**June 2021**
Version

La Capitale

# Life Insurance and Critical Illness Insurance

## Application

T073 (2021-06)



Application No.: 11665271

## TABLE OF CONTENTS

## INSTRUCTIONS FOR THE ADVISOR

- Print legibly in ink.
- This application must be used for:
  - Applying for individual life or critical illness insurance
  - Converting individual or group term insurance
  - Exchanging individual term insurance
  - Exercising a guaranteed insurability option
  - Adding coverage to an existing contract. If a life insurance contract, it must have been issued after December 31, 2016.
- 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 both life insurance and a main critical illness insurance 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 Civil Service Insurer Inc. 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 and the proposed insured:
  - The 2 notices (Section 17)
  - The Conditional Certificate of Temporary Insurance, if issued (Section 16)
- Submit all of the application form pages except the pages that must be given to the policyholder and the proposed insured.

### 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 *(IND121E)***, if the coverage that is selected is permanent life insurance. |
| **Replacement** | ☐ Prior notice of replacement<br>☐ ***Cancellation-surrender* form *(IND108E)***, 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 |
| **Preauthorized debit (PAD) method of payment** | ☐ Preauthorized Debit (PAD) agreement (Section 12)<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 Civil Service Insurer Inc. **If the cheque is received upon delivery of the policy, the Conditional Certificate of Temporary Insurance does not apply.** |

In this application, "proposed insured" designates any proposed insureds; "policyholder" designates any policyholders and "the Insurer" designates La Capitale Civil Service Insurer 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 *(IND108E)*.**

☐ Conversion of individual insurance (life and critical illness insurance) – Contract Nos. being converted

_____

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

◯ Total

☐ Individual term insurance exchange – Contract numbers to be transferred:

_____

◯ 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)

Sex: ◯ Male ◯ Female

Date of birth: Year Month Day

Marital status

Are you a Canadian citizen? ◯ Yes ◯ No – **If not,** are you a permanent resident of Canada? ◯ Yes ◯ No

Country of birth

In Canada since: Year Month Day

S.I.N.: For permanent life insurance

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)

Sex: ◯ Male ◯ Female

Date of birth: Year Month Day

Marital status

Are you a Canadian citizen? ◯ Yes ◯ No – **If not,** are you a permanent resident of Canada? ◯ Yes ◯ No

Country of birth

In Canada since: Year Month Day

S.I.N.: For permanent life insurance

Address (No., street, apt.)

City | Province | Postal code

Country | Email address

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

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## 2 GENERAL INFORMATION (cont.)

### 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).**

## 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 _____

Sex: ◯ Male ◯ Female Date of birth: ____ ____ ____ (Year Month Day)

Relationship to proposed insured 1 _____ Relationship to proposed insured 2 _____

Marital status _____ S.I.N. _____ (For permanent life insurance)

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 _____

Sex: ◯ Male ◯ Female Date of birth: ____ ____ ____ (Year Month Day)

Relationship to proposed insured 1 _____ Relationship to proposed insured 2 _____

Marital status _____ S.I.N. _____ (For permanent life insurance)

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**

**I.D.** Use original documents only.

◯ Driver's licence ◯ Health insurance card ◯ Passport

◯ Other photo I.D. issued by a federal or provincial authority: _____

Document No.: _____

Expiry date (if available): ____ ____ (Year Month)

Issuing authority: _____

Province or country of issue: _____

**POLICYHOLDER 2**

**I.D.** Use original documents only.

◯ Driver's licence ◯ Health insurance card ◯ Passport

◯ Other photo I.D. issued by a federal or provincial authority: _____

Document No.: _____

Expiry date (if available): ____ ____ (Year Month)

Issuing authority: _____

Province or country of issue: _____

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## 2 GENERAL INFORMATION (cont.)

