**May 2015 version**

La Capitale
Insurance and Financial Services

# Life Insurance and Critical Illness Insurance

## Application

T073 (05-2015)

Application No.: 11665271

## INSTRUCTIONS FOR THE ADVISOR

- Print legibly in ink.
- This application must be completed in the presence of the policyholder and the proposed insured.
- This application must be used for:
  - – Applying for individual life insurance or critical illness insurance
  - – Converting individual or group term insurance
  - – Exercising a guaranteed insurability option
  - – Adding coverage to an existing contract
- When there are more than 2 proposed insureds:
  - – Complete one or more extra application forms
  - – Replace the application number of each extra application form with the number of the first application form
  - – Submit all related applications together
- Separate application forms must be completed if:
  - – More than one contract must be issued
  - – If traditional and universal life insurance (*Life Saver*) and critical illness main coverages are applied for since these coverages require separate contracts
- If the proposed insured under main coverage is a child, provide information about the child in either the "Proposed Insured 1" or "Proposed Insured 2" boxes.
- Any cheques must be made out to La Capitale Insurance and Financial Services from a Canadian dollar account with a Canadian financial institution.
- All required signatures must be entered.
- Any corrections or changes made to the application must be initialled by the policyholder or the proposed insured, as applicable.
- Give the policyholder:
  - – The 2 notices in Section 19
  - – The Conditional Certificate of Temporary Insurance, if issued (Section 18)
- Submit all of the application form pages except the pages that must be given to the policyholder.

| ATTACH THE FOLLOWING DOCUMENTS, AS APPLICABLE. | |
|---|---|
| **The policyholder is a company** | ☐ Copy of the Board of Directors' resolution authorizing the transaction and designating the person authorized to act on behalf of the company<br>☐ Verification of Identity – Corporation and Other Entities form, if the coverage that is selected is traditional permanent or universal life insurance (*Life Saver*). |
| **Replacement** | ☐ Prior notice of replacement<br>☐ Cancellation-surrender form if an internal replacement |
| **Disability income benefit to cover a loan** | ☐ Proof of loan from a financial institution indicating the names of borrowers, the date and balance of the loan and the monthly payment amount |
| **Disability income benefit to cover a lease** | ☐ Copy of the lease |
| **Disability income benefit of more than $2,000 in replacement income** | ☐ Employee: Copy of pay stub<br>☐ Self-employed: T4, T1 and income and expenses statements for the last 2 complete fiscal years |
| **Preauthorized debit (PAD) method of payment** | ☐ Preauthorized Debit (PAD) agreement (Section 13)<br>☐ Cheque specimen or bank information. **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.** |
| **Annual method of premium payment** | ☐ Cheque made out to La Capitale Insurance and Financial Services. **If the cheque is received upon delivery of the policy, the Conditional Certificate of Temporary Insurance does not apply.** |
| **Universal life insurance coverage (*Life Saver*)** | ☐ Illustration signed by the policyholder |
| **Lump-sum deposit of $100,000 or more as savings in a universal life insurance coverage (*Life Saver*)** | ☐ Identification of Politically Exposed Foreign Persons form |

In this application, "proposed insured" means any proposed insureds; "policyholder" means any policyholders and "the Insurer" means La Capitale Insurance and Financial Services Inc.

**Contract No.:** Leave this blank

## 1 BASIC INFORMATION

**1.1** Language of correspondence: ☐ English ☐ French

**1.2** Indicate if this is: ☐ a new application OR ☐ additional coverage to existing contract No.: ____________

**1.3** Should any contract resulting from this application be issued at the same time as another contract? ☐ Yes ☐ No

**If so**, indicate the number of the other application: ____________

### 1.4 REASON FOR APPLICATION

☐ External replacement Complete and attach the prior notice of replacement.

☐ Internal replacement – Contract Nos. being replaced: ____________

Complete and attach the prior notice of replacement and the cancellation-surrender form available in the illustration software.

☐ Conversion of individual insurance – Contract Nos. being converted: ____________

☐ Partial – Should any excess amount be cancelled? ☐ Yes ☐ No

☐ Total

☐ Conversion of group insurance

☐ Exercising a guaranteed insurability option under contract No.: ____________

## 2 GENERAL INFORMATION

### 2.1 PROPOSED INSURED'S INFORMATION

**PROPOSED INSURED 1**

Last name | First name | Last name at birth (if different)

Gender: ☐ Male ☐ Female Date of birth: Year Month Day | S.I.N. | Occupation

Marital status | Place of birth: Province | Country

Permanent resident of Canada? ☐ Yes ☐ No In Canada since: ____________

Address (No., street, apt.)

City | Province | Postal code

Country | Email address

Area code Home tel. | Area code Work tel. | (extension) | Area code Cell tel.

**PROPOSED INSURED 2**

Last name | First name | Last name at birth (if different)

Gender: ☐ Male ☐ Female Date of birth: Year Month Day | S.I.N. | Occupation

Marital status | Place of birth: Province | Country

Permanent resident of Canada? ☐ Yes ☐ No In Canada since: ____________

Address (No., street, apt.)

City | Province | Postal code

Country | Email address

Area code Home tel. | Area code Work tel. | (extension) | Area code Cell tel.

## 2.2. POLICYHOLDER'S INFORMATION

**If the policyholder is a natural person, complete Section A.**

**If the policyholder is a company, complete Section B.**

It is not possible to name 2 policyholders **if applying for waiver of premiums (WP)** or universal life insurance (*Life Saver*).

## A THE POLICYHOLDER IS A NATURAL PERSON

### A.1 POLICYHOLDER'S INFORMATION

- ☐ The proposed insured 1 is the policyholder
- ☐ The proposed insured 2 is the policyholder
- ☐ The proposed insureds 1 and 2 are policyholders 1 and 2 respectively

Go to Section A.2, Verification of Policyholder's Identity

- ☐ Other — Provide all information in Section A.

**POLICYHOLDER 1 (if different from the proposed insured 1 or 2)**

Last name ______ First name ______

Marital status ______ Gender: ☐ Male ☐ Female

Relationship to proposed insured 1 ______ Relationship to proposed insured 2 ______

Date of birth: Year Month Day ______ S.I.N. ______

Occupation ______

Address (No., street, apt.) ______

City ______ Province ______

Country ______ Postal code ______

Area code Home tel. ______ Area code Work tel. ______ (extension) ______

Area code Cell tel. ______ Email address ______

**POLICYHOLDER 2 (if different from the proposed insured 1 or 2)**

Last name ______ First name ______

Marital status ______ Gender: ☐ Male ☐ Female

Relationship to proposed insured 1 ______ Relationship to proposed insured 2 ______

Date of birth: Year Month Day ______ S.I.N. ______

Occupation ______

Address (No., street, apt.) ______

City ______ Province ______

Country ______ Postal code ______

Area code Home tel. ______ Area code Work tel. ______ (extension) ______

Area code Cell tel. ______ Email address ______

### A.2 VERIFICATION OF POLICYHOLDER'S IDENTITY **Always complete this section for each policyholder.**

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.

**POLICYHOLDER 1**

**ID** Use original documents only.

- ☐ Birth certificate ☐ Driver's licence
- ☐ Passport ☐ Health insurance card

Document No.: ______

Province or country of issue: ______

**POLICYHOLDER 2**

**ID** Use original documents only.

- ☐ Birth certificate ☐ Driver's licence
- ☐ Passport ☐ Health insurance card

Document No.: ______

Province or country of issue: ______

### A.3 VERIFICATION OF TAX STATUS (FATCA) **Always complete this section for each policyholder.**

**POLICYHOLDER 1**

Is Policyholder 1 an American citizen or resident for the purposes of income tax in the United States? ☐ Yes ☐ No

**If so**, enter the American federal tax identification number (NIF or TIN) or Policyholder 1's Social Security Number (SSN).

______

**POLICYHOLDER 2**

Is Policyholder 2 an American citizen or resident for the purposes of income tax in the United States? ☐ Yes ☐ No

**If so**, enter the American federal tax identification number (NIF or TIN) or Policyholder 2's Social Security Number (SSN).

______

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### A.4 SUBROGATED POLICYHOLDER

**Multiple policyholders (except for Quebec)** – If there is more than one policyholder, ownership type is:

If a choice is not indicated, the contract will be issued with all policyholders having right of survivorship.

☐ Right of survivorship: If a policyholder should die while the contract is in force, his or her interest will be transferred to the surviving policyholder.

☐ Joint ownership: If a policyholder should die while the contract is in force, his or her interest will be transferred to the assigns unless he or she has designated a subrogated policyholder, in which case the interest will be transferred to the subrogated policyholder.

**Multiple policyholders (Quebec)** – If a policyholder should die while the contract is in force, his or her interest will be transferred to the assigns unless he or she has designated a subrogated policyholder, in which case the interest will be transferred to the subrogated policyholder.

#### SUBROGATED POLICYHOLDER OF POLICYHOLDER 1

Last name (company name, if applicable) ____ First name ____

Relationship to Policyholder 1 ____ Gender: ☐ Male ☐ Female

Date of birth: Year Month Day

#### SUBROGATED POLICYHOLDER OF POLICYHOLDER 2

Last name (company name, if applicable) ____ First name ____

Relationship to Policyholder 2 ____ Gender: ☐ Male ☐ Female

Date of birth: Year Month Day

### A.5 THIRD PARTY DETERMINATION

#### POLICYHOLDER 1

Is Policyholder 1 acting in accordance with the instructions of another person (third party)? ☐ Yes ☐ No

**If so**, provide the following information about the third party:

Last name ____ First name ____

Relationship to Policyholder 1 ____ Occupation or key activity ____

Date of birth: Year Month Day

Address (No., street, apt.) ____

City ____ Province ____

Country ____ Postal code ____

If the third party is a company: Business number ____

Place of registration ____

#### POLICYHOLDER 2

Is Policyholder 2 acting in accordance with the instructions of another person (third party)? ☐ Yes ☐ No

**If so**, provide the following information about the third party:

Last name ____ First name ____

Relationship to Policyholder 2 ____ Occupation or key activity ____

Date of birth: Year Month Day

Address (No., street, apt.) ____

City ____ Province ____

Country ____ Postal code ____

If the third party is a company: Business number ____

Place of registration ____

## B THE POLICYHOLDER IS A COMPANY

Attach a copy of the Board of Directors' resolution authorizing the transaction and designating the person authorized to act on behalf of the company.

