Simplified Advantage
Application Form

Contract No.	Leave this blank

Note: The contract will be issued by by La Capitale Insurance and Financial Services Inc. (the Insurer).

1 INFORMATION

INSURED 1

○ Male ○ Female	Last name	First name		
Last name at birth (if different)		Date of birth Year / Month / Day	Age at nearest birthday	Social Insurance Number
Address (number and street)				
City		Province		
Postal code	Telephone	Email address		
Occupation (mandatory)		Employer (current or past)		
Employer's address				

INSURED 2

○ Male ○ Female	Last name	First name		
Last name at birth (if different)		Date of birth Year / Month / Day	Age at nearest birthday	Social Insurance Number

Only complete the shaded sections if Insured 2 has a different address from Insured 1.

Address (number and street)		
City		Province
Postal code	Telephone	Email address

Please initial any changes made.

1 INFORMATION (Cont.)

POLICYHOLDER (Only complete the shaded sections if policyholder is different from Insured 1)

◯ Male ◯ Female	Last name	First name	
Last name at birth (if different)		Date of birth Year / Month / Day	Social Insurance Number
Address (number and street)			
City		Province	
Postal code	Telephone	Email address	
Occupation (mandatory)		Employer (current or past)	
Employer's address			

VERIFICATION OF POLICYHOLDER'S IDENTITY

ID (original document only): ◯ Birth certificate ◯ Passport ◯ Driver's licence ◯ Health insurance card[1]

Document No.	Province or country of issue

VERIFICATION OF TAX (FATCA) CLASSIFICATION

Is the policyholder a U.S. citizen or a U.S. resident for U.S. tax purposes? ◯ Yes ◯ No **If so,** provide the following information about the policyholder:

U.S. federal taxpayer identification number (U.S. TIN) or social security number (SSN)

THIRD-PARTY INVOLVEMENT

Is the policyholder acting in accordance with the instructions of another person (third party)? ◯ Yes ◯ No **If so,** provide the following information about the third party:

Name of third party		Date of birth Year / Month / Day	Relationship to policyholder
Address (number and street)			City
Province		Postal code	Occupation or key activity
If the third party is a company	Business number (BN)	Place of incorporation	

Note 1: 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.

2 INSURED AMOUNT SELECTION

See the Table of Monthly Premiums for premium rates.

	INSURED 1	INSURED 2
Select the insured amount desired from the following minimums and maximums: Insured age 40 to 70[2] when applying: $5,000 to $100,000 Insured age 71 to 80[2] when applying: $5,000 to $50,000 If you are age 70[2] or less, the insured amount, combined with any insured amount already in force under existing *Simplified Advantage* coverage, may not exceed $100,000. If you are age 71[2] or more, the insured amount, combined with any insured amount already in force under 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.[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 a nnual premium payment method is selected**

INSURED AGE 40 TO 70[2] WHEN APPLYING: MINIMUM OF $5,000 MAXIMUM OF $100,000

Age[2] 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[2] WHEN APPLYING: MINIMUM OF $5,000 MAXIMUM OF $50,000

Age[2] 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		×	$	=	$ 0.00	A
Insured 2		×	$	=	$ 0.00	B
Fixed monthly fee				+	$5.00	C
Total monthly premium (**A** + **B** + **C**)				=	$ 0.00	D

ANNUAL PREMIUM CALCULATION

D × **12** =	$	E
7.5% discount (**E** × **.075**) =	$ 0.00	F
Annual premium (**E** − **F**)* =	$	

*Amount of the cheque to be enclosed

Note 2: Age at nearest birthday

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[2] inclusive, have a permanent Social Insurance Number (one not beginning with the figure 9) and be able to answer NO to 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?	○ No ○ Yes	○ No ○ Yes
b) Do you currently have another life insurance application being assessed by La Capitale?	○ No ○ Yes	○ No ○ Yes
c) During the next 12 months, do you intend to submit an application for another life insurance product with La Capitale?	○ No ○ Yes	○ No ○ Yes
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?	○ No ○ Yes	○ No ○ Yes
3. Have you ever been diagnosed or undergone treatments for an incurable condition that has reduced your life expectancy to less than 24 months?	○ No ○ Yes	○ No ○ Yes
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?	○ No ○ Yes	○ No ○ Yes
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: a) Angina, coronary bypass, myocardial infarction (heart attack), heart failure or cardiomyopathy b) Peripheral vascular disease c) Cerebrovascular accident (stroke) d) Any blood disorder, other than iron-deficiency anemia e) Cancer (other than basal cell carcinoma), malignant tumor or leukemia f) Chronic kidney disease g) A chronic respiratory condition requiring the administration of oxygen h) Liver disease (other than fatty liver) i) Diabetic coma or insulin shock j) Multiple sclerosis or a primary immunodeficiency disease k) Attempted suicide l) Alcohol or drug abuse	○ No ○ Yes	○ No ○ Yes
6. During the last three years, have you suffered from high blood pressure (hypertension) not controlled by medication or monitored by a physician?	○ No ○ Yes	○ No ○ Yes
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?	○ No ○ Yes	○ No ○ Yes
8. Does your current weight exceed the maximum weight indicated in the table?	○ No ○ Yes	○ No ○ Yes