### A.3 VERIFICATION OF TAX CLASSIFICATION

**Always complete this section for each policyholder.**

#### A.3.1 Foreign Account Tax Compliance Act (FATCA)

**POLICYHOLDER 1**

Is policyholder 1 a U.S. citizen or a U.S. resident for U.S. tax purposes?
◯ Yes ◯ No

**If so**, indicate policyholder 1's U.S. taxpayer identification number (U.S. TIN).

**POLICYHOLDER 2**

Is policyholder 2 a U.S. citizen or a U.S. resident for U.S. tax purposes?
◯ Yes ◯ No

**If so**, indicate policyholder 2's U.S. taxpayer identification number (U.S. TIN).

#### A.3.2 Common Reporting Standard (CRS)

**POLICYHOLDER 1**

Is policyholder 1 a resident of a jurisdiction other than Canada or the United States for tax purposes? ◯ Yes ◯ No

**If so**, enter policyholder 1's country and the foreign taxpayer identification number.

Country | Idenfication number

**POLICYHOLDER 2**

Is policyholder 2 a resident of a jurisdiction other than Canada or the United States for tax purposes? ◯ Yes ◯ No

**If so**, enter policyholder 2's country and the foreign taxpayer identification number.

Country | Idenfication number

### A.4 THIRD PARTY DETERMINATION

**Always complete this section for each policyholder.**

**POLICYHOLDER 1**

Is policyholder 1 acting in accordance with the instructions of another person (third party)? ◯ Yes ◯ No – **If so**, complete the Third-Party Determination section of the ***Verification of an Individual's Identity*** **form *(IND121E)***.

**POLICYHOLDER 2**

Is policyholder 2 acting in accordance with the instructions of another person (third party)? ◯ Yes ◯ No – **If so**, complete the Third-Party Determination section of the ***Verification of an Individual's Identity*** **form *(IND121E)***.

### A.5 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 | Sex: ◯ 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 | Sex: ◯ Male ◯ Female

Date of birth: Year Month Day

## 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 permanent life insurance, complete the *Verification of an Entity's Identity* form *(IND034E)*.**

Name (company name)

Address (No., street, apt.)

City | Province | Country | Postal code

Business number | Place of registration

Name and title of authorized signatories:

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## 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 |
|---|---|---|
| Employment status | ◯ Employee ◯ Self-employed ◯ Student ◯ Farmer ◯ Retiree ◯ At-home spouse ◯ Unemployed | ◯ Employee ◯ Self-employed ◯ Student ◯ Farmer ◯ Retiree ◯ At-home spouse ◯ Unemployed |
| Employer's name | | |
| Is your occupation with the armed forces, natural resources (forestry, mining, the oil or natural gas industries), rail, fishing or marine transport (high seas, outside Canada) industries, performing arts (music, cinema, circus, etc.), bars and entertainment (bar employee, stunt performer, etc.), professional sports (athlete), aviation or professional scuba diving? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| Do you have to work at a height of more than 10 metres (35 feet)? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| Are you on disability? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| Occupation | | |
| 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: | ◯ No ◯ Yes: Year Month | ◯ No ◯ Yes: Year Month |

## 2 GENERAL INFORMATION (cont.)

### 2.4 FINANCIAL INFORMATION (cont.)

#### 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: $ _____

## 3 CHOICE OF COVERAGE

### 3.1 MAIN COVERAGE

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **PERMANENT LIFE INSURANCE** | | |
| ***Non-participating Permanent Advantage*** <br> * The premium payment period varies according to the proposed insured's age. Refer to the illustration and the contract. | ◯ **Individual** – Premium payable: ◯ for 20 years ◯ to age 65 Minimum 25 years ◯ for life <br> ◯ **Joint** – Premium payable: ◯ for 20 years ◯ to age 65 Minimum 25 years* ◯ for life <br> Insured amount payable: <br> ◯ on first-to-die basis <br> ◯ on last-to-die basis, premiums payable until 1st death <br> ◯ on last-to-die basis, premiums payable until 2nd death <br> **Insured amount:** $ _____ | ◯ **Individual** – Premium payable: ◯ for 20 years ◯ to age 65 Minimum 25 years ◯ for life <br> ◯ **Joint** – Premium payable: ◯ for 20 years ◯ to age 65 Minimum 25 years* ◯ for life <br> Insured amount payable: <br> ◯ on first-to-die basis <br> ◯ on last-to-die basis, premiums payable until 1st death <br> ◯ on last-to-die basis, premiums payable until 2nd death <br> **Insured amount:** $ _____ |
| ***T100*** <br> ◯ **Enhanced** <br> ◯ **Pure** | ◯ **Individual** <br> ◯ **Joint** <br> Insured amount payable: <br> ◯ on first-to-die basis <br> ◯ on last-to-die basis, premiums payable until 1st death <br> ◯ on last-to-die basis, premiums payable until 2nd death <br> **Insured amount:** $ _____ | ◯ **Individual** <br> ◯ **Joint** <br> Insured amount payable: <br> ◯ on first-to-die basis <br> ◯ on last-to-die basis, premiums payable until 1st death <br> ◯ on last-to-die basis, premiums payable until 2nd death <br> **Insured amount:** $ _____ |
| **TERM LIFE INSURANCE** | | |
| **Fixed-Term** <br> ◯ **Enhanced** <br> ◯ **Pure** <br> ⚠ **If this is a fixed-term rider, complete section 3.2.** | ◯ **Individual** ◯ **Joint first-to-die** <br> **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years <br> **Insured amount:** $ _____ | ◯ **Individual** ◯ **Joint first-to-die** <br> **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years <br> **Insured amount:** $ _____ |
| **Enhanced Decreasing Term** | ◯ **Individual** ◯ **Joint first-to-die** <br> **Term:** ◯ 15 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years <br> **Insured amount:** $ _____ | ◯ **Individual** ◯ **Joint first-to-die** <br> **Term:** ◯ 15 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years <br> **Insured amount:** $ _____ |