When the selected coverage is traditional permanent or universal life insurance (*Life Saver*), complete the Verification of Identity – Corporation and Other Entities form available in the illustration software.

Name (company name) ____

Address (No., street, apt.) ____

City ____ Province ____ Country ____ Postal code ____

Business number ____ Place of registration ____

Name and title of authorized signatories: ____

# 2 GENERAL INFORMATION (cont.)

## 2.3. PURPOSE OF INSURANCE

**2.3.1 Personal insurance:**

☐ Mortgage insurance ☐ Final expenses ☐ Estate protection ☐ Income protection ☐ Other: ______

**Business insurance:**

☐ Loan security ☐ Key person ☐ Buy out associates/redeem shares ☐ Other: ______

**2.3.2** Is there an existing or planned agreement according to which a person other than the policyholder or a designated beneficiary will hold any rights to, titles to or interests in the contract to be issued as a result of this application? ☐ Yes ☐ No **If so**, provide details: ______

**2.3.3** Will a loan or financing be used for paying the premiums of the contract to be issued as a result of this application?
☐ Yes ☐ No **If so**, provide complete details of the agreement terms and identify the parties to it: ______

## 2.4 FINANCIAL INFORMATION

### A THE PROPOSED INSURED'S FINANCIAL INFORMATION (Complete for proposed insureds age 16 and over.)

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **Employer's name** | | |
| **Employer's address** (No., street, city, province, postal code) | | |
| **Annual gross income** (including salary, commissions and bonuses) | $ | $ |
| **Other income** | $ | $ |
| **Source of other income** | | |
| **Total assets** (real estate, equity capital in companies, stocks, bonds, etc.) | $ | $ |
| **Total liabilities** (mortgages, loans, etc.) | $ | $ |
| Have you declared bankruptcy in the last 5 years? **If so**, indicate the date you were discharged from bankruptcy, if applicable: | ☐ Yes ☐ No Year Month | ☐ Yes ☐ No Year Month |

### B THE POLICYHOLDER'S FINANCIAL INFORMATION WHEN A COMPANY

**Company's key activities:** ______

**% of the proposed insured's interest in the company:** ______ % Proposed insured 1 ______ % Proposed insured 2

**Company's assets:** $ ______ **Fair market value:** $ ______

**Company's liabilities:** $ ______ **Net profit for the current year:** $ ______

**Net worth:** $ ______ **Net profit for the previous year:** $ ______

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## 3 CHOICE OF COVERAGE

**Separate contracts will be issued for traditional or universal life (*Life Saver*) insurance and critical illness insurance main coverages. Therefore separate applications must be completed for each of these benefits.**

### 3.1 MAIN COVERAGE

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **PERMANENT LIFE INSURANCE** | | |
| ***Non-participating Permanent Advantage***<br><br>* The premium payment period varies according to the proposed insured's age. Refer to the illustration and the contract. | ☐ **Individual**<br>Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years ☐ for life<br>☐ **Joint**<br>Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years* ☐ for life<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ | ☐ **Individual**<br>Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years ☐ for life<br>☐ **Joint**<br>Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years* ☐ for life<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ |
| ***100% Pure Protection*** | ☐ **Individual** ☐ Critical Illness Option<br>☐ **Joint**<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ | ☐ **Individual** ☐ Critical Illness Option<br>☐ **Joint**<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ |
| ***100% Pure Evolvement*** | ☐ **Individual**<br>☐ **Joint**<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ | ☐ **Individual**<br>☐ **Joint**<br>☐ Insured amount payable on first-to-die basis<br>☐ Insured amount payable on last-to-die basis, premiums payable until 1st death<br>☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death<br>**Insured amount: $** ________________ |
| **TERM LIFE INSURANCE** | | |
| **Fixed Term**<br><br>If applying for a fixed term rider, complete Section 3.2. | ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ | ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ |
| ***20.10 Protection*** | ☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ | ☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ |
| **Decreasing Term** | ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ | ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>☐ **Individual** ☐ **Joint first-to-die**<br>**Insured amount: $** ________________ |
| ***The Provider***<br>*Monthly income for your loved ones*<br><br>The policyholder must be a natural person. Not available with universal life insurance coverage (*Life Saver*). | ☐ 15 years ☐ 20 years ☐ 25 years<br>☐ **Fixed term**<br>☐ **Decreasing term**<br>**Monthly insured amount: $** ________________ | ☐ 15 years ☐ 20 years ☐ 25 years<br>☐ **Fixed term**<br>☐ **Decreasing term**<br>**Monthly insured amount: $** ________________ |

## 3 CHOICE OF COVERAGE (cont.)

### 3.1 MAIN COVERAGE (cont.)

#### UNIVERSAL LIFE INSURANCE (*Life Saver*)

* The premium payment period varies according to the proposed insured's age. Refer to the illustration and the contract.

For lump sum deposits of $100,000 or more, complete the form entitled Identification of Politically Exposed Foreign Persons available in the illustration software.

**PROPOSED INSURED 1**

☐ **Individual**
Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years ☐ for life

☐ **Joint**
Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years* ☐ for life

☐ Insured amount payable on first-to-die basis
☐ Insured amount payable on last-to-die basis, premiums payable until 1st death
☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death

**Insured amount: $** ______________

**Investment instructions:**

| | | | |
|---|---|---|---|
| Liquidity account | ____% | American Equity (Dynamic) | ____% |
| 3-year GIC | ____% | Canadian Balanced (Dynamic) | ____% |
| 5-year GIC | ____% | Global Equity (Dynamic) | ____% |
| 10-year GIC | ____% | Canadian Dividend (AGF) | ____% |
| Canadian equity index | ____% | Global Balanced (AGF) | ____% |
| American equity index | ____% | Conservative Profile (NBI) | ____% |
| International equity index | ____% | Moderate Profile (NBI) | ____% |
| Canadian bond index | ____% | Balanced Profile (NBI) | ____% |
| Canadian Equity (Dynamic) | ____% | Growth Profile (NBI) | ____% |
| | | Aggressive Profile (NBI) | ____% |
| | | **Total: 100%** | |

**Tax strategy:**
☐ Notice of assessment ☐ Health and estate ☐ No strategy

**Periodic savings premium:**
☐ Optimal savings premium based on selected strategy:
☐ Savings premium based on selected method of payment:
☐ Annual $__________ ☐ Monthly $__________

**Additional savings premiums:**
(cash deposit): $ __________

**PROPOSED INSURED 2**

☐ **Individual**
Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years ☐ for life

☐ **Joint**
Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 minimum 25 years* ☐ for life

☐ Insured amount payable on first-to-die basis
☐ Insured amount payable on last-to-die basis, premiums payable until 1st death
☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death

**Insured amount: $** ______________

**Investment instructions:**

| | | | |
|---|---|---|---|
| Liquidity account | ____% | American Equity (Dynamic) | ____% |
| 3-year GIC | ____% | Canadian Balanced (Dynamic) | ____% |
| 5-year GIC | ____% | Global Equity (Dynamic) | ____% |
| 10-year GIC | ____% | Canadian Dividend (AGF) | ____% |
| Canadian equity index | ____% | Global Balanced (AGF) | ____% |
| American equity index | ____% | Conservative Profile (NBI) | ____% |
| International equity index | ____% | Moderate Profile (NBI) | ____% |
| Canadian bond index | ____% | Balanced Profile (NBI) | ____% |
| Canadian Equity (Dynamic) | ____% | Growth Profile (NBI) | ____% |
| | | Aggressive Profile (NBI) | ____% |
| | | **Total: 100%** | |

**Tax strategy:**
☐ Notice of assessment ☐ Health and estate ☐ No strategy

**Periodic savings premium:**
☐ Optimal savings premium based on selected strategy:
☐ Savings premium based on selected method of payment:
☐ Annual $__________ ☐ Monthly $__________

**Additional savings premiums:**
(cash deposit): $ __________

#### IMPORTANT NOTICE CONCERNING LA CAPITALE INVESTMENT ACCOUNTS

Amounts invested in La Capitale universal life insurance *(Life Saver)* investment accounts are not guaranteed, except in the event of the death of the policyholder. These accounts' returns are tied to the performance of a market index or underlying fund, less any applicable management fees. The value of the market index or underlying fund fluctuates depending on the market value of the securities that make up the index or fund. The value of these accounts may, depending on the performance of the market index or underlying fund, increase or decrease on a daily basis and even fall lower than the initial capital invested if the rate of return, after deduction of management fees, is negative.

Should the market index or underlying fund be unavailable or cease to be used by the Insurer for any reason whatsoever, the Insurer reserves the right to replace it with another market index or underlying fund it deems equivalent or to determine the applicable rate of return.

#### CRITICAL ILLNESS

**Extended coverage**

For *Simplified Second Chance*, use the specific application form.

