May 2015 version

La Capitale
Insurance and
Financial Services

Long Term Care

Preselection Guide and Insurance Application

T120 (05-2015)

Preselection Guide

QUESTIONNAIRE

In order to be eligible for Long Term Care coverage, the proposed insured must be able to answer NO to all of the questions below.

	PROPOSED INSURED 1		PROPOSED INSURED 2	
	Yes	No	Yes	No
1. Are you currently receiving disability or workers' compensation benefits?	☐	☐	☐	☐
2. Are you currently receiving, or has it been recommended that you receive, home care or care in a rehabilitation day centre?	☐	☐	☐	☐
3. Have you ever been treated by a physician for, or been told that you have, any of the following condition:				
a) Immune system disorder, including Acquired Immunodeficiency Syndrome (AIDS), AIDS-related syndrome or positive test results for human immunodeficiency virus (HIV)?	☐	☐	☐	☐
b) Paralysis, multiple sclerosis, muscular dystrophy or Parkinson's disease?	☐	☐	☐	☐
c) Alzheimer's disease, senility, dementia, chronic memory loss or other cerebral disorder?	☐	☐	☐	☐
d) Huntington's chorea or amyotrophic lateral sclerosis (Lou Gehrig's disease)?	☐	☐	☐	☐
e) Amputation of any part of your body due to illness?	☐	☐	☐	☐
f) Kidney failure or cirrhosis?	☐	☐	☐	☐
g) More than one cerebrovascular accident (stroke) or transient ischemic attack in the last 2 years?	☐	☐	☐	☐
h) Cancer that has spread from its original site?	☐	☐	☐	☐
4. Do you have a handicap that limits your ability to perform any of the following activities: dressing, feeding, walking, bathing, toileting, taking prescription drugs, doing housework, transferring, running errands or managing personal finances?	☐	☐	☐	☐

In order to be eligible, a proposed insured age 70 or over must have consulted a physician during the last 3 years for a complete medical examination including a blood profile.

WEIGHT AND HEIGHT TABLE

Using the following table, check that the proposed insured's height and weight meet the eligibility criteria. If not, the proposed insured is not eligible. This table applies to both men and women.

The proposed insured's weight should be stable for a minimum of 12 months prior to the application.

IMPERIAL			METRIC		
Height (ft. and in.)	**Minimum weight (lb.)**	**Maximum weight (lb.)**	**Height (cm)**	**Minimum weight (kg)**	**Maximum weight (kg)**
4'10"	81	196	147	37	89
4'11"	84	203	150	38	92
5'00"	89	210	152	40	95
5'01"	94	217	155	43	98
5'02"	96	223	157	44	101
5'03"	98	230	160	44	104
5'04"	101	237	163	46	108
5'05"	104	243	165	47	110
5'06"	107	248	168	49	112
5'07"	111	253	170	50	115
5'08"	114	261	173	52	118
5'09"	117	269	175	53	122
5'10"	119	278	178	54	126
5'11"	122	290	180	55	132
6'00"	125	297	183	57	135
6'01"	128	305	185	58	138
6'02"	132	312	188	60	142
6'03"	136	320	191	62	145
6'04"	139	325	193	63	147
6'05"	143	330	196	65	150
6'06"	146	337	198	66	153

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UNACCEPTABLE RISKS

In order to be eligible, the proposed insured must not suffer from any of the health problems mentioned in the following list:

A

- Acquired Immunodeficiency-Syndrome (AIDS)
- Acromegaly
- Alcohol abuse
- Alpha-antitrypsin deficiency
- Alzheimer's disease
- Amnesia
- Amputation due to disease or amputation of more than one limb
- Aneurysms (recurrent or multiple)
- Aneurysm with tobacco use within the last 24 months
- Angina with history of heart surgery
- Arthritis (severe), with limitations, durable medical equipment use or surgery recommended
- Asthma with tobacco use within the last 24 months
- Ataxia (unstable gait)
- Autonomic neuropathy