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## 3 CHOICE OF COVERAGE (cont.)

### 3.1 MAIN COVERAGE (cont.)

**CRITICAL ILLNESS**

⚠ For *Simplified Second Chance*, complete the Application form (T079).

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **Fixed term to age 75** | **Premium payable:** ◯ in 15 instalments ◯ to age 65 ◯ until expiry<br>**Insured amount:** $ _____<br>☐ **Reimbursement of premiums on death**<br>☐ **Reimbursement of premiums on surrender or expiry**<br>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.<br>◯ 15-year term ◯ on expiry | **Premium payable:** ◯ in 15 instalments ◯ to age 65 ◯ until expiry<br>**Insured amount:** $ _____<br>☐ **Reimbursement of premiums on death**<br>☐ **Reimbursement of premiums on surrender or expiry**<br>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.<br>◯ 15-year term ◯ on expiry |
| **Fixed term** | **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years<br>**Insured amount:** $ _____ | **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years<br>**Insured amount:** $ _____ |
| **Children's Critical Illness** | **Insured amount:** $ _____<br>☐ Health Option | **Insured amount:** $ _____<br>☐ Health Option |

### 3.2 ADDITIONAL BENEFITS AND RIDERS

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **Fixed-term rider** | **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years<br>**Insured amount:** $ _____ | **Term:** ◯ 10 years ◯ 20 years ◯ 25 years ◯ 30 years ◯ 35 years<br>**Insured amount:** $ _____ |
| **Disability Income Benefit**<br>⚠ Section 8 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** |
| **Accidental Death and Dismemberment** | **Insured amount:** $ _____ | **Insured amount:** $ _____ |
| **Guaranteed Insurability** | **Insured amount:** $ _____ | **Insured amount:** $ _____ |
| ⚠ ***The Provider, Monthly income for your loved ones* rider**<br>Not available if the policyholder is a company. | ◯ **Fixed term** ◯ **Decreasing term**<br>**Term:** ◯ 15 years ◯ 20 years ◯ 25 years<br>**Monthly insured amount:** $ _____ | ◯ **Fixed term** ◯ **Decreasing term**<br>**Term:** ◯ 15 years ◯ 20 years ◯ 25 years<br>**Monthly insured amount:** $ _____ |
| ***Accidental Fracture* rider** | ◯ **Individual** ◯ **Individual with children*** ◯ **1 unit** ◯ **2 units** | ◯ **Individual** ◯ **Individual with children*** ◯ **1 unit** ◯ **2 units** |

**Children's Life Insurance rider*** ⚠ Section 3.3 must be completed.

| | PROPOSED INSURED CHILD 1 | PROPOSED INSURED CHILD 2 |
|---|---|---|
| **Children's Critical Illness rider***<br>⚠ Complete the *children's critical illness rider questionnaire (IND046E).* | Last name: _____<br>First name: _____<br>Date of birth: ____ ____ ____ (Year Month Day)<br>**Insured amount:** $ _____ | Last name: _____<br>First name: _____<br>Date of birth: ____ ____ ____ (Year Month Day)<br>**Insured amount:** $ _____ |

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

## 3 CHOICE OF COVERAGE (cont.)

### 3.3 CHILDREN'S LIFE INSURANCE RIDER

#### 3.3.1 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 4 children, use as many additional applications as necessary.**

| | Last name | First name | Sex | Date of birth (Year Month Day) |
|---|---|---|---|---|
| Child 1 | | | ○ M ○ F | |
| Child 2 | | | ○ M ○ F | |
| Child 3 | | | ○ M ○ F | |
| Child 4 | | | ○ M ○ F | |

#### 3.3.2 Insured amount: $ _____

The insured amount must be the same for all children.