**Proposed Insured 1**

**Premium payable:**
☐ **In 15 instalments** ☐ **Until age 65** ☐ **Until expiry**

**Insured amount: $** ______________

☐ **Reimbursement of premiums on death**

☐ **Reimbursement of premiums on surrender or expiry**
If premiums are payable until expiry, choose the time when the percentage of reimbursement of premiums on surrender or expiry will be equal to 100% of the premiums paid. Certain conditions apply.
☐ 15-year term ☐ On expiry

**Proposed Insured 2**

**Premium payable:**
☐ **In 15 instalments** ☐ **Until age 65** ☐ **Until expiry**

**Insured amount: $** ______________

☐ **Reimbursement of premiums on death**

☐ **Reimbursement of premiums on surrender or expiry**
If premiums are payable until expiry, choose the time when the percentage of reimbursement of premiums on surrender or expiry will be equal to 100% of the premiums paid. Certain conditions apply.
☐ 15-year term ☐ On expiry

**Children's Critical Illness**

Proposed Insured 1: **Insured amount: $** ______________
☐ Health Option

Proposed Insured 2: **Insured amount: $** ______________
☐ Health Option

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### 3.2 ADDITIONAL BENEFITS AND RIDERS

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| Accidental Death and Dismemberment | Insured amount: $ ______________ | Insured amount: $ ______________ |
| Guaranteed Insurability | Insured amount: $ ______________ | Insured amount: $ ______________ |
| Disability Income Benefit<br>Section 7 must be completed. | $ ____________________/month<br>Duration of coverage:<br>☐ 20 years ☐ 25 years ☐ 30 years<br>Maximum period of benefit payments:<br>☐ 2 years ☐ 5 years ☐ Until expiry | $ ____________________/month<br>Duration of coverage:<br>☐ 20 years ☐ 25 years ☐ 30 years<br>Maximum period of benefit payments:<br>☐ 2 years ☐ 5 years ☐ Until expiry |
| Waiver of premiums (WP)<br>The policyholder's personal and medical information must be provided (Sections 5 and 6).<br>Not available if the policyholder is a company or if there is more than one policyholder. | ☐ Disability of policyholder<br>☐ Disability or death of policyholder | ☐ Disability of policyholder<br>☐ Disability or death of policyholder |
| Fixed term rider | ☐ 10 years ☐ 20 years ☐ 25 years<br>☐ 30 years ☐ 35 years<br>Insured amount: $ ______________ | ☐ 10 years ☐ 20 years ☐ 25 years<br>☐ 30 years ☐ 35 years<br>Insured amount: $ ______________ |
| The Provider, *Monthly income for your loved ones* rider<br>Not available if the policyholder is a company. | ☐ 15 years ☐ 20 years ☐ 25 years<br>☐ Fixed term ☐ Decreasing term<br>Monthly insured amount: $ ____________ | ☐ 15 years ☐ 20 years ☐ 25 years<br>☐ Fixed term ☐ Decreasing term<br>Monthly insured amount: $ ____________ |
| Critical Illness rider | ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>Insured amount: $ ______________ | ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years<br>Insured amount: $ ______________ |
| *Accidental Fracture* rider | ☐ 1 unit ☐ 2 units<br>☐ Individual ☐ Individual with children* | ☐ 1 unit ☐ 2 units<br>☐ Individual ☐ Individual with children* |
| Children's Life Insurance rider*<br>Section 11 must be completed. | Insured amount: $ ______________ | Insured amount: $ ______________ |
| Children's Critical Illness rider*<br>The section for children must be completed. | Insured amount: $ ______________ | Insured amount: $ ______________ |

*The children must be the proposed insured's as indicated on the child's birth certificate or by virtue of legal adoption.

## 4 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). In Quebec, the minor beneficiary's legal guardian will receive the payable benefit unless an official trustee has been named.

**Contingent beneficiary:** If a beneficiary predeceases the insured, any benefits will be payable to the contingent beneficiary.

### 4.1 LIFE INSURANCE

**PROPOSED INSURED 1**

| Last name | First name | Date of birth Year | Month | Day | Relationship to the insured (in Quebec, relationship to the policyholder) | Check one Revocable | Irrevocable | Share % Total: 100% |
|---|---|---|---|---|---|---|---|---|
| **BENEFICIARY** | | | | | | | | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| **CONTINGENT BENEFICIARY** | | | | | | | | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |

**PROPOSED INSURED 2**

| Last name | First name | Date of birth Year | Month | Day | Relationship to the insured (in Quebec, relationship to the policyholder) | Check one Revocable | Irrevocable | Share % Total: 100% |
|---|---|---|---|---|---|---|---|---|
| **BENEFICIARY** | | | | | | | | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |
| **CONTINGENT BENEFICIARY** | | | | | | | | |
| | | | | | | ☐ | ☐ | |
| | | | | | | ☐ | ☐ | |

## 4.2 EXTENDED CRITICAL ILLNESS INSURANCE AND CHILDREN'S CRITICAL ILLNESS

### Extended Critical Illness Insurance

***For critical illness coverage***, do not designate a beneficiary since the benefits are payable to the policyholder.

If ***reimbursement of premiums on death*** is selected, a beneficiary must be designated.

If ***reimbursement of premiums on surrender or expiry*** is selected, the policyholder is the beneficiary unless there is another designation made.

### Children's Critical Illness

***For critical illness*** and ***Health Option* coverage**, do not designate a beneficiary since the benefits are payable to the policyholder.

For the ***death benefit***, a beneficiary must be designated.

**PROPOSED INSURED 1**

**BENEFICIARY**

| Last name | First name | Date of birth<br>Year Month Day | Relationship to the insured (in Quebec, relationship to the policyholder) | Check one<br>Revocable | Irrevocable | Share %<br>Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |

**CONTINGENT BENEFICIARY**

| Last name | First name | Date of birth<br>Year Month Day | Relationship | Revocable | Irrevocable | Share % | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |

**PROPOSED INSURED 2**

**BENEFICIARY**

| Last name | First name | Date of birth<br>Year Month Day | Relationship to the insured (in Quebec, relationship to the policyholder) | Check one<br>Revocable | Irrevocable | Share %<br>Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |

**CONTINGENT BENEFICIARY**

| Last name | First name | Date of birth<br>Year Month Day | Relationship | Revocable | Irrevocable | Share % | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |
| | | | | ☐ | ☐ | | ☐ Surrender/expiry<br>☐ At death |

## SECTIONS RESERVED FOR THE PROPOSED INSURED AGE 18 AND OVER
(If the proposed insured is under age 18, go to Section 9)

# 5 PERSONAL INFORMATION

## 5.1 OTHER INSURANCE IN FORCE OR PENDING

**PROPOSED INSURED 1**

Do you currently hold a life (**LIFE**), critical illness (**CI**), long-term care (**LTC**) or disability (**DI**) insurance contract or have a pending application for any of these types of insurance? ☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | LTC | DI | Insured amount | Accidental Death | Company name | Year and month issued (check if pending)<br>Year | <br>Month | <br>Pending | Personal/ business<br>P | <br>B | Will the insurance applied for replace the existing insurance contract?<br>Complete the prior notice of replacement, if required. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |

**PROPOSED INSURED 2**

Do you currently hold a life (**LIFE**), critical illness (**CI**), long-term care (**LTC**) or disability (**DI**) insurance contract or have a pending application for any of these types of insurance? ☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | LTC | DI | Insured amount | Accidental Death | Company name | Year and month issued (check if pending)<br>Year | <br>Month | <br>Pending | Personal/ business<br>P | <br>B | Will the insurance applied for replace the existing insurance contract?<br>Complete the prior notice of replacement, if required. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | ☐ | $ | $ | | | | ☐ | ☐ | ☐ | ☐ Yes ☐ No |

## 5.2 PREVIOUS INSURANCE COVERAGE

**PROPOSED INSURED 1**

Have you ever had a life (**LIFE**), critical illness (**CI**) or 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 |
|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | | | |
| | | ☐ | ☐ | ☐ | | | |

**PROPOSED INSURED 2**

Have you ever had a life (**LIFE**), critical illness (**CI**) or 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 |
|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | | | |
| | | ☐ | ☐ | ☐ | | | |

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## 5 PERSONAL INFORMATION (cont.)

### 5.3. TOBACCO USE

**PROPOSED INSURED 1**

In 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? ☐ Yes ☐ No **If so**:

| Type | Quantity | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

If you quit smoking in the last 12 months, indicate the date: Year ____ Month ____

**PROPOSED INSURED 2**

In 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? ☐ Yes ☐ No **If so**:

| Type | Quantity | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

If you quit smoking in the last 12 months, indicate the date: Year ____ Month ____

**Check YES or NO. For each "YES" answer, provide details or complete the requested questionnaire, available in the illustration software.**

| | | PROPOSED INSURED 1 Yes | PROPOSED INSURED 1 No | PROPOSED INSURED 2 Yes | PROPOSED INSURED 2 No |
|---|---|---|---|---|---|
| | **ALCOHOL** | | | | |
| 5.4 | Do you drink alcohol? **If so**, indicate your current weekly consumption (number of glasses of beer, wine and spirits). ____ | ☐ | ☐ | ☐ | ☐ |
| 5.5 | In the last 5 years, has your consumption of alcohol changed? **If so**, complete the alcohol use questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **DRUG AND OPIATE USE** | | | | |
| 5.6 | Do you take, or have you ever used, drugs or opiates or narcotics such as cocaine, LSD, barbiturates, amphetamines or other similar substances? **If so**, complete the drug or opiate use questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **DRIVING RECORD** | | | | |
| 5.7 | Have you ever been charged with or found guilty of impaired driving? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 5.8 | In the last 5 years, has your driver's licence been suspended or revoked? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 5.9 | In the last 5 years, have you been found guilty of 3 or more violations of the Highway Safety Code? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **CRIMINAL RECORD** | | | | |
| 5.10 | Have you ever been charged with or found guilty of any criminal offence? **If so**, specify the type, date, sentence and probation for each offence. ____ | ☐ | ☐ | ☐ | ☐ |
| | **AVIATION** | | | | |
| 5.11 | Do you plan to take part in or, in the last 2 years, have you taken part in any flights other than as a passenger? **If so**, complete the aviation questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **HAZARDOUS SPORTS** | | | | |
| 5.12 | Do you plan to take part in or, in the last 2 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity? **If so**, complete the appropriate questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **TRAVEL OR RESIDENCE ABROAD** | | | | |
| 5.13 | In the last 2 years, have you travelled or resided outside of Canada or the United States? **If so**, complete the travel and residence abroad questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 5.14 | Are you planning to travel or reside outside of Canada or the United States in the next 2 years? **If so**, complete the travel and residence abroad questionnaire. | ☐ | ☐ | ☐ | ☐ |

