premium payment method is selected
- A 7.5% discount applies when the annual premium payment method is selected

INSURED AGE 40 TO 70 <sup>1</sup> WHEN APPLYING: MINIMUM OF \$5,000 MAXIMUM OF \$100,000				
Age <sup>1</sup> when applying	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
40	\$1.77	\$2.55	\$1.47	\$2.06
41	\$1.77	\$2.56	\$1.47	\$2.07
42	\$1.78	\$2.57	\$1.47	\$2.08
43	\$1.78	\$2.59	\$1.47	\$2.09
44	\$1.79	\$2.60	\$1.47	\$2.10
45	\$1.79	\$2.61	\$1.47	\$2.11
46	\$1.84	\$2.75	\$1.51	\$2.19
47	\$1.89	\$2.89	\$1.54	\$2.27
48	\$1.94	\$3.02	\$1.58	\$2.34
49	\$1.99	\$3.16	\$1.61	\$2.42
50	\$2.04	\$3.30	\$1.65	\$2.50
51	\$2.10	\$3.52	\$1.73	\$2.65
52	\$2.17	\$3.74	\$1.81	\$2.80
53	\$2.23	\$3.96	\$1.89	\$2.96
54	\$2.30	\$4.18	\$1.97	\$3.11
55	\$2.36	\$4.40	\$2.05	\$3.26
56	\$2.56	\$4.70	\$2.18	\$3.44
57	\$2.76	\$5.00	\$2.31	\$3.62
58	\$2.96	\$5.30	\$2.44	\$3.81
59	\$3.16	\$5.60	\$2.57	\$3.99
60	\$3.36	\$5.90	\$2.70	\$4.17
61	\$3.64	\$6.31	\$2.90	\$4.43
62	\$3.92	\$6.71	\$3.10	\$4.69
63	\$4.19	\$7.12	\$3.30	\$4.95
64	\$4.47	\$7.52	\$3.50	\$5.21
65	\$4.75	\$7.93	\$3.70	\$5.47
66	\$5.15	\$8.42	\$3.95	\$5.85
67	\$5.54	\$8.90	\$4.20	\$6.22
68	\$5.94	\$9.39	\$4.44	\$6.60
69	\$6.33	\$9.87	\$4.69	\$6.97
70	\$6.90	\$10.67	\$5.22	\$7.47

INSURED AGE 71 TO 80 <sup>1</sup> WHEN APPLYING: MINIMUM OF \$5,000 MAXIMUM OF \$50,000				
Age <sup>1</sup> when applying	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
71	\$7.48	\$11.46	\$5.74	\$7.96
72	\$8.05	\$12.26	\$6.27	\$8.46
73	\$8.90	\$13.16	\$6.98	\$9.07
74	\$9.76	\$14.07	\$7.69	\$9.68
75	\$10.61	\$14.97	\$8.40	\$10.29
76	\$11.73	\$16.42	\$9.21	\$11.38
77	\$12.85	\$17.86	\$10.02	\$12.47
78	\$13.98	\$19.31	\$10.83	\$13.55
79	\$15.10	\$20.75	\$11.64	\$14.64
80	\$16.22	\$22.20	\$12.45	\$15.73

MONTHLY PREMIUM CALCULATION				
Number of increments of \$1,000	Monthly premium per \$1,000			
Insured 1	<input type="text"/>	×	\$ <input type="text"/>	= \$ <input type="text"/> <b>A</b>
Insured 2	<input type="text"/>	×	\$ <input type="text"/>	= \$ <input type="text"/> <b>B</b>
Fixed monthly fee		+	<b>\$5.00</b>	<b>C</b>
Total monthly premium (A + B + C)				= \$ <input type="text"/> <b>D</b>
ANNUAL PREMIUM CALCULATION				
				<b>D × 12 = \$ <input type="text"/> <b>E</b></b>
				7.5% discount (E × .075) = \$ <input type="text"/> <b>F</b>
				Annual premium (E - F) = \$ <input type="text"/> <b>G*</b>

\* Amount of the cheque to be enclosed

## 6 BENEFICIARY INFORMATION

**A beneficiary is not designated:** If a beneficiary is not designated, any benefit will be paid to the policyholder, if living, or to his or her 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 is married or civilly united, this designation is considered irrevocable unless the policyholder 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). 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's estate, successors or legal heirs, and not those of the insured.