#### 3.3.3 Height and weight

| CHILD 1 | CHILD 2 | CHILD 3 | CHILD 4 |
|---|---|---|---|
| Height: _____ ○ cm ○ ft./in. | Height: _____ ○ cm ○ ft./in. | Height: _____ ○ cm ○ ft./in. | Height: _____ ○ cm ○ ft./in. |
| Weight: _____ ○ kg ○ lb. | Weight: _____ ○ kg ○ lb. | Weight: _____ ○ kg ○ lb. | Weight: _____ ○ kg ○ lb. |

#### 3.3.4 Beneficiary information

Before designating a beneficiary, read Section 4.

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

#### 3.3.5 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 |
|---|---|---|---|---|---|
| ○ | ○ | $ _____ | | | ☐ |

**CHILD 3**

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 4**

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 |
|---|---|---|---|---|---|
| ○ | ○ | $ _____ | | | ☐ |

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## 3 CHOICE OF COVERAGE (cont.)

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

#### 3.3.6 Medical information

**Answer all questions by checking YES or NO. For each "YES" answer, provide details in Section 3.3.7 Additional Information.**

Each of the proposed insured children:

| | CHILD 1 | | CHILD 2 | | CHILD 3 | | CHILD 4 | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| a) Does he or she have a physical or intellectual impairment or any other congenital illness or disorder? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| b) Does he or she have, or previously have, any other illness or disorder requiring hospitalization, consultation with a specialist or taking medication for more than 14 consecutive days? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| c) For a child age 3 or under, was he or she born prematurely (less than 36 weeks of pregnancy) and have developmental delay? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| d) Does he or she have signs or symptoms for which a physician has not yet been consulted or for which follow-up or treatment has been recommended? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| e) Has an insurance application for him or her been declined, modified, cancelled, deferred or rated with a higher premium? | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

#### 3.3.7 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, medication or treatments, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited, current state of health or any other information. |
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## 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). Any amount payable to a beneficiary who has reached the age of majority is payable directly to this person. In Quebec, the minor beneficiary's legal guardian will receive the payable benefit, unless an official trustee has been named.

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

**Estate, successors and legal heirs:** The terms "estate", successors" or "legal heirs" refer to the policyholder's estate, successors or legal heirs, and not those of the insured.

### 4.1 LIFE INSURANCE

#### PROPOSED INSURED 1

**BENEFICIARY**

| Last name | First name | Date of birth (Year Month Day) | Relationship to the proposed insured 1 (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 proposed insured 1 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% |
|---|---|---|---|---|---|---|
| | | | | ○ | ○ | |
| | | | | ○ | ○ | |

**TRUSTEE FOR A MINOR BENEFICIARY (NOT APPLICABLE IN #QUEBEC)**

| Last name of minor beneficiary | First name of minor beneficiary | Last name of trustee | First name of trustee |
|---|---|---|---|
| | | | |

#### PROPOSED INSURED 2

**BENEFICIARY**

| Last name | First name | Date of birth (Year Month Day) | Relationship to the proposed insured 2 (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 proposed insured 2 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% |
|---|---|---|---|---|---|---|
| | | | | ○ | ○ | |
| | | | | ○ | ○ | |

**TRUSTEE FOR A MINOR BENEFICIARY (NOT APPLICABLE IN QUEBEC)**

| Last name of minor beneficiary | First name of minor beneficiary | Last name of trustee | First name of trustee |
|---|---|---|---|
| | | | |

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## 4 BENEFICIARY INFORMATION (cont.)