B

- Bedsores
- Blastomycosis
- Buerger's disease or thromboangiitis obliterans

C

- Chagas' disease (active)
- Chromosomal abnormality
- Cirrhosis
- Confusion
- Cystic fibrosis

D

- Dementia
- Demyelination or demyelinating disease
- Depression (current)
- Drug use (current)

E

- Esophageal varices

F

- Factor V Leiden
- Friedreich's ataxia

G

- Gastric balloon catheter
- Gaucher's disease
- Giant cell arteritis (active)

H

- Heart attack (with history of two attacks)
- Hemiplegia
- Hemodialysis or peritoneal dialysis
- Hemophilia
- Hepatitis (chronic, active) – Type A, B, C, non-A, non-B or autoimmune
- Hospitalization (current or anticipated)
- Human Immunodeficiency Virus positive (HIV+)
- Hunter's syndrome
- Huntington's chorea
- Hurler syndrome
- Hydrocephalus

I

- IADL deficits
- Immune system disorders
- Intestinal angina

K

- Kaposi's sarcoma
- Korsakoff's pychosis or Korsakoff's syndrome

L

- Lesch-Nyhan syndrome
- Lou Gehrig's disease or amyotrophic lateral sclerosis
- Lymphoid interstitial pneumonia

M

- Marfan syndrome
- Melanoma with recurrence
- Memory loss
- Mentally handicapped
- Mixed connective tissue disease
- Mobility limitations
- Monoclonal gammopathy
- Multiple myeloma
- Multiple sclerosis
- Muscular dystrophy

N

- Neurofibromatosis
- Neurogenic bladder

O

- Organic brain syndrome
- Osler-Weber-Rendu disease
- Oxygen use

P

- Paraplegia
- Parkinson's disease
- Polyarteritis nodosa
- Portal hypertension
- Post-polio syndrome
- Posterolateral sclerosis
- Progressive muscular atrophy
- Psychoneurosis
- Psychopathy
- Psychosis
- Pulmonary fibrosis (symptomatic)

Q

- Quadriplegia

S

- Sarcoidosis (active)
- Schizophrenia
- Scleroderma (active)
- Sclerosing cholangitis
- Senility
- Shy-Drager syndrome
- Sleep apnea with history of narcolepsy or with tobacco use within the last 24 months
- Spinal muscular atrophy
- Surgery, planned or recommended
- Syphilis (stage IV)

T

- Telangiectasias
- Transverse myelitis (acute or other)

V

- Ventriculo-peritoneal shunt
- Von Hippel-Lindau disease

W

- Waldenstrom's macroglobulinemia
- Walker use
- Wegener's granulomatosis
- Wernicke-Korsakoff syndrome
- Whipple's disease
- Wilson's disease
- Wiskott-Aldrich syndrome

X

- Xeroderma pigmentosa

INELIGIBLE DRUG CATEGORIES

All medications that the proposed insured takes, whether prescribed or bought over the counter, are important and must be disclosed in the application. We have indicated below **certain categories of medications that are usually ineligible**, since their use indicates that the proposed insured is at risk on account of significant health problems.

INELIGIBLE DRUG CATEGORIES

- Anti-dementia medications
- Anti-neoplastic medications
- Anti-Parkinson's medications
- Antipsychotic medications
- Chemotherapy agents
- Injectable medications
- Anti-tubercular medications
- Centrally acting analgesics
- IV infusion medications
- Narcotic or opioid analgesics
- Steroidal medications at or greater than 5 mg/day

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INELIGIBLE MEDICATIONS

The list below includes some of the medications from the categories listed previously. This list is not exhaustive, as new medications are continuously released on the market. Also, some medications approved for new conditions may become ineligible.