## 6 MEDICAL INFORMATION (Do not complete Section 6 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)

### 6.1 MEDICAL HISTORY

**Check YES or NO. For each "YES" answer:**
**– Circle the relevant illness, condition or situation.**
**– Provide details in Section 6.2 Additional Information or complete the requested questionnaire, available in the illustration software.**

| Question | Proposed Insured 1 Yes | Proposed Insured 1 No | Proposed Insured 2 Yes | Proposed Insured 2 No |
|---|---|---|---|---|
| **6.1.1** Have you ever consulted for, been treated for or shown signs or symptoms of any of the following conditions? | | | | |
| a) CARDIOVASCULAR SYSTEM: High blood pressure, high level of cholesterol or triglicerides, chest pain, palpitations, irregular heart beat, heart murmur, acute rheumatic fever, heart attack, cerebrovascular accident, aneurysm or any other heart or blood vessel disorder? | ☐ | ☐ | ☐ | ☐ |
| b) RESPIRATORY SYSTEM: Asthma, emphysema, shortness of breath, chronic bronchitis, sleep apnea or any other pulmonary or respiratory disorder? **If so**, complete the respiratory disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| c) GASTROINTESTINAL SYSTEM: | | | | |
| c1. Hepatitis, cirrhosis of the liver, pancreatitis or other liver disorder? | ☐ | ☐ | ☐ | ☐ |
| c2. Ulcerative colitis, Crohn's disease, hemorrhage, esophagus, stomach, gallbladder or intestine disorder? **If so**, complete the intestinal disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| d) GENITOURINARY SYSTEM: Urine abnormalities, kidney, bladder, prostate or genital organ disorder, sexually transmitted diseases or abnormal PAP tests? | ☐ | ☐ | ☐ | ☐ |
| e) ENDOCRINE SYSTEM: | | | | |
| e1. Thyroid gland disorder or other endocrine condition? | ☐ | ☐ | ☐ | ☐ |
| e2. Diabetes? **If so**, complete the diabetes questionnaire. | ☐ | ☐ | ☐ | ☐ |
| f) MUSCULOSKELETAL SYSTEM: | | | | |
| f1. Back or neck pain or disorder? **If so**, complete the back or neck disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| f2. Arthritis, gout, bursitis, tendonitis, sprain or other muscle, ligament, bone or joint disorder? **If so**, complete the musculoskeletal disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| g) NERVOUS SYSTEM: Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness, tingling or any other neurological disorder? | ☐ | ☐ | ☐ | ☐ |
| h) MENTAL HEALTH: Depression, burnout, adjustment disorder, anxiety, fatigue/overstress or any other psychological, psychiatric or mental disorder? **If so**, complete the psychological disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| i) IMMUNE SYSTEM: Lupus, AIDS-related complex, AIDS or test results indicating possible exposure to AIDS or HIV (Human Immunodeficiency Virus) or any other immune system disorder? | ☐ | ☐ | ☐ | ☐ |
| j) GENERAL: | | | | |
| j1. Anemia or other blood disease, leukemia, lymph node disorder, cancer, tumour, cyst, polyp, nodule, skin disease or abnormal skin lesion, eye or ear condition or breast disorder including lumps? | ☐ | ☐ | ☐ | ☐ |
| j2. Any other physical or mental disorder not mentioned in Question 6.1.1 a) in j1? | ☐ | ☐ | ☐ | ☐ |
| **6.1.2** Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of drugs or alcohol? | ☐ | ☐ | ☐ | ☐ |
| **6.1.3** In the last 5 years, | | | | |
| a) Have you had an electrocardiogram, X-ray, CT scan, MRI, blood tests or follow-up, screening or diagnostic tests? | ☐ | ☐ | ☐ | ☐ |
| b) Have you been admitted as a patient to any hospital or clinic? | ☐ | ☐ | ☐ | ☐ |
| **6.1.4** In the last 5 years, have you been disabled or absent from work for a period of 4 consecutive weeks or more due to illness or injury? | ☐ | ☐ | ☐ | ☐ |

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## 6 MEDICAL INFORMATION (cont.) **(Do not complete Section 6 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)**

### 6.1 MEDICAL HISTORY (cont.)

| | | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 6.1.5 | In the last 2 years, have you undergone a mammography or breast ultrasound? | ☐ | ☐ | ☐ | ☐ |
| 6.1.6 | Have you ever consulted or been advised to consult a physician or a specialist or been advised to receive treatment following abnormal findings of an ultrasound, biopsy or mammography? | ☐ | ☐ | ☐ | ☐ |
| 6.1.7 | Are you taking any medication? **If so**, specify which medications. | ☐ | ☐ | ☐ | ☐ |
| 6.1.8 | Do you have any symptoms or signs for which you have not yet consulted? | ☐ | ☐ | ☐ | ☐ |
| 6.1.9 | Do you have to consult a physician or a specialist, undergo a treatment or surgery or take follow-up or diagnostic tests which have not yet been performed? | ☐ | ☐ | ☐ | ☐ |
| 6.1.10 | Have you previously had complications during a pregnancy or at childbirth (gestational diabetes, preeclampsia, cesarian section, postpartum depression)? | ☐ | ☐ | ☐ | ☐ |
| 6.1.11 | a) Are you pregnant? | ☐ | ☐ | ☐ | ☐ |
| | b) **If so**, what is the due date? | Year | Month | Year | Month |

### 6.2 ADDITIONAL INFORMATION

If you need extra space, attach an extra sheet, duly dated and signed.

| Question No. | Proposed Insured's name | Diagnosis, date of diagnosis, dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited |
|---|---|---|
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## 6 MEDICAL INFORMATION (cont.) **(Do not complete Section 6 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)**

### 6.3 HEIGHT AND WEIGHT

**PROPOSED INSURED 1**

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

In the last twelve months, have you lost 4.5 kg (10 lb.) or more?
☐ Yes ☐ No **If so**, how much weight was lost? ________ ☐ kg ☐ lb.

Reason for the weight loss: ________

**PROPOSED INSURED 2**

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

In the last twelve months, have you lost 4.5 kg (10 lb.) or more?
☐ Yes ☐ No **If so**, how much weight was lost? ________ ☐ kg ☐ lb.

Reason for the weight loss: ________

### 6.4 PHYSICIANS

#### 6.4.1 Personal physician

**PROPOSED INSURED 1**

Name of personal physician

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

**PROPOSED INSURED 2**

Name of personal physician

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

#### 6.4.2 Last physician consulted

**PROPOSED INSURED 1**

Name of last physician consulted, if different

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

**PROPOSED INSURED 2**

Name of last physician consulted, if different

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

### 6.5 FAMILY HISTORY

Have any of the proposed insured's immediate family members, meaning father, mother, brother or sister, whether living or deceased, ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? **If so**, provide required information below.

| PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|
| Yes | No | Yes | No |
| ☐ | ☐ | ☐ | ☐ |

| Proposed Insured's name | Relationship to Proposed Insured | Name of disease (if cancer, specify type) | Age at diagnosis of the disease | Age if alive | Age at death | Cause of death |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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## 7 DISABILITY INCOME BENEFIT

### PROPOSED INSURED 1

#### 7.1 PURPOSE OF BENEFIT REQUEST

☐ **To cover a loan**

Attach proof of loan from a financial institution indicating the names of borrowers, the date and balance of the loan and the monthly payment amount.

☐ Mortgage loan ☐ Personal loan ☐ Agricultural loan
☐ Commercial loan ☐ Line of credit

Monthly payment (principal + interest) or current balance of line of credit used: $ __________

Loan already insured in case of disability? ☐ Yes ☐ No
Will this loan insurance be cancelled? ☐ Yes ☐ No

☐ **To cover a lease** Attach a copy of the lease.

☐ **Income replacement**

If the Disability Income Benefit applied for is > $2,000, attach proof of income:
**Employee:** Copy of pay stub. **Self-employed:** T4, T1 and income and expenses statements for the last 2 complete fiscal years.

### PROPOSED INSURED 2

#### 7.1 PURPOSE OF BENEFIT REQUEST

☐ **To cover a loan**

Attach proof of loan from a financial institution indicating the names of borrowers, the date and balance of the loan and the monthly payment amount.

☐ Mortgage loan ☐ Personal loan ☐ Agricultural loan
☐ Commercial loan ☐ Line of credit

Monthly payment (principal + interest) or current balance of line of credit used: $ __________

Loan already insured in case of disability? ☐ Yes ☐ No
Will this loan insurance be cancelled? ☐ Yes ☐ No

☐ **To cover a lease** Attach a copy of the lease.

☐ **Income replacement**

If the Disability Income Benefit applied for is > $2,000, attach proof of income:
**Employee:** Copy of pay stub. **Self-employed:** T4, T1 and income and expenses statements for the last 2 complete fiscal years.

**ANSWER ALL QUESTIONS REGARDLESS OF THE PURPOSE OF THE BENEFIT REQUEST.**

### Proposed Insured 1

**7.2** Are you ☐ a salaried employee or ☐ self-employed?

**7.3** Name and address of your employer or company:

____________________

____________________

**7.4** Type of company (line of business):

____________________

**7.5** If you are self-employed, what percentage is your interest in the company? _____ %

**7.6** Number of years with this employer or self-employed: _____

**7.7** Number of hours worked/week: _____

**7.8** Number of weeks worked/year: _____

**7.9** Number of years in a similar company: _____

**7.10** Type of employment: ☐ Temporary ☐ Permanent

**7.11** What is your job title?

____________________

____________________

**7.12** Briefly describe your duties:

____________________

____________________

**7.13** What percentage of your work is considered as manual work? _____ %

**7.14** Do you have any disability insurance, in force or pending, through your employer? ☐ Yes ☐ No **If so:**

Name of insurance company __________ % of salary _____

**7.15** Do you have any disability insurance (including loan/credit insurance) in force or pending? ☐ Yes ☐ No **If so:**

| Year issued | Name of insurance company | Monthly Benefit |
|---|---|---|
| | | $ _____ /month |
| | | $ _____ /month |

Additional comments

____________________

____________________

____________________

### Proposed Insured 2

**7.2** Are you ☐ a salaried employee or ☐ self-employed?

**7.3** Name and address of your employer or company:

____________________

____________________

**7.4** Type of company (line of business):

____________________

**7.5** If you are self-employed, what percentage is your interest in the company? _____ %

**7.6** Number of years with this employer or self-employed: _____

**7.7** Number of hours worked/week: _____

**7.8** Number of weeks worked/year: _____

**7.9** Number of years in a similar company: _____

**7.10** Type of employment: ☐ Temporary ☐ Permanent

**7.11** What is your job title?

____________________

____________________

**7.12** Briefly describe your duties:

____________________

____________________

**7.13** What percentage of your work is considered as manual work? _____ %

**7.14** Do you have any disability insurance, in force or pending, through your employer? ☐ Yes ☐ No **If so:**

Name of insurance company __________ % of salary _____

**7.15** Do you have any disability insurance (including loan/credit insurance) in force or pending? ☐ Yes ☐ No **If so:**

| Year issued | Name of insurance company | Monthly Benefit |
|---|---|---|
| | | $ _____ /month |
| | | $ _____ /month |

Additional comments

____________________

____________________

____________________

# SECTIONS RESERVED FOR CHILDREN (UNDER AGE 18)

1) If applying for a Children's Critical Illness Rider, complete Sections 8, 9 and 10.
2) If applying for life insurance as the main coverage and the proposed insured is under age 18, complete Sections 9 and 10.
3) If applying for critical illness insurance as the main coverage and the proposed insured is under age 18, complete Sections 9 and 10.
4) If applying for a Children's Life Insurance Rider, complete Section 11.