### 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 (Year Month Day) | Relationship to the proposed insured 1 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |

**CONTINGENT BENEFICIARY**

| Last name | First name | Date of birth (Year Month Day) | Relationship to the proposed insured 1 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |

**TRUSTEE FOR A MINOR BENEFICIARY (NOT APPLICABLE IN QUEBEC)**

| Last name of minor beneficiary | First name of minor beneficiary | Last name of trustee | First name of trustee |
|---|---|---|---|
| | | | |

#### PROPOSED INSURED 2

**BENEFICIARY**

| Last name | First name | Date of birth (Year Month Day) | Relationship to the proposed insured 2 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |

**CONTINGENT BENEFICIARY**

| Last name | First name | Date of birth (Year Month Day) | Relationship to the proposed insured 2 (in Quebec, relationship to the policyholder) | Check one: Revocable | Check one: Irrevocable | Share % Total: 100% | Premium reimbursement/ death benefit |
|---|---|---|---|---|---|---|---|
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |
| | | | | ○ | ○ | | ☐ Surrender/expiry ☐ At death |

**TRUSTEE FOR A MINOR BENEFICIARY (NOT APPLICABLE IN QUEBEC)**

| Last name of minor beneficiary | First name of minor beneficiary | Last name of trustee | First name of trustee |
|---|---|---|---|
| | | | |

## 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 |
|---|---|---|---|---|---|---|---|
| | | ◯ | ◯ | ◯ | | | |
| | | ◯ | ◯ | ◯ | | | |
| | | ◯ | ◯ | ◯ | | | |

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## 5 PERSONAL INFORMATION (cont.)

### 5.3. TOBACCO USE

**Always complete for all proposed insureds**

| PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|
| In the last 12 months, how often have you smoked cigarettes or used any form of tobacco or nicotine (including marijuana/cannabis containing any tobacco or nicotine product) or used a substitute (nicotine gum or patch), electronic cigarette or vape device? | In the last 12 months, how often have you smoked cigarettes or used any form of tobacco or nicotine (including marijuana/cannabis containing any tobacco or nicotine product) or used a substitute (nicotine gum or patch), electronic cigarette or vape device? |
| ◯ Daily ◯ Occasionally/socially ◯ Rarely<br>◯ I stopped smoking in the last 12 months<br>◯ I stopped smoking more than 12 months ago ◯ I have never smoked | ◯ Daily ◯ Occasionally/socially ◯ Rarely<br>◯ I stopped smoking in the last 12 months<br>◯ I stopped smoking more than 12 months ago ◯ I have never smoked |

## 6 LIFESTYLE HABITS AND MEDICAL INFORMATION

**Section 6 must be completed if basic requirements are MEDICAL INFORMATION.**
**If basic requirements are MEDICAL INFORMATION or TELEPHONE INTERVIEW, complete sections 6.1 to 6.5 if MEDICAL INFORMATION is selected.**
**Do not complete Section 6 if TELEPHONE INTERVIEW is selected.**

### 6.1 LIFESTYLE HABITS

**Answer all questions by checking YES or NO. For each "YES" answer, provide details in Section 6.3 or complete the requested questionnaire.**

| | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| **6.1.1 Alcohol use** | | | | |
| a) In the last 12 months, have you consumed more than 15 alcoholic beverages per week (1 alcoholic beverage = 1 small bottle of beer, 1 six-ounce glass of wine or 1 ounce of spirits)? **If so,** complete the ***alcohol use questionnaire (IND031E)***. | ◯ | ◯ | ◯ | ◯ |
| b) In the last 5 years, has your consumption of alcohol changed? **If so**, complete the ***alcohol use questionnaire (IND031E)***. | ◯ | ◯ | ◯ | ◯ |
| c) Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of alcohol? **If so,** provide the dates and reasons for the consultations and any other information. _____ | ◯ | ◯ | ◯ | ◯ |
| **6.1.2 Drug and opiate use** | | | | |
| a) Do you currently use, or in the last 12 months have you used, marijuana, cannabis or hashish (1.5 g) more than 3 times per week? **If so,** complete the ***drug or opiate use questionnaire (IND021E)***. | ◯ | ◯ | ◯ | ◯ |
| b) Do you use, 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 (IND021E)***. | ◯ | ◯ | ◯ | ◯ |
| c) Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of drugs? **If so,** provide the dates and reasons for the consultations and any other information. _____ | ◯ | ◯ | ◯ | ◯ |
| **6.1.3 Driving record** | | | | |
| a) Have you ever been charged with or found guilty of impaired driving? **If so**, complete the ***driving record questionnaire (IND020E)***. | ◯ | ◯ | ◯ | ◯ |
| b) In the last 5 years, has your driver's licence been suspended or revoked? **If so**, complete the ***driving record questionnaire (IND020E)***. | ◯ | ◯ | ◯ | ◯ |
| c) 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 (IND020E)***. | ◯ | ◯ | ◯ | ◯ |
| **6.1.4 Criminal record:** 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. | ◯ | ◯ | ◯ | ◯ |
| **6.1.5 Aviation:** 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 (IND024E)***. | ◯ | ◯ | ◯ | ◯ |

