Affirmative
Application form

La Capitale

Policy No.	Leave this blank

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

1 PERSONAL INFORMATION

INSURED 1

○ Male ○ Female	Last name	First name	Last name at birth (if different)	Date of birth Year / Month / Day
Address (number and street)				Social Insurance Number
City			Postal code	Telephone
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
				Social Insurance Number

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
Address (number and street)				Social Insurance Number
City			Postal code	Telephone
Occupation (mandatory)	Employer (current or past)		Employer's address	

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 (YYYY/MM/DD)	Relationship to policyholder
Address (number, street, apartment)		City
Province	Postal code	Occupation or key activity
If the third party is a company	Corporation No.	Place of incorporation

Please initial any changes made.

2 INSURANCE COVERAGE SELECTION

Select the amount of insurance in units of $2,500, up to a maximum of 10 units ($25,000) and calculate the premium. This amount of insurance, combined with any amount of insurance already in force under an existing *Affirmative* policy, may not exceed $25,000. If applicable, the portion of the premium corresponding to any amount in excess of $25,000 will be reimbursed. The insurance amount is doubled in the event of accidental death before age 85.

MONTHLY PREMIUM CALCULATION

	NUMBER OF UNITS (MAXIMUM OF 10)		MONTHLY PREMIUM PER UNIT OF $2,500		MONTHLY PREMIUM
Insured 1		×	$	=	$ 0.00
Insured 2		×	$	=	$ 0.00

MONTHLY PREMIUM PER UNIT

1 unit = **$2,500** of life insurance or **$5,000** in the event of accidental death before age 85

AGE	MALE		FEMALE		AGE	MALE		FEMALE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER		NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
18-22	$5.55	$6.53	$5.18	$6.27	**50-52**	$11.53	$22.55	$10.31	$16.61
23-25	$5.55	$6.99	$5.18	$6.70	**53-55**	$13.02	$25.95	$11.24	$18.05
26-28	$5.86	$7.65	$5.65	$7.67	**56-58**	$14.71	$29.58	$12.17	$19.35
29-31	$6.08	$8.56	$5.87	$7.89	**59-61**	$16.65	$33.39	$13.13	$20.45
32-34	$6.42	$9.64	$6.28	$8.76	**62-64**	$19.90	$38.83	$15.66	$23.58
35-37	$7.01	$10.99	$6.85	$9.95	**65-67**	$23.13	$43.92	$18.16	$26.41
38-40	$7.85	$12.76	$7.72	$11.59	**68-70**	$25.32	$50.14	$19.87	$29.37
41-43	$8.30	$14.45	$8.11	$12.16	**71-73**	$30.85	$59.39	$23.89	$35.34
44-46	$9.31	$16.92	$8.60	$13.71	**74-76**	$39.84	$71.78	$29.26	$43.06
47-49	$10.33	$19.58	$9.42	$15.15	**77-80**	$57.01	$94.46	$41.91	$55.88

3 ELIGIBILITY

You don't need to take a medical exam when applying. To be eligible, you need to be between age 18 and 80 inclusive, have a permanent Social Insurance Number, that is, 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 to apply for *Affirmative* coverage.	INSURED 1	INSURED 2
1– Are you currently residing in a hospital, clinic, convalescent home or institution providing specialized care; are you housebound for health reasons, are you unable to carry out unassisted one or more activities of daily living (such as bathing, dressing, getting up, walking or feeding) or do you suffer from incontinence?	○ No ○ Yes	○ No ○ Yes
2– Do you suffer from an incurable condition that has reduced your life expectancy to less than 24 months; have you been informed that you have tested positive for Human Immunodeficiency Virus (HIV) or do you have Acquired Immune Deficiency Syndrome (AIDS) or any other AIDS-related illness?	○ No ○ Yes	○ No ○ Yes
3– During the last 3 years, have you:		
a) Suffered an angina attack, a myocardial infarction or cerebrovascular accident (stroke), or undergone a dilatation, a coronary bypass or any other cardiac surgery; or	○ No ○ Yes	○ No ○ Yes
b) Received an organ or bone marrow transplant or been advised that your condition required such a procedure; or	○ No ○ Yes	○ No ○ Yes
c) Been diagnosed or treated for any form of cancer, or are you currently under investigation for any such condition?	○ No ○ Yes	○ No ○ Yes
4– During the last 2 years, have you:		
a) Had your driver's licence suspended or revoked due to impaired driving or an accumulation of demerit points?	○ No ○ Yes	○ No ○ Yes
b) Been monitored or hospitalized, or have you received treatment for alcohol or drug abuse?	○ No ○ Yes	○ No ○ Yes
c) Used hard drugs such as cocaine, hallucinogens, opium, heroin, morphine, amphetamines, anabolic steroids other than those prescribed by a physician, or methadone, whether or not it was prescribed by a physician?	○ No ○ Yes	○ No ○ Yes