## 8 CHILDREN'S INFORMATION FOR THE CHILDREN'S CRITICAL ILLNESS RIDER

The children must be the proposed insured's as indicated on the child's birth certificate or by virtue of legal adoption. All the proposed insured's children under age 18 must be identified. When there are more than 2 children, use as many additional applications as necessary.

| | Last name | First name | Gender | Date of birth Year Month Day |
|---|---|---|---|---|
| Child 1 | | | ☐ M ☐ F | |
| Child 2 | | | ☐ M ☐ F | |

## 9 PERSONAL INFORMATION

### 9.1 OTHER INSURANCE IN FORCE OR PENDING

**PROPOSED INSURED 1 OR CHILD 1**

Does the child currently hold a life (**LIFE**) or critical illness (**CI**) insurance contract or have a pending application for any of these types of insurance?
☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | Insured amount | Accidental Death | Company name | Year and month issued (check if pending) Year | Month | Pending | Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required. |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | $ | $ | | | | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | $ | $ | | | | ☐ | ☐ Yes ☐ No |

**PROPOSED INSURED 2 OR CHILD 2**

Does the child currently hold a life (**LIFE**) or critical illness (**CI**) insurance contract or have a pending application for any of these types of insurance?
☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | Insured amount | Accidental Death | Company name | Year and month issued (check if pending) Year | Month | Pending | Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required. |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | $ | $ | | | | ☐ | ☐ Yes ☐ No |
| ☐ | ☐ | $ | $ | | | | ☐ | ☐ Yes ☐ No |

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# 9 PERSONAL INFORMATION (cont.)

## 9.2 PREVIOUS INSURANCE COVERAGE

**PROPOSED INSURED 1 OR CHILD 1**

Has the child ever had a life (**LIFE**) or critical illness (**CI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium?
☐ Yes ☐ No **If so**, provide details on these applications.

| Year | Month | LIFE | CI | Company name | Decision | Reason |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | | | |
| | | ☐ | ☐ | | | |

**PROPOSED INSURED 2 OR CHILD 2**

Has the child ever had a life (**LIFE**) or critical illness (**CI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium?
☐ Yes ☐ No **If so**, provide details on these applications.

| Year | Month | LIFE | CI | Company name | Decision | Reason |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | | | |
| | | ☐ | ☐ | | | |

## 9.3 CHILD'S FAMILY HISTORY

| | PROPOSED INSURED 1 OR CHILD 1 | | PROPOSED INSURED 2 OR CHILD 2 | |
|---|---|---|---|---|
| **9.3.1 Child's brothers and sisters** | **Yes** | **No** | **Yes** | **No** |
| Does the child have any brothers or sisters? | ☐ | ☐ | ☐ | ☐ |
| **If so**, how many? | | | | |

**9.3.2 Previous insurance coverage of the child's family members**

**PROPOSED INSURED 1 OR CHILD 1**

List below any life (**LIFE**), critical illness (**CI**) or disability (**DI**) insurance in force or pending on the lives of parents, brothers and sisters:

| Name of the child's family member | Relationship to the child | LIFE | CI | DI | Insured amount | Company name | Year issued | Pending |
|---|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | $ | | | ☐ |
| | | ☐ | ☐ | ☐ | $ | | | ☐ |

**PROPOSED INSURED 2 OR CHILD 2**

List below any life (**LIFE**), critical illness (**CI**) or disability (**DI**) insurance in force or pending on the lives of parents, brothers and sisters:

| Name of the child's family member | Relationship to the child | LIFE | CI | DI | Insured amount | Company name | Year issued | Pending |
|---|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | $ | | | ☐ |
| | | ☐ | ☐ | ☐ | $ | | | ☐ |

**9.3.3 Child's parents' financial information** Complete if the insured amount applied for is greater than $100,000.

a) Parents' annual income: $ ____________

b) Parents' net worth (assets-liabilities): $ ____________

## 9 PERSONAL INFORMATION (cont.)

### 9.4. TOBACCO USE

**PROPOSED INSURED 1 OR CHILD 1**

In last 12 months, has the child 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? ☐ Yes ☐ No **If so**:

| Type | Quantity | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

If the child quit smoking in the last 12 months, indicate the date: Year ___ Month ___

**PROPOSED INSURED 2 OR CHILD 2**

In last 12 months, has the child 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? ☐ Yes ☐ No **If so**:

| Type | Quantity | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

If the child quit smoking in the last 12 months, indicate the date: Year ___ Month ___

**Check YES or NO. For each "YES" answer, provide details or complete the requested questionnaire, available in the illustration software.**

| | Question | PROPOSED INSURED 1 OR CHILD 1 Yes | No | PROPOSED INSURED 2 OR CHILD 2 Yes | No |
|---|---|---|---|---|---|
| | **ALCOHOL** | | | | |
| 9.5 | Does the child drink alcohol? **If so**, indicate the child's current weekly consumption (number of glasses of beer, wine and spirits). ______ | ☐ | ☐ | ☐ | ☐ |
| | **DRUG AND OPIATE USE** | | | | |
| 9.6 | Does the child take, or ever used, drugs or opiates or narcotics such as cocaine, LSD, barbiturates, amphetamines or other similar substances? **If so**, complete the drug or opiate use questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **DRIVING RECORD** | | | | |
| 9.7 | Has the child ever been charged with or found guilty of impaired driving? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 9.8 | Has the child's driver's licence ever been suspended or revoked? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 9.9 | Has the child been found guilty of one or more violations of the Highway Safety Code? **If so**, complete the driving record questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **CRIMINAL RECORD** | | | | |
| 9.10 | Has the child ever been charged with or found guilty of any criminal offence? **If so**, specify the type, date, sentence and probation for each offence. ______ | ☐ | ☐ | ☐ | ☐ |
| | **AVIATION** | | | | |
| 9.11 | Does the child plan to take part in or, in the last 2 years, has he or she taken part in flights other than as a passenger? **If so**, complete the aviation questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **HAZARDOUS SPORTS** | | | | |
| 9.12 | Does the child plan to take part in or, in the last 2 years, has he or she taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity? **If so**, complete the appropriate questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | **TRAVEL OR RESIDENCE ABROAD** | | | | |
| 9.13 | In the last 2 years, has the child travelled or resided outside of Canada or the United States? **If so**, complete the travel and residence abroad questionnaire. | ☐ | ☐ | ☐ | ☐ |
| 9.14 | Is the child planning to travel or reside outside of Canada or the United States in the next 2 years? **If so**, complete the travel and residence abroad questionnaire. | ☐ | ☐ | ☐ | ☐ |

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## 10 MEDICAL INFORMATION (Do not complete Section 10 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)

### 10.1 MEDICAL HISTORY

**Check YES or NO. For each "YES" answer:**
**– Circle the relevant illness, condition or situation.**
**– Provide details in Section 10.2 Additional Information or complete the requested questionnaire, available in the illustration software.**

| | | PROPOSED INSURED 1 OR CHILD 1 | | PROPOSED INSURED 2 OR CHILD 2 | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| **10.1.1** | Has the child ever consulted a physician for, been diagnosed with or shown any signs or symptoms of any of the following conditions: | | | | |
| | a) Cardiac malformation or other congenital abnormality? | ☐ | ☐ | ☐ | ☐ |
| | b) Cerebral palsy, amyotrophic lateral sclerosis, muscular dystrophy, cystic fibrosis or delay in physical or mental development? | ☐ | ☐ | ☐ | ☐ |
| **10.1.2** | Is the child under 1 year old? | ☐ | ☐ | ☐ | ☐ |
| | **If so**, was he or she born more than 4 weeks prematurely? | ☐ | ☐ | ☐ | ☐ |
| **10.1.3** | Has the child ever consulted for, been treated for or shown signs or symptoms of the following conditions? | | | | |
| | a) CARDIOVASCULAR SYSTEM: High blood pressure, high level of cholesterol or triglicerides, chest pain, palpitations, irregular heart beat, heart murmur, acute rheumatic fever, heart attack, cerebrovascular accident, aneurysm or any other heart or blood vessel disorder? | ☐ | ☐ | ☐ | ☐ |
| | b) RESPIRATORY SYSTEM: Asthma, emphysema, shortness of breath, chronic bronchitis, sleep apnea or any other pulmonary or respiratory disorder? **If so**, complete the respiratory disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | c) GASTROINTESTINAL SYSTEM: | | | | |
| | c1. Hepatitis, cirrhosis of the liver, pancreatitis or other liver disorder? | ☐ | ☐ | ☐ | ☐ |
| | c2. Ulcerative colitis, Crohn's disease, hemorrhage, esophagus, stomach, gallbladder or intestine disorder? **If so**, complete the intestinal disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | d) GENITOURINARY SYSTEM: Urine abnormalities, kidney, bladder, prostate or genital organ disorder, sexually transmitted diseases or abnormal PAP tests? | ☐ | ☐ | ☐ | ☐ |
| | e) ENDOCRINE SYSTEM: | | | | |
| | e1. Thyroid gland disorder or other endocrine condition? | ☐ | ☐ | ☐ | ☐ |
| | e2. Diabetes? **If so**, complete the diabetes questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | f) MUSCULOSKELETAL SYSTEM: | | | | |
| | f1. Back or neck pain or disorder? **If so**, complete the back or neck disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | f2. Arthritis, gout, bursitis, tendonitis, sprain or other muscle, ligament, bone or joint disorder? **If so**, complete the musculoskeletal disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | g) NERVOUS SYSTEM: Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness, tingling or any other neurological disorder? | ☐ | ☐ | ☐ | ☐ |
| | h) MENTAL HEALTH: Attention deficit disorder, autism, depression, adjustment disorder, anxiety, fatigue/ overstress or any other psychological, psychiatric or mental disorder? **If so**, complete the psychological disorders questionnaire. | ☐ | ☐ | ☐ | ☐ |
| | i) IMMUNE SYSTEM: Lupus, AIDS-related complex, AIDS or test results indicating possible exposure to AIDS or HIV (Human Immunodeficiency Virus) or any other immune system disorder? | ☐ | ☐ | ☐ | ☐ |
| | j) GENERAL: | | | | |
| | j1. Anemia or other blood disease, leukemia, lymph node disorder, cancer, tumour, cyst, polyp, nodule, skin disease or skin lesion, eye or ear condition or breast disorder including lumps? | ☐ | ☐ | ☐ | ☐ |
| | j2. Any other physical or mental disorder not mentioned in Question 10.1.3 a) in j1? | ☐ | ☐ | ☐ | ☐ |
| **10.1.4** | Has the child ever received treatment or has he or she been advised to undergo treatment or to consult a physician regarding his or her consumption of drugs or alcohol? | ☐ | ☐ | ☐ | ☐ |