## 6.1 LIFESTYLE HABITS (cont.)

| | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| **6.1.6 Hazardous sports:** Do you plan to take part in or, in the last 2 years, have you taken part in mountain climbing ***(IND023E)***, extreme skiing ***(IND029E)***, extreme snowmobiling ***(IND029E)***, motor vehicle racing ***(IND025E)***, hang gliding ***(IND026E)***, skydiving ***(IND027E)***, scuba diving ***(IND028E)***, any other hazardous sport or activity ***(IND029E)***? **If so**, complete the appropriate questionnaire. | ○ | ○ | ○ | ○ |
| **6.1.7 Travel or residence abroad** | | | | |
| a) Are you planning to travel or live in one of the following countries? Afghanistan, Burundi, North Korea, Iran, Iraq, Libya, Mali, Niger, Nigeria, Central African Republic, Somalia, South Sudan, Syria, the Republic of Chad, Yemen? | ○ | ○ | ○ | ○ |
| b) In the next 2 years, are you planning to travel or reside abroad, other than in the following regions: United States, European Union, United Kingdom, Japan, Australia, New Zealand, the Caribbean (with an all-inclusive package)? **If so,** answer questions b1 and b2. | ○ | ○ | ○ | ○ |
| b1. Is this for work or business? **If so,** complete the ***travel and residence abroad questionnaire (IND032E)***. | ○ | ○ | ○ | ○ |
| b2. Is it for a period of 12 weeks or more per year? **If so,** complete the ***travel and residence abroad questionnaire (IND032E)***. | ○ | ○ | ○ | ○ |

## 6.2 MEDICAL HISTORY

**Answer all questions by checking YES or NO. For each "YES" answer:**
**– Circle the relevant illness, condition or situation.**
**– Provide details in Section 6.3 Additional Information or complete the requested questionnaire.**

| | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| **6.2.1 Have you ever consulted for, been treated for or shown signs or symptoms of any of the following conditions?** | | | | |
| a) CARDIOVASCULAR SYSTEM: | | | | |
| a1. High blood pressure? **If so**, indicate the number of drugs prescribed to treat this condition and if they are effective in managing it in Section 6.3. | ○ | ○ | ○ | ○ |
| a2. 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: | | | | |
| b1. Asthma, emphysema, shortness of breath, chronic bronchitis? **If so**, complete the ***respiratory disorders questionnaire (IND014E)***. | ○ | ○ | ○ | ○ |
| b2. Obstructive sleep apnea? **If so,** indicate if you use CPAP therapy for this condition, for how many years and the degree of severity of your symptoms (asymptomatic, mild, moderate, severe) in Section 6.3. | ○ | ○ | ○ | ○ |
| b3. Any other pulmonary or respiratory disorder? **If so**, complete the ***respiratory disorders questionnaire (IND014E)***. | ○ | ○ | ○ | ○ |
| 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 (IND018E)***. | ○ | ○ | ○ | ○ |
| 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 (IND015E)***. | ○ | ○ | ○ | ○ |
| f) MUSCULOSKELETAL SYSTEM: | | | | |
| f1. Back or neck pain or disorder? **If so**, complete the ***back or neck disorders questionnaire (IND013E)***. | ○ | ○ | ○ | ○ |
| f2. Arthritis, gout, bursitis, tendonitis, sprain or other muscle, ligament, bone or joint disorder? **If so**, complete the ***musculoskeletal disorders questionnaire (IND012E)***. | ○ | ○ | ○ | ○ |
| g) NERVOUS SYSTEM: | | | | |
| g1. Epilepsy? **If so**, complete the ***epilepsy questionnaire (IND134E)***. | ○ | ○ | ○ | ○ |
| g2. 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? | ○ | ○ | ○ | ○ |

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## 6 LIFESTYLE HABITS AND MEDICAL INFORMATION (cont.)