A

- Adriamycin
- Agrylin
- Akineton
- Alferon
- Alkeran
- Antabuse
- Aptivus
- Arava
- Aricept
- Artane
- AZT

B

- Baclofen
- Benztropine
- Bicnu
- Blenoxane
- Bromocriptine
- Busulfex/ Busulfan
- Byetta

C

- Campral
- Carbex
- Carbidopa
- Casodex

C (cont.)

- CeeNU
- Cerefolin
- Cerubidine
- Chrysotherapy
- Clozaril
- Cogentin
- Cognex
- Cytosar-U
- Cytoxan

D

- Dacarbazine (DTIC)
- Dantrium
- Donepezil
- Dopar
- Dostinex
- Doxil

E

- Eldepryl
- Enbrel
- Ergamisol
- Ergoloid Mesylate
- Etoposide
- Eulexin
- Exelon

F

- Femara
- Forteo
- Foscavir
- FUDR

G

- Galantamine
- Geodon
- Gerimal
- Gleevec
- Gold Therapy

H

- Haldol
- Haloperidol
- Herceptin
- Humira
- Hydergine
- Hydrea

I

- Ifex
- Imuran (except for ulcerative colitis)
- Insulin ≥ 41 units per day
- Interferon
- Intron

K

- Kemadrin

L

- L-Dopa
- Lanvis
- Laradopa
- Lasix ≥ 80 mg per day
- Leukeran
- Leukine
- Levadopa
- Levsin
- Lioresal
- Loxitane
- Lysodren

M

- Matulane
- Megace
- Mellaril
- Meridia
- Mesoridazine
- Mestinon
- Methadone
- Mitomycin
- Moban
- Moditen
- Molindone
- Myleran

N

- Natrecor
- Navane
- Neosar
- Neupogen
- Nilandron
- Niloric
- Nipent
- Novantrone

O

- Oxycodone
- OxyContin

P

- Parlodel
- Permitil
- Platinol
- Pramipexole
- Prednisone ≥ 6 mg per day
- Priftin
- Procyclidine
- Prokine
- Proleukin
- Prolixin
- Prostigmin

R

- Razadyne
- Rebetron
- Regonol
- Remicaid
- Reminyl
- Retrovir
- Rilutek
- Risperdal
- Risperidone
- Rituxan
- Rivastigmine
- Roferon
- Rubex

S

- Serentil
- Seroquel
- Sinemet
- Stelazine
- Symadine
- Symmetrel

T

- TACE
- Tacrine
- Tarceva
- Tasmar
- Teslac
- Thioplex
- Thorazine
- Timespan
- Toposar
- Trelstar
- Tridural
- Trihexane
- Trilafon
- Tysabri

V

- Velban
- Viadur
- Videx
- VePesid

W

- Wellcovorin
- Wellferon

X

- Xeloda
- Xenical

Z

- Zanosar
- Zyprexa

SIGNIFICANT MEDICATIONS*

Generally, proposed insureds who take the following medications are ineligible. Nevertheless, the application for insurance may be approved depending on dosage, frequency and reasons for taking the medication.

- Arimidex
- Bumex – depending on dosage
- Chrysotherapy
- Cortisone injections
- Epidural anesthesia
- Fareston
- Insulin – depending on dosage
- Lasix – depending on dosage
- Lupron
- Lyrica
- Methotrexate (Folex)
- Mirapex
- Neurontin
- Nitroglycerin/ nitroglycerin patch
- Plaquenil
- Purinethol
- Requip
- Steroids – depending on dosage
- Zoladex

Proposed insureds who use narcotics on a regular basis are ineligible. Nevertheless, the application will be reviewed if the proposed insured uses narcotics fewer than two times per week or suffers from chronic pain. The following are examples of narcotics:

- Codeine
- Darvocet
- Darvon
- Empracet
- Hydrocodone
- Oxycontin
- Percocet
- Percodan
- Propacet
- Tylox
- Tylenol 2, 3, 4
- Vicodin

* These lists are not exhaustive.