## 10 MEDICAL INFORMATION (cont.) **(Do not complete Section 10 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)**

### 10.1 MEDICAL HISTORY (cont.)

| | Proposed Insured 1 or Child 1 Yes | Proposed Insured 1 or Child 1 No | Proposed Insured 2 or Child 2 Yes | Proposed Insured 2 or Child 2 No |
|---|---|---|---|---|
| **10.1.5** In the last 5 years, | | | | |
| a) Has the child had an electrocardiogram, X-ray, CT scan, MRI, blood tests or follow-up, screening or diagnostic tests? | ☐ | ☐ | ☐ | ☐ |
| b) Has the child been admitted as a patient to any hospital or clinic? | ☐ | ☐ | ☐ | ☐ |
| **10.1.6** In the last 5 years, has the child been disabled or absent from work or school for a period of 4 consecutive weeks or more due to illness or injury? | ☐ | ☐ | ☐ | ☐ |
| **10.1.7** In the last 2 years, has the child undergone a mammography or breast ultrasound? | ☐ | ☐ | ☐ | ☐ |
| **10.1.8** Has the child ever consulted or been advised to consult a physician or a specialist or been advised to receive treatment following abnormal findings of an ultrasound, biopsy or mammography? | ☐ | ☐ | ☐ | ☐ |
| **10.1.9** Is the child taking any medication? **If so**, specify which medications. | ☐ | ☐ | ☐ | ☐ |
| **10.1.10** Does the child have any symptoms or signs for which he or she has not yet consulted? | ☐ | ☐ | ☐ | ☐ |
| **10.1.11** Does the child have to consult a physician or a specialist, undergo a treatment or surgery or take follow-up or diagnostic tests which have not yet been performed? | ☐ | ☐ | ☐ | ☐ |
| **10.1.12** Has the child previously had complications during a pregnancy or at childbirth (gestational diabetes, preeclampsia, caesarian section, postpartum depression)? | ☐ | ☐ | ☐ | ☐ |
| **10.1.13** a) Is the child pregnant? | ☐ | ☐ | ☐ | ☐ |
| b) **If so**, what is the due date? | Year | Month | Year | Month |

### 10.2 ADDITIONAL INFORMATION

If you need extra space, attach an extra sheet, duly dated and signed.

| Question No. | Child's name | Diagnosis, date of diagnosis, dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited |
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# 10 MEDICAL INFORMATION (cont.) (Do not complete Section 10 if a PARAMEDICAL EXAMINATION or a TELEPHONE INTERVIEW is requested.)

## 10.3 HEIGHT AND WEIGHT

**PROPOSED INSURED 1 OR CHILD 1**

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

In the last twelve months, has the child lost 4.5 kg (10 lb.) or more?
☐ Yes ☐ No **If so**, how much weight was lost? ________ ☐ kg ☐ lb.

Reason for the weight loss: ________________

**PROPOSED INSURED 2 OR CHILD 2**

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

In the last twelve months, has the child lost 4.5 kg (10 lb.) or more?
☐ Yes ☐ No **If so**, how much weight was lost? ________ ☐ kg ☐ lb.

Reason for the weight loss: ________________

## 10.4 PHYSICIANS

### 10.4.1 Personal physician

**PROPOSED INSURED 1 OR CHILD 1**

Name of personal physician

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

**PROPOSED INSURED 2 OR CHILD 2**

Name of personal physician

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

### 10.4.2 Last physician consulted

**PROPOSED INSURED 1 OR CHILD 1**

Name of last physician consulted, if different

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

**PROPOSED INSURED 2 OR CHILD 2**

Name of last physician consulted, if different

Address

Area code Tel.

Date of last consultation

Reason for last consultation

Year Month Day

Results and current condition (consultations or treatments recommended)

## 10.5 FAMILY HISTORY

Have any of the child's immediate family members, meaning father, mother, brother, sister or maternal or paternal grandparents, whether living or deceased, ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? **If so**, provide required information below.

| PROPOSED INSURED 1 OR CHILD 1 | | PROPOSED INSURED 2 OR CHILD 2 | |
|---|---|---|---|
| Yes | No | Yes | No |
| ☐ | ☐ | ☐ | ☐ |

| Child's name | Relationship to the child | Name of disease (if cancer, specify type) | Age at diagnosis of the disease | Age if alive | Age at death | Cause of death |
|---|---|---|---|---|---|---|
| | | | | | | |
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SECTION RESERVED FOR CHILDREN'S LIFE INSURANCE RIDER

## 11 CHILDREN'S LIFE INSURANCE RIDER

### 11.1 CHILDREN'S INFORMATION FOR THE CHILDREN'S LIFE INSURANCE RIDER

The children must be the proposed insured's as indicated on the child's birth certificate or by virtue of legal adoption. All the proposed insured's children under age 18 must be identified. When there are more than 2 children, use as many additional applications as necessary.

| | Last name | First name | Gender | Date of birth (Year / Month / Day) |
|---|---|---|---|---|
| Child 1 | | | ☐ M ☐ F | |
| Child 2 | | | ☐ M ☐ F | |

### 11.2 BENEFICIARY INFORMATION

| Last name | First name | Date of birth (Year / Month / Day) | Relationship to the children (in Quebec, relationship to the policyholder) | Check one: Revocable | Irrevocable |
|---|---|---|---|---|---|
| | | | | ☐ | ☐ |

### 11.3 OTHER INSURANCE IN FORCE OR PENDING

**CHILD 1**

Does the child currently hold a life (**LIFE**) or critical illness (**CI**) insurance contract or have a pending application for any of these types of insurance?
☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | Insured amount | Company name | Year and month issued (check if pending): Year | Month | Pending |
|---|---|---|---|---|---|---|
| ☐ | ☐ | $ | | | | ☐ |

**CHILD 2**

Does the child currently hold a life (**LIFE**) or critical illness (**CI**) insurance contract or have a pending application for any of these types of insurance?
☐ Yes ☐ No **If so**, provide the details of these contracts or applications.

| LIFE | CI | Insured amount | Company name | Year and month issued (check if pending): Year | Month | Pending |
|---|---|---|---|---|---|---|
| ☐ | ☐ | $ | | | | ☐ |

### 11.4 PREVIOUS INSURANCE COVERAGE

**CHILD 1**

Has the child ever had a life (**LIFE**) or critical illness (**CI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium?
☐ Yes ☐ No **If so**, provide details on these applications.

| Year | Month | LIFE | CI | Company name | Decision | Reason |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | | | |

**CHILD 2**

Has the child ever had a life (**LIFE**) or critical illness (**CI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium?
☐ Yes ☐ No **If so**, provide details on these applications.

| Year | Month | LIFE | CI | Company name | Decision | Reason |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | | | |

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## 11 CHILDREN'S LIFE INSURANCE RIDER (cont.)

### 11.5 NON-MEDICAL INFORMATION

**Check YES or NO. For each "YES" answer, provide details in Section 11.8 Additional Information.**

| | | CHILD 1 Yes | CHILD 1 No | CHILD 2 Yes | CHILD 2 No |
|---|---|---|---|---|---|
| | **Alcohol and drugs** | | | | |
| 11.5.1 | Has the child ever consulted, been treated or hospitalized for alcohol or drug abuse? | ☐ | ☐ | ☐ | ☐ |
| | **Driving record** | | | | |
| 11.5.2 | Has the child ever had his or her driver's licence restricted or revoked, or does the child have 3 or more violations of the Highway Safety Code? | ☐ | ☐ | ☐ | ☐ |
| | **Aviation and hazardous sports** | | | | |
| 11.5.3 | In the last 2 years, has the child flown a plane, taken flying lessons, taken part in scuba diving, skydiving, hang gliding or any other hazardous sport or activity or does he or she plan to do so? | ☐ | ☐ | ☐ | ☐ |

### 11.6 MEDICAL INFORMATION

**Check YES or NO. For each "YES" answer:**
**– Circle the relevant illness, condition or situation.**
**– Provide details in Section 11.8 Additional Information.**

| | CHILD 1 Yes | CHILD 1 No | CHILD 2 Yes | CHILD 2 No |
|---|---|---|---|---|
| Has the child consulted, been treated or hospitalized for cardiac or cerebral malformation, diabetes, cancer, tumor, leukemia, kidney disorder, asthma, convulsions, epilepsy, neurological disorder, depression, anxiety, liver disorder or Hepatitis B or C or is he or she a carrier of Hepatitis B or C or Acquired Immune Deficiency Syndrome (AIDS) or does he or she have an AIDS-related condition or tested positive for HIV? | ☐ | ☐ | ☐ | ☐ |

### 11.7 HEIGHT AND WEIGHT

| CHILD 1 | CHILD 2 |
|---|---|
| Height: ________ ☐ cm ☐ ft./in. Weight: ________ ☐ kg ☐ lb. | Height: ________ ☐ cm ☐ ft./in. Weight: ________ ☐ kg ☐ lb. |

### 11.8 ADDITIONAL INFORMATION

If you need extra space, attach an extra sheet, duly dated and signed.

| Question No. | Child's name | Diagnosis, date of diagnosis, dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited |
|---|---|---|
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## 12 PREMIUM PAYMENT

### PREMIUM PAYMENT METHOD SELECTION

☐ **Annual** Cheque must be made out to La Capitale Insurance and Financial Services.