### 6.2 MEDICAL HISTORY (cont.)

| | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| h) MENTAL HEALTH: | | | | |
| h1. Depression, burnout, insomnia, adjustment disorder, anxiety, fatigue/overwork, stress, postpartum depression or any other psychological, psychiatric or mental disorder? **If so**, complete the ***psychological disorders questionnaire (IND017E)***. | ○ | ○ | ○ | ○ |
| 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) CANCER OR TUMOR: | | | | |
| j1. Breast or ovarian cyst? **If so,** indicate the degree of severity (benign, malignant) and if you have already had a surgical procedure or excision for this condition in Section 6.3. | ○ | ○ | ○ | ○ |
| j2. Polyp? **If so**, indicate on which part of the body (nose, colon, uterus, other) in Section 6.3. | ○ | ○ | ○ | ○ |
| j3. Leukemia, cancer, cyst, nodule, lymph node disorder, tumor (benign or malignant), other? **If so,** provide all details in Section 6.3. | ○ | ○ | ○ | ○ |
| k) GENERAL: Anemia or other blood disease, skin disease or abnormal skin lesion, eye or ear condition or breast disorder (including lumps)? | ○ | ○ | ○ | ○ |
| l) Have you ever consulted for, been treated for or shown signs or symptoms of any other physical or psychological disorder not mentioned in the preceding questions? | ○ | ○ | ○ | ○ |
| **6.2.2** PREGNANCY AND CHILDBIRTH | | | | |
| a) Are you pregnant? | ○ | ○ | ○ | ○ |
| a1. **If so**, what is the due date? | Year Month | | Year Month | |
| b) Have you previously had complications during a pregnancy or at childbirth (gestational diabetes, preeclampsia, cesarian section, postpartum depression, etc.)? | ○ | ○ | ○ | ○ |
| **6.2.3** PHYSICIANS, TESTS AND MEDICAL CONSULTATIONS | | | | |
| a) In the last 2 years, have you consulted a physician for a reason other than routine annual examinations or benign conditions (cold, flu, upper respiratory infection, etc.)? **If so,** provide the dates and reasons for the consultations and your current state of health. | ○ | ○ | ○ | ○ |
| b) In the last 2 years, have you undergone routine tests (blood work, urinalysis, Pap test) or screening tests that have been recommended because of your age (mammography, colonoscopy, prostate exam)? | ○ | ○ | ○ | ○ |
| b1. **If so,** were the results normal? **If not,** provide the dates and details of any abnormal test results. | ○ | ○ | ○ | ○ |
| c) In the last 5 years, have you had an electrocardiogram, X-ray, CT scan, MRI, mammography, breast ultrasound, blood tests, follow-ups, screening or diagnostic tests? **If so,** provide the dates, results and any other information. | ○ | ○ | ○ | ○ |
| d) In the last 5 years, have you ever consulted or been advised to consult a physician or a specialist or been advised to receive treatment following abnormal findings of a breast ultrasound, biopsy, mammography or Pap test? **If so,** provide the results, diagnosis, date of diagnosis, dates and reasons for the consultations and any other information. | ○ | ○ | ○ | ○ |
| e) In the last 5 years, have you been admitted as a patient to a hospital or clinic? **If so,** provide the name and address of the hospital or the clinic, the admission date and any other information. | ○ | ○ | ○ | ○ |
| f) Do you have signs or symptoms for which you have not yet sought medical attention, do you need to do so or have you been advised to consult a physician or specialist, undergo a treatment or surgery or have follow-up or diagnostic tests which have not yet been performed? **If so,** indicate the signs and symptoms, the dates and reasons for the upcoming consultations and any other information. | ○ | ○ | ○ | ○ |
| **6.2.4** DISABILITY OR ABSENCE FROM WORK: 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? **If so,** provide the dates, reasons, return-to-work date and any other information. | ○ | ○ | ○ | ○ |
| **6.2.5** MEDICATIONS: Are you taking any medication? **If so,** specify. | ○ | ○ | ○ | ○ |

## 6 LIFESTYLE HABITS AND MEDICAL INFORMATION (cont.)

### 6.3 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, medication or treatments, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited, current state of health or any other information. |
|---|---|---|
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### 6.4 HEIGHT AND WEIGHT

**PROPOSED INSURED 1**

Height: _____ ◯ cm ◯ ft./in. Weight: _____ ◯ kg ◯ lb.

Other than for childbirth, has your weight decreased by 4.5 kg (10 lb.) or more in the last 12 months? ◯ Yes ◯ No

**If so,** was the weight loss intentional? ◯ Yes ◯ No – **If not,** provide details: _____

How much weight did you lose? _____ ◯ kg ◯ lb.

**PROPOSED INSURED 2**

Height: _____ ◯ cm ◯ ft./in. Weight: _____ ◯ kg ◯ lb.