NOTE FOR THE ADVISOR FOR OBTAINING AN UNDERWRITING OPINION ON THE POSSIBILITY OF ISSUING LIMITED COVERAGE

Name of drug: _____

Dosage and frequency: _____

Start date: _____

Date of last change in dosage and frequency: _____

Specific diagnosis warranting this prescription: _____

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Complete the following application for insurance only if the proposed insured is eligible.

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La Capitale
Insurance and Financial Services

Long Term Care

Insurance Application

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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 long-term care insurance
  - 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.
- 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 14
  - The Conditional Certificate of Temporary Insurance, if issued (Section 13)
- Submit all of the application form pages except the pages that must be given to the policyholder.

ATTACH THE FOLLOWING DOCUMENTS, AS APPLICABLE.	
In all cases	☐ Preselection Guide ☐ Illustration signed by the policyholder
Replacement	☐ Prior notice of replacement ☐ Cancellation-surrender form if an internal replacement
Preauthorized debit (PAD) method of premium payment	☐ Preauthorized Debit (PAD) agreement (Section 8) ☐ 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.**

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Application No.: 11665271

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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.

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 GENERAL INFORMATION (cont.)

2.2 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
☐ Other Provide all information in Sections 2.2 to 2.6.

Go to Section 2.3, Verification of Policyholder's Identity

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 _____

2.3 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: _____

2.4 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 _____ First name _____

Relationship to Policyholder 1 _____ Gender: ☐ Male ☐ Female

Date of birth: Year Month Day _____

SUBROGATED POLICYHOLDER OF POLICYHOLDER 2

Last name _____ First name _____

Relationship to Policyholder 2 _____ Gender: ☐ Male ☐ Female

Date of birth: Year Month Day _____

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2 GENERAL INFORMATION (cont.)

2.5 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 _____

2.6 FINANCIAL INFORMATION

	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.)	$	$

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3 CHOICE OF COVERAGE

LONG TERM CARE: Attach the illustration, signed by the policyholder

PROPOSED INSURED 1

☐ **2 years** ☐ **3 years** ☐ **5 years** ☐ **For life**

Monthly benefit: $ _____

Both options may be selected:
☐ Plus Option ☐ Indexation Option

PROPOSED INSURED 2

☐ **2 years** ☐ **3 years** ☐ **5 years** ☐ **For life**

Monthly benefit: $ _____

Both options may be selected:
☐ Plus Option ☐ Indexation Option

4 BENEFICIARY INFORMATION FOR PLUS OPTION (reimbursement of premiums upon death)

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.

PROPOSED INSURED 1

BENEFICIARY

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

CONTINGENT BENEFICIARY

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

PROPOSED INSURED 2

BENEFICIARY

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

CONTINGENT BENEFICIARY

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

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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) Year	Month	Pending	Personal/ business P	B	Will the insurance applied for replace the existing insurance contract? 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) Year	Month	Pending	Personal/ business P	B	Will the insurance applied for replace the existing insurance contract? 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
		☐	☐	☐			
		☐	☐	☐			

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 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.	☐	☐	☐	☐

6 MEDICAL INFORMATION

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.**	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.	☐	☐	☐	☐

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6 MEDICAL INFORMATION (cont.)

6.1 MEDICAL HISTORY (cont.)

		PROPOSED INSURED 1		PROPOSED INSURED 2	
		Yes	No	Yes	No
6.1.1	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 disorder, 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?	☐	☐	☐	☐
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.)

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 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.