☐ Cheque attached to this application $ ____________

☐ Cheque to be received on policy delivery **If this option is selected, the Conditional Certificate of Temporary Insurance does not apply.**

☐ **Preauthorized debit (PAD)** Do not enclose a cheque to cover the initial premium.

Fill out the Preauthorized Debit (PAD) agreement in Section 13. **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**

## 13 PREAUTHORIZED DEBIT (PAD) AGREEMENT

I, the undersigned, authorize La Capitale Insurance and Financial Services Inc. (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 or from the account identified below.

### BANK ACCOUNT INFORMATION

Enclose a cheque specimen or complete according to the example below:

⑈243⑈ ⑆00005⑉123⑆ 12345⑉123456⑈

Branch number | Financial institution number | Account number

Branch number ______ Financial institution number ______ Account number ______

**PAD type:** ☐ Personal ☐ Business

**Withdrawal date:** The ______ of each month (between the 1st and 28th 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.

Payor's name ______________________ Payor's address (if other than policyholder) ______________________

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

### SIGNATURE OF PERSON PAYING PREMIUM

✗ ______________________

Signature of person paying premium

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

## 14 QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE
(life insurance, disability income or critical illness) (Must be completed for all proposed insureds)

**Give the Conditional Certificate of Temporary Insurance to the policyholder if all questions in this section are answered NO.**

Have you ever consulted for, been treated for or shown signs or symptoms of the following:

| | Question | PROPOSED INSURED 1 Yes | PROPOSED INSURED 1 No | PROPOSED INSURED 2 Yes | PROPOSED INSURED 2 No |
|---|---|---|---|---|---|
| **14.1** | Cardiac or blood vessel disorders, including hypertension or high blood pressure, chest pain, angina, heart attack or stroke (cerebrovascular accident), cancer or tumor, AIDS (Acquired Immunodeficiency Syndrome), AIDS-related complex or any other immune system disorder, diabetes, chronic renal or pulmonary failure, chronic liver disease, multiple sclerosis, paralysis, Parkinson's disease or Alzheimer's disease? | ☐ | ☐ | ☐ | ☐ |
| **14.2** | In the last 30 days, have you consulted or been treated by a physician or other practitioner for a reason other than pregnancy without complications or a minor condition for which no other follow-up visit has been scheduled or planned or for which the results are as yet unknown? | ☐ | ☐ | ☐ | ☐ |
| **14.3** | In the last 3 years, have you had an application for individual or group life, disability, critical illness or long-term care insurance declined, deferred, modified, cancelled or rated with a higher premium? | ☐ | ☐ | ☐ | ☐ |
| **14.4** | Have you ever been or are you currently on leave from work due to disability? | ☐ | ☐ | ☐ | ☐ |

## 15 AUTHORIZATION TO DISCLOSE INFORMATION TO THE ADVISOR OR TO THE GENERAL AGENT

The policyholder and the proposed insured authorize the Insurer to disclose to the advisor or to the general agent personal information collected in the application or during the underwriting process that may affect the premium rate or contract issuance. This information generally includes the results of medical or laboratory tests, medical, employment and alcohol or drug consumption history, criminal record, financial information or any other information considered when evaluating the application.

**The Insurer may decide not to disclose this information to the advisor or the general agent even if this Authorization is signed.**

This Authorization will remain valid for 45 days after the contract is issued or a notice that the application was declined has been sent. This Authorization may be cancelled at any time by sending written notice to the Insurer.

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

**POLICYHOLDER 1'S SIGNATURE**

X ______________________

Policyholder 1's signature

**POLICYHOLDER 2'S SIGNATURE**

X ______________________

Policyholder 2's signature

**PROPOSED INSURED 1'S SIGNATURE**

X ______________________

Proposed insured 1's signature or his or her legal guardian's signature, if the proposed insured is under age 18 in Quebec or under age 16 outside Quebec

**PROPOSED INSURED 2'S SIGNATURE**

X ______________________

Proposed insured 2's signature or his or her legal guardian's signature, if the proposed insured is under age 18 in Quebec or under age 16 outside Quebec

## 16 DECLARATIONS AND APPLICATION SIGNATURES

The policyholder and the proposed insured hereby declare that all of the answers and explanations given in this application and, where applicable, in any other related form including in any telephone or face-to-face interview, are true and complete, in the knowledge that the Insurer shall base any decision to issue the contract on this information.

Subject to the general conditions of the contract and the conditions of the Conditional Certificate of Temporary Insurance, if issued, the policyholder and the proposed insured agree that all insurance shall become effective on the date on which the Insurer accepts this application, provided that it is accepted without modification, that the initial premium has been paid and that there have been no changes in the insurable risk of each proposed insured since the application was signed.

The policyholder and the proposed insured acknowledge that any suicide of a proposed insured during the first two years following the effective date of any life insurance benefit issued for that person 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.

The policyholder acknowledges having read the illustration containing information about the coverage applied for, including guaranteed and non-guaranteed elements and any applicable restrictions, reductions and exclusions. The policyholder acknowledges that his or her advisor has provided satisfactory explanations.

The policyholder acknowledges having read and understood the Important Notice concerning La Capitale investment accounts.

If the Conditional Certificate of Temporary Insurance was issued, the policyholder acknowledges having read and understood it.

The policyholder acknowledges having received and read the MIB, Inc. notice, the notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews and the Personal Information Protection Notice.

Moreover, the proposed insured consents to the policyholder taking out this insurance.

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

**POLICYHOLDER 1'S SIGNATURE**

X ______________________

Policyholder 1's signature

**POLICYHOLDER 2'S SIGNATURE**

X ______________________

Policyholder 2's signature

**PROPOSED INSURED 1'S SIGNATURE**

X ______________________

Proposed insured 1's signature or his or her legal guardian's signature, if the proposed insured is under age 18 in Quebec or under age 16 outside Quebec

**PROPOSED INSURED 2'S SIGNATURE**

X ______________________

Proposed insured 2's signature or his or her legal guardian's signature, if the proposed insured is under age 18 in Quebec or under age 16 outside Quebec

**ADVISOR'S SIGNATURE**

X ______________________

Advisor's signature

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Contract No.: Leave this blank

## 17 AUTHORIZATION

1. 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.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
3. This authorization shall also be valid for the collection, use and communication of personal information regarding my minor children insofar as they are concerned by my application.
4. A photocopy of this authorization shall be considered as valid as the original.

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

**PROPOSED INSURED 1'S SIGNATURE**

X ______________________

Proposed insured 1's signature (authorized to sign if age 14 or over in Quebec and if age 16 or over outside Quebec)

X ______________________

Signature of a parent or legal guardian if proposed insured 1 is a minor

______________________

Please print the parent's or legal guardian's name

**PROPOSED INSURED 2'S SIGNATURE**

X ______________________

Proposed insured 2's signature (authorized to sign if age 14 or over in Quebec and if age 16 or over outside Quebec)

X ______________________

Signature of a parent or legal guardian if proposed insured 2 is a minor

______________________

Please print the parent's or legal guardian's name

**ADVISOR'S SIGNATURE**

X ______________________

Advisor's signature

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## 18 CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE (life insurance, disability income or critical illness)

**Give to the policyholder only if the proposed insured has answered NO to the questions in section 14.**

The Conditional Certificate of Temporary Insurance (the "Certificate") guarantees limited insurance coverage while the insurance application identified by the number at the bottom of this page is being reviewed by the Insurer. Being covered by the Certificate does not guarantee that the application will be accepted.

**Effective date of the Certificate**

The Certificate shall be effective when the following conditions are met:
- the proposed insured has answered "No" to the questions related to the Certificate;
- the answers to all the questions are complete and accurate;
- the first annual premium has been paid or the Preauthorized Debit (PAD) Agreement has been duly completed and signed; and
- the policyholder must not have asked that the contract's effective date be set for a specific subsequent date.

Subject to the above-mentioned terms and conditions, the Certificate shall be effective on the later of the following dates:
- the signature date of the duly completed application; or
- the date of completion of the last test, exam or telephone interview or declaration or form required prior to reviewing the application.

**Termination of Certificate**

The temporary coverage provided under this Certificate shall be terminated on the earliest of the following events:
- the effective date of the requested contract;
- the date a counteroffer is sent by the Insurer to the advisor;
- the date a notice is sent by the Insurer to the policyholder declining the requested contract;
- the date a notice is sent by the Insurer to the advisor or to the policyholder regarding its decision to terminate this Certificate;
- the date on which the policyholder requests cancellation of the application; or
- the 60th day following the effective date of the Certificate.

### 18.1 – Terms and exclusions with respect to Life Insurance

If the proposed insured dies while his or her Certificate is in force, the payment of the insurance amount shall be made as if the requested contract had been issued, subject to the terms and exclusions set forth in said contract and in the Certificate, with the latter taking precedence.

No insurance amount shall be payable under the Certificate if the proposed insured is under 15 days old or over age 64.

No insurance amount shall be payable under the Certificate in the event of misrepresentation, omission, concealment or fraud in the application or any other related document.

On the effective date of the Certificate, the proposed insured must constitute an insurable risk at the standard rate according to the Insurer's underwriting criteria.

In the event of the suicide of the proposed insured, whether or not this person is of sound mind, the Certificate shall be null and void and the Insurer's sole responsibility shall be limited to reimbursing any premium paid.

The sole additional benefits and riders to which section 18.1 applies are those that include a life insurance benefit (excluding accidental death).

The insurance amount payable for each proposed insured under the Certificate, or any other certificate in force with the Insurer, corresponds to the lesser of:
- the insurance amount requested MINUS any portion of the insurance amount requested as a result of the exercise of a conversion privilege or a guaranteed insurability option, or the replacement of contracts in force with the Insurer; or
- $500,000.

### 18.2 – Terms and exclusions with respect to Disability Income Benefits

If the proposed insured enters a state of total disability while his or her Certificate is in force, the Insurer shall review his or her file according to its usual underwriting criteria without considering any changes in the nature of this person's insurable risk which may have occurred following the effective date of the Certificate.