4 SMOKER OR NON-SMOKER STATUS

	INSURED 1	INSURED 2
During the last 12 months, have you used tobacco in any form?	○ No ○ Yes	○ No ○ Yes

5 BENEFICIARY DESIGNATION IN THE EVENT OF DEATH

FOR INSURED 1		FOR INSURED 2	
Full name	Date of birth Year / Month / Day	Full name	Date of birth Year / Month / Day
Relationship to policyholder	○ Revocable ○ Irrevocable[1]	Relationship to policyholder	○ Revocable ○ Irrevocable[1]

IMPORTANT: If you live in Quebec and the beneficiary you have named is the person to whom you are married or civilly united, this designation is considered irrevocable unless you indicate that you wish for the designation to be REVOCABLE.

Note 1: Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, or carry out certain changes or transactions, you must obtain the beneficiary's consent. If the irrevocable beneficiary is a minor, the consent of the beneficiary's legal guardian is required in addition to any other legal formalities.

Please initial any changes made.

6 PREMIUM PAYMENT OPTIONS

THE PREMIUM IS PAYABLE BY ANY OF THE FOLLOWING METHODS:

○ **Preauthorized debit (PAD) agreement (personal)**:[2] I authorize La Capitale or its agent to debit the fixed monthly amounts required for payments due to La Capitale from the account indicated on the enclosed cheque specimen.

You will receive notice at least 10 days prior to the scheduled date of the first PAD, confirming the amount and date of the PADs. 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 sample PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, you may contact La Capitale or visit www.cdnpay.ca.

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

X _____ _____

Payor's signature | Year / Month / Day

IMPORTANT: Please enclose a VOID cheque from your financial institution.

○ **Annual payment:** I have enclosed a cheque in the amount of the total monthly premium, multiplied by 12.

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 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.

Please initial any changes made.

TO BE READ AND RETAINED BY THE POLICYHOLDER

La Capitale
Financial Group

MEDICAL INFORMATION BUREAU 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 Medical Information Bureau (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, 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:

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

Continued on reverse >>

7 DECLARATIONS AND AUTHORIZATIONS

1– I hereby confirm that the information provided in this application is true and complete, in the knowledge that the Insurer shall base its decision to approve or decline my application on this information. 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 shall 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 shall be those that are in effect on the date on which the application is received by the Insurer.

3– I hereby authorize the Insurer and its reinsurers to gather only that information required for the underwriting and administration of my file, as well as for claims settlement purposes, from any individual or public, parapublic or private organization holding personal information about myself, notably from health professionals and health establishments, the Medical Information Bureau, financial institutions, other insurance and reinsurance companies, personal information agents, investigation and credit agencies, my employer or previous employers. I also authorize the Insurer and its reinsurers to communicate personal information about myself to such individuals or organizations that is required for the purposes of my file or required by law, as well as to request an investigation report regarding myself. Finally, I authorize the Insurer and its reinsurers to make a brief report to MIB providing personal information about my health.

This authorization shall also be 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 shall be considered as valid as the original.

4– I acknowledge that I have read the important information in the *Affirmative* leaflet as well as the Medical Information Bureau Notice and the Personal Information Protection Notice.

5– 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)

8 VERIFICATION OF POLICYHOLDER'S IDENTITY (It is mandatory that this section be filled out by the advisor.)

ID (original documents only)	Document No.	Province or country of issue
◯ Birth certificate ◯ Passport ◯ Driver's licence ◯ Health insurance card[3]		

9 ADVISOR'S PERSONAL INFORMATION

Full name	Code

T056 (02-2013)
100%

Note 3: 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.

Please initial any changes made.

TO BE READ AND RETAINED BY THE POLICYHOLDER (cont.)

MIB receives personal information, and the collection, use and communication of such information is 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 fulfill 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
Administration Department
625 Jacques-Parizeau St, PO Box 16040
Quebec QC G1K 7X8