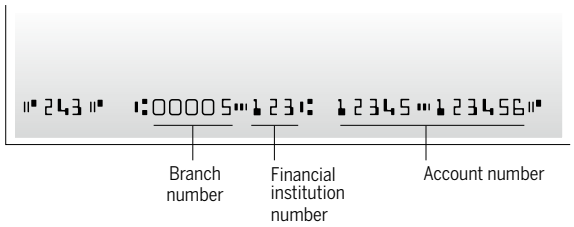
Fill out the Preauthorized Debit (PAD) agreement in Section 8. **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**

8 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:



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

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9 QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE
(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:

		PROPOSED INSURED 1		PROPOSED INSURED 2	
		Yes	No	Yes	No
9.1	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?	☐	☐	☐	☐
9.2	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?	☐	☐	☐	☐
9.3	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?	☐	☐	☐	☐
9.4	Have you ever been or are you currently on leave from work due to disability?	☐	☐	☐	☐

10 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

PROPOSED INSURED 2'S SIGNATURE

X _____
Proposed insured 2's signature

11 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 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.

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

PROPOSED INSURED 2'S SIGNATURE

X _____
Proposed insured 2's signature

ADVISOR'S SIGNATURE

X _____
Advisor's signature

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Contract No.: Leave this blank

12 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. 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

_____
Proposed insured 1's signature

PROPOSED INSURED 2'S SIGNATURE

_____
Proposed insured 2's signature

ADVISOR'S SIGNATURE

_____
Advisor's signature

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13 CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE

Give to the policyholder only if the proposed insured has answered NO to the questions in section 9.

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 or 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.

Terms and exclusions

If the proposed insured enters a state of dependency 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 his or her Certificate. Therefore, in the event that:

- the Insurer would have issued a standard long-term care insurance contract, then a contract in accordance with the application shall be issued;
- the Insurer would have issued a reduced or amended long-term care insurance contract, then a reduced or amended contract shall be issued;
- the Insurer would not have issued a long-term care insurance contract, then no contract shall be issued and the Certificate shall be terminated.

If a contract is issued pursuant to a Certificate, it shall be issued under the same terms as the requested contract, subject to the terms and exclusions of the Certificate, with the latter taking precedence.

If the proposed insured does not enter a state of dependency 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 contract will be issued and, if so, under what terms.

No monthly benefit shall be payable under the Certificate if the proposed insured is under age 30 or over age 70.

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

No monthly benefit shall be payable under the Certificate if the state of dependency of the proposed insured results from a suicide attempt or self-inflicted bodily injuries, whether or not the person 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; from ingesting poison or inhaling gas, whether wilfully or not; from ingesting narcotics or other drugs, with or without a medical prescription, in such quantity that they become toxic; from committing or attempting to commit a criminal act; from bodily injuries suffered during military operations or while participating in a public uprising, a riot or an insurrection; from a mental or nervous disorder without any organic cause.

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

- the monthly benefit requested MINUS any portion of the monthly benefit requested as a result of a replacement of contracts in force with the Insurer; or
- $2,000 per month.

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

La Capitale Insurance and Financial Services Inc. (the Insurer)

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14 NOTICE

To be given to the policyholder

14.1 – 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

14.2 – 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.

14.3 – 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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15 TELEPONE OR FACE-TO-FACE INTERVIEW ORDERS

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)

16 ADVISOR'S REPORT

16.1 Who initiated this application process? ☐ Advisor ☐ Policyholder ☐ Proposed insured ☐ Acquaintance ☐ Other advisor ☐ Other: _____

16.2 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: _____

16.3 Did you complete this application in the presence of the policyholder and the proposed insured? ☐ Yes ☐ No

If not, explain: _____

16.4 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
16.5 How long have you known the proposed insured?		
16.6 What is the relationship between you and the proposed insured?		
16.7 Have you completed and given the Conditional Certificate of Temporary Insurance to the policyholder?	☐ Yes ☐ No	☐ Yes ☐ No

16.8 ADVISOR'S INFORMATION

Advisor's name _____ Advisor's code ____ General Agent _____ General Agent's code ____

16.9 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
		%		
		%		
		%		

COMPLETE AND SIGN THE ADVISOR'S DECLARATION IN SECTION 16.11 ON THE NEXT PAGE.

16 ADVISOR'S REPORT (cont.)

16.10 SPECIAL INSTRUCTIONS

16.11 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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La Capitale