Therefore, in the event that, on the effective date of the Certificate and **subject to the coming into force of the life insurance contract to which the disability income benefit is attached,**
- the Insurer would have issued a standard disability income benefit, then a disability income benefit in accordance with the application shall be issued;
- the Insurer would have issued a reduced or amended disability income benefit, then a reduced or amended disability income benefit shall be issued;
- the Insurer would not have issued a disability income benefit, then no disability income benefit shall be issued and the Certificate shall be terminated.

**If a disability income benefit is issued pursuant to a Certificate, it shall be issued under the same terms as the requested coverage, including the elimination period, subject to the terms and exclusions of the Certificate, with the latter taking precedence.**

If the proposed insured does not enter a state of total disability while his or her Certificate is in force, any changes in the nature of the insurable risk regarding this person which may have occurred following the signature of the application shall be taken into consideration in order to determine if a disability income benefit will be issued and, if so, under what terms.

No disability income benefit amount shall be payable under the Certificate if the proposed insured is under age 18 or over age 55.

No disability income benefit amount shall be payable under the Certificate in the event of misrepresentation, omission, concealment or fraud in the application or any other related document.

No disability income benefit amount shall be payable under the Certificate if the disability of the proposed insured results from a wilfully self-inflicted bodily injury or from a suicide attempt, whether or not the proposed insured is of sound mind; from bodily injuries suffered when the proposed insured was driving a vehicle when under the influence of drugs or alcohol in excess of the legal limit; from pregnancy, except for complications due to pregnancy; from wilfully ingesting poison or wilfully inhaling gas; from ingesting narcotics or other drugs, with or without a medical prescription, in such quantity that they become toxic; from bodily injuries suffered during military operations or while participating in a public uprising, a riot or an insurrection; from being involved, directly or indirectly, in a criminal act, participating in a risky sport or being on a flight other than as a regular passenger on a normally scheduled flight.

The disability income benefit amount payable for each proposed insured under the Certificate, or any other certificate in force with the Insurer, corresponds to the lesser of:
- the disability income benefit amount requested MINUS any portion of the disability income benefit amount requested as a result of a replacement of contracts in force with the Insurer; or
- $2,000 per month.


Continued on the next page

**18.3 – Terms and exclusions with respect to Critical Illness Insurance**

If the proposed insured develops an insured critical illness or undergoes a covered surgical procedure while his or her Certificate is in force, the payment of the insurance amount shall be made as if the requested contract had been issued, subject to the terms and exclusions set forth in said contract and in the Certificate, with the latter taking precedence.

No insurance amount shall be payable under the Certificate if the proposed insured is under 31 days old or over age 60.

No insurance amount shall be payable under the Certificate in the event of misrepresentation, omission, concealment or fraud in the application or any other related document.

On the effective date of the Certificate, the proposed insured must constitute an insurable risk at the standard rate according to the Insurer's underwriting criteria.

No insurance amount shall be payable under the Certificate if the proposed insured is diagnosed with cancer or a benign brain tumor OR dies within 30 days of the date of the diagnosis of an insured critical illness or of a covered surgical procedure.

No insurance amount shall be payable under the Certificate if the critical illness or surgical procedure results from a wilfully self-inflicted bodily injury or from a suicide attempt, whether or not the proposed insured is of sound mind; from driving a motorized vehicle when under the influence of drugs or alcohol in excess of the legal limit; from the use of alcohol or drugs; from an act of war, whether it is declared or not; from being involved, directly or indirectly, in a criminal act, participating in a risky sport or being on a flight other than as a regular passenger on a normally scheduled flight.

The sole additional benefits and riders to which section 18.3 applies are those that include a critical illness benefit.

The insurance amount payable for each proposed insured under the Certificate, or any other certificate in force with the Insurer, corresponds to the lesser of:

- the insurance amount requested MINUS any portion of the insurance amount requested as a result of a replacement of contracts in force with the Insurer; or
- $500,000 MINUS any other insured amount under a critical illness insurance payable by the Insurer to the proposed insured.

No advisor may amend the terms of this Certificate.

Indicate the name of the proposed insured eligible* for temporary protection:

| | |
|---|---|
| Eligible proposed insured's name | Eligible proposed insured's name |

* In the event of a claim, the Insurer shall validate the eligibility of proposed insured.

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

**ADVISOR'S SIGNATURE**

Advisor's signature

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## 19 NOTICE

**To be given to the policyholder**

### 19.1 – 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 called the MIB, Inc. (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, the 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

### 19.2 – Notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews

In order to examine your application for insurance, the Insurer may wish to obtain some additional information.

**Investigation:** A representative from an investigation company may contact you to ask you for some personal and financial information.

**Medical examination and tests:** A physician or nurse from a paramedical company may ask you to undergo a medical examination, an electrocardiogram, chest X-ray or other diagnostic tests. Blood, urine or saliva samples may be taken. These samples may be analyzed to check for the presence of HIV antibodies, also known as the AIDS virus, determine your cholesterol level and screen for liver or kidney disorders, diabetes or the presence of nicotine, narcotics or prescription drugs.

You must give written consent before any samples are taken.

Your cooperation in ensuring any medical appointments are scheduled without delay is greatly appreciated.

**Telephone or face-to-face interview:** A telephone or face-to-face interview may be necessary to complete your application for insurance. If so, an evaluator working on behalf of La Capitale will contact you to schedule an appointment for a telephone or face-to-face interview, using the information given in the application. The interview will take from 30 minutes to an hour and you will be asked questions concerning your medical history (complete contact information of physicians you consulted in the last five years, a list of your medications, your height and weight, etc.), your pastimes and lifestyle habits. Please have this information handy. Your assessment will also include a brief memory exercise. The evaluator will not be able to let you know if you are eligible or not after the interview. The information obtained in the interview will be included with that stated in the application as well as any received from your physician.

### 19.3 – Personal Information Protection Notice

La Capitale 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, La Capitale 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 La Capitale.

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 Inc.**
Individual Life and Health Insurance Department
625 Jacques-Parizeau St, PO Box 16040
Quebec QC G1K 7X8

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## 20 TELEPHONE INTERVIEW OR MEDICAL REQUIREMENTS ORDERS

**20.1** Is this a pre-screening exercise? ☐ Yes ☐ No **If so**, do not order a telephone interview or medical requirements.

The following situations are pre-screening:

1) The proposed insured has consulted for, was treated for or has shown signs or symptoms of one of the following diseases: cardiac disorders (infarct, angina, bypass), diabetes, cancer, chronic renal or pulmonary failure, chronic liver disease, multiple sclerosis, paralysis, Parkinson's disease or Alzheimer's disease; or
2) In the last 3 years, the proposed insured has had an application for individual or group insurance declined, deferred or rated with a higher premium.

### 20.2. TELEPHONE INTERVIEW ORDER

If a telephone interview is to be ordered, indicate the best time of day to reach the proposed insured:

| | | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|---|
| **1st choice** | Day of the week: | | |
| | Time of day: | ☐ morning ☐ afternoon ☐ evening | ☐ morning ☐ afternoon ☐ evening |
| | | Area code Tel. (extension) | Area code Tel. (extension) |
| **2nd choice** | Day of the week: | | |
| | Time of day: | ☐ morning ☐ afternoon ☐ evening | ☐ morning ☐ afternoon ☐ evening |
| | | Area code Tel. (extension) | Area code Tel. (extension) |

### 20.3. MEDICAL REQUIREMENTS ORDER

| MEDICAL REQUIREMENTS | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| Paramedical examination | ☐ | ☐ |
| HIV urine | ☐ | ☐ |
| Blood profile | ☐ | ☐ |
| Prostate-specific antigen | ☐ | ☐ |
| Inspection report (Portamedic) | ☐ | ☐ |
| Electrocardiogram | ☐ | ☐ |
| Exercise ECG | ☐ | ☐ |
| Medical examination | ☐ | ☐ |
| Pulmonary X-ray | ☐ | ☐ |

☐ **Medical requirements to be ordered by the Insurer**

☐ **Medical requirements to be ordered by the advisor**

Date ordered: Year Month Day Order confirmation No.: ____________

Medical requirements ordered from:
- ☐ ExamOne
- ☐ MedAxio
- ☐ Portamedic/Hooper Holmes
- ☐ QUS
- ☐ Watermark

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## 21 ADVISOR'S REPORT

**21.1** Who initiated this application process? ☐ Advisor ☐ Policyholder ☐ Proposed insured ☐ Acquaintance
☐ Other advisor ☐ Other: ______________________

**21.2** Do the policyholder and the proposed insured speak or read the application language? ☐ Yes ☐ No
**If not**, who explained the application content to the policyholder and the proposed insured? ______________________
In your opinion, did they understand the explanations? ☐ Yes ☐ No Provide any applicable details: ______________________

**21.3** Did you complete this application in the presence of the policyholder and the proposed insured? ☐ Yes ☐ No
**If not**, explain: ______________________

**21.4** Are you aware of any information that was not included in this application that could affect the underwriting process with regard to the proposed insured?
☐ Yes ☐ No **If so**, explain: ______________________

| | | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|---|
| **21.5** | How long have you known the proposed insured? | | |
| **21.6** | What is the relationship between you and the proposed insured? | | |
| **21.7** | Have you completed and given the Conditional Certificate of Temporary Insurance to the policyholder? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**21.8 ADVISOR'S INFORMATION**

| Advisor's name | Advisor's code | General Agent | General Agent's code |
|---|---|---|---|
| | | | |

**21.9 COMMISSIONS**

Are the commissions to be shared? ☐ Yes ☐ No **If so**, provide information on how the commissions are to be shared.

| Advisor's name | Advisor's code | Split | General Agent | General Agent's code |
|---|---|---|---|---|
| | | % | | |
| | | % | | |
| | | % | | |

**21.10 SPECIAL INSTRUCTIONS**

______________________

______________________

**21.11 ADVISOR'S DECLARATION**

I hereby declare that the information provided in this section is true.

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 acknowledge having provided all information on the requested coverage, 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 is complete, accurate, and up-to-date.

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

**ADVISOR'S SIGNATURE**

✗ ______________________
Advisor's signature

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