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
During the last 12 months, have you smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as gum, nicotine patch or electronic cigarette?	○ No ○ Yes	○ No ○ Yes

Note 2: Age at nearest birthday

5 BENEFICIARY INFORMATION

A beneficiary is not designated: If a beneficiary is not designated, any benefits will be payable 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. When a trustee is designated, 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.

FOR INSURED 1	
Full name	Date of birth Year Month Day
Relationship to the insured (in Quebec, relationship to the policyholder)	○ Revocable ○ Irrevocable

FOR INSURED 2	
Full name	Date of birth Year Month Day
Relationship to the insured (in Quebec, relationship to the policyholder)	○ Revocable ○ Irrevocable

6 PREMIUM PAYMENT

PREMIUM PAYMENT METHOD SELECTION

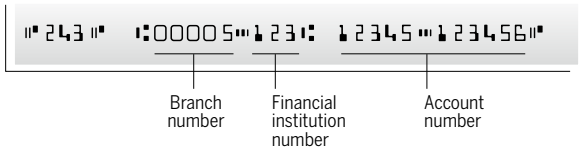
○ **Preauthorized Debit (PAD) (personal)**[3] Do not enclose a cheque to cover the initial premium. Complete the Preauthorized Debit (PAD) agreement in section 7.

○ **Annual**

7 PREAUTHORIZED DEBIT (PAD) AGREEMENT

I, the undersigned, authorize La Capitale or its agent to debit the fixed monthly amounts required for payment due to La Capitale from the account indicated on the enclosed cheque specimen or from the account identified below.

BANK ACCOUNT INFORMATION – Enclose a cheque specimen or complete according to the example below.



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 La Capitale.

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 La Capitale of 30 days' written notice prior to the scheduled date of the next PAD. Furthermore, 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 PAD that is not authorized or is not consistent with this agreement. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, contact La Capitale or visit www.cdnpay.ca.

_____
Premium payor's name

Premium payor's date of birth (if neither the policyholder nor Insured 1 or 2):
Year Month Day

_____
Premium payor's address (if neither the policyholder nor Insured 1 or 2)

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

X _____
Premium payor's signature

La Capitale, 625 Jacques-Parizeau St, Quebec QC G1R 2G5
Telephone: 418 528-2211 or 1 800 463-4433 – Email: fmi@lacapitale.com

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.

Note 3: 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.

Please initial any changes made.

8 DECLARATIONS AND AUTHORIZATIONS

1– I hereby confirm that the information provided in this application is true and complete, 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 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 the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., for such purposes.

This authorization is also valid for the collection, use and communication of personal information regarding my minor children insofar as it is relevant to this application. A photocopy of this authorization is considered as valid as the original.

5– I acknowledge that I have read the important information in the *Simplified Advantage* leaflet as well as the MIB Pre-Notice and the Personal Information Protection Notice.

6– Moreover, each and every proposed insured consents to the policyholder taking out this insurance.

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

X _____ X _____ X _____

Insured 1's signature | Insured 2's signature | Policyholder's signature (if different from Insured 1)

9 ADVISOR'S PERSONAL INFORMATION

Full name	Code

10 COMMISSIONS

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

11 SPECIAL INSTRUCTIONS

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

_____

_____

12 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

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TO BE READ AND RETAINED BY THE POLICYHOLDER

La Capitale
Insurance and
Financial Group

MIB PRE-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 Disclosure Office
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.

PERSONAL INFORMATION PROTECTION NOTICE

The Insurer protects the confidentiality of your personal information, which it keeps in a folder named *"Insurance, annuities, credit and associated financial services."* Only employees, mandataries, distribution partners (such as agents and their firms) and service providers have access to your personal information when such access is required to perform their duties, carry out their mandate or fulfil their service contract. In some cases, the Insurer may do business with service providers located outside of Canada. In this situation, some of your personal information may be transferred to another country where it is subject to the legislation in force in that country. All service providers, whether they are located in Canada or not, are required to protect your personal information in accordance with the policies and practices of the Insurer.

You have the right to access your file. You may also have any information corrected if you demonstrate that it is inaccurate or incomplete. Make your request in writing to the following address:

La Capitale Insurance and Financial Services
Individual Life and Health Insurance
625 Jacques-Parizeau St, PO Box 16040
Quebec QC G1K 7X8


La Capitale
Insurance and
Financial Group