	Full name of beneficiary	Date of birth			Relationship to the insured (in Quebec, relationship to the policyholder)	Check one	
		Year	Month	Day		Revocable	Irrevocable
INSURED 1	_____	_ _	_	_ _	_____	<input type="checkbox"/>	<input type="checkbox"/>
INSURED 2	_____	_ _	_	_ _	_____	<input type="checkbox"/>	<input type="checkbox"/>

## 7 PREMIUM PAYMENT METHOD SELECTION

- Preauthorized Debit (PAD) (personal)<sup>2</sup>** – Do not enclose a cheque to cover the initial premium. Complete Section 9.
- Annual** – Enclose a cheque made payable to La Capitale Civil Service Insurer Inc. for the amount indicated in Box G of Section 5.

## 8 PREMIUM PAYOR'S INFORMATION

Check only one box:  Insured 1 is the payor **OR**  Insured 2 is the payor

## 9 PREAUTHORIZED DEBIT (PAD) AGREEMENT

**Bank account information:**  Cheque specimen attached  Banking information provided below:

			_ _	_ _	_ _ _ _ _ _ _
Branch number	Financial institution number	Account number	Branch number	Financial institution number	Account number

**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](http://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](http://www.cdnpay.ca).

I authorize the Insurer or its mandatary to debit the fixed monthly amounts required for payment 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\_\_\_\_\_.

\_\_\_\_\_  
Premium payor's signature

**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](mailto:fim@lacapitale.com)

Note 2: The monthly premium may be adjusted slightly depending on the date of issue and date of the first preauthorized payment, in order to ensure the total annual premium is withdrawn during the first year.

**10 DECLARATIONS AND AUTHORIZATIONS**

- 1- I hereby confirm that the information provided in this application is true, in the knowledge that the Insurer bases its decision to approve or decline my application on this information and I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled.
- 2- I understand that if I am eligible, the insurance will become effective on the date on which the Insurer approves this application, provided that the initial premium has been paid and there have been no changes in the nature of the insurable risk of the proposed insured since the date on which the application was signed. I further agree that the applicable premiums will be those that are in effect on the date on which the application is received by the Insurer.
- 3- I agree that the suicide of a proposed insured that occurs during the first two years following the effective date of any life insurance benefit issued for that person causes the contract to be null and void with regard to that person and that the Insurer's only obligation is limited to the reimbursement of the premiums paid for this benefit.
- 4- 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, for these same purposes, the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
- 5- A photocopy of this authorization is considered as valid as the original.
- 6- I acknowledge that I have read the important information in the *Simplified Advantage* leaflet as well as the MIB, Inc. Notice and the Personal Information Protection Notice.
- 7- Moreover, each and every proposed insured consents to the policyholder taking out this insurance.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

 \_\_\_\_\_  
Insured 1's signature

 \_\_\_\_\_  
Insured 2's signature

**11 SATISFACTION GUARANTEE**

Within 10 days of receipt of my policy, I may cancel my contract by submitting a request in writing and returning the policy to the Insurer at 625 Jacques-Parizeau St, Quebec QC G1R 2G5. I may cancel my contract without giving any reasons for my decision. I will receive a full refund of all premiums already paid to the Insurer.

**12 ADVISOR'S PERSONAL INFORMATION**

Full name	Code
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**13 COMMISSIONS**

Full name of advisor	Code	Split %
Full name of advisor	Code	Split %

**14 SPECIAL INSTRUCTIONS**

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

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**15 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 *Simplified Advantage*, including guaranteed and non-guaranteed elements and any applicable restrictions, reductions and exclusions.

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\_\_\_\_\_.

X

\_\_\_\_\_  
Advisor's signature

**TO BE READ AND RETAINED BY THE POLICYHOLDER**

**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 known as MIB, Inc. (MIB).

Any information regarding your insurability is 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, 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](mailto:privacy@mib.com).

**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 one or more 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 Civil Service Insurer Inc.**  
Individual Insurance and Financial Services  
625 Jacques-Parizeau St, PO Box 16040  
Quebec QC G1K 7X8



625 Jacques-Parizeau St, PO Box 16040  
Quebec QC G1K 7X8