Other than for childbirth, has your weight decreased by 4.5 kg (10 lb.) or more in the last 12 months? ◯ Yes ◯ No

**If so,** was the weight loss intentional? ◯ Yes ◯ No – **If not,** provide details: _____

How much weight did you lose? _____ ◯ kg ◯ lb.

### 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, 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 before age 65? **If so,** provide the required information below. Don't indicate family history of high blood pressure or high levels of cholesterol.

| 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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Application No.: 11665271

La Capitale

## 7 SUPPLEMENTARY SECTION FOR PROPOSED INSUREDS UNDER AGE 18 (PROPOSED INSURED CHILDREN)

**Always complete for all proposed insureds under age 18.**

### 7.1 PROPOSED INSURED CHILD'S BROTHERS AND SISTERS

Does the proposed insured child have any brothers or sisters?

**If so**, how many?

| | PROPOSED INSURED CHILD 1 | | PROPOSED INSURED CHILD 2 | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| | ○ | ○ | ○ | ○ |
| | _____ | | _____ | |

### 7.2 PREVIOUS INSURANCE COVERAGE OF THE PROPOSED INSURED CHILD'S FAMILY MEMBERS

**PROPOSED INSURED 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 proposed insured child's family member | Relationship to the proposed insured child | LIFE | CI | DI | Insured amount | Company name | Year issued | Pending |
|---|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | $ | | | ☐ |
| | | ☐ | ☐ | ☐ | $ | | | ☐ |

**PROPOSED INSURED 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 proposed insured child's family member | Relationship to the proposed insured child | LIFE | CI | DI | Insured amount | Company name | Year issued | Pending |
|---|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | $ | | | ☐ |
| | | ☐ | ☐ | ☐ | $ | | | ☐ |

### 7.3 PROPOSED INSURED CHILD'S PARENTS' FINANCIAL INFORMATION

Complete if the insured amount applied for is greater than $100,000.

**7.3.1** Parents' annual income: $ _____

**7.3.2** Parents' net worth (assets-liabilities): $ _____

### 7.4 PROPOSED INSURED CHILD'S MEDICAL HISTORY

**Answer all questions by checking YES or NO. For each "YES" answer:**
**– Circle the relevant illness, condition or situation.**
**– Provide details in Section 7.5 Additional Information**

| | | PROPOSED INSURED CHILD 1 | | PROPOSED INSURED CHILD 2 | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| **7.4.1** | Has the proposed insured 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? | ○ | ○ | ○ | ○ |
| **7.4.2** | Is the proposed insured child under 1 year old? | ○ | ○ | ○ | ○ |
| | **If so**, was he or she born more than 4 weeks prematurely? | ○ | ○ | ○ | ○ |

### 7.5 ADDITIONAL INFORMATION

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

| Question No. | Proposed insured child's name | Diagnosis, date of diagnosis, dates of consultations, reasons, results, medication or treatments, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited, current state of health or any other information. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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## 8 DISABILITY INCOME BENEFIT

### PROPOSED INSURED 1

**8.1 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.**

### PROPOSED INSURED 2

**8.1 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.**

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

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

_____

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

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

**8.5** Do you work 20 hours or more per week? ◯ Yes ◯ No

**8.6** Do you work 39 weeks (9 months) or more per year? ◯ Yes ◯ No

**8.7** Have you worked 12 months or more for this employer? ◯ Yes ◯ No

**8.8** Type of employment: ◯ Temporary ◯ Permanent

**8.9** What is your job title?

_____

_____

**8.10** Briefly describe your duties:

_____

_____

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

**8.12** 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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

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

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

**8.5** Do you work 20 hours or more per week? ◯ Yes ◯ No

**8.6** Do you work 39 weeks (9 months) or more per year? ◯ Yes ◯ No

**8.7** Have you worked 12 months or more for this employer? ◯ Yes ◯ No

**8.8** Type of employment: ◯ Temporary ◯ Permanent

**8.9** What is your job title?

_____

_____

**8.10** Briefly describe your duties:

_____

_____

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

**8.12** 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

_____

_____

_____

_____

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_____

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_____

_____

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## 9 QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE

**Always complete this section for each proposed insured.**

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

| | | PROPOSED INSURED 1 | | PROPOSED INSURED 2 | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| | Have you ever consulted for, been treated for or shown signs or symptoms of the following: | | | | |
| 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 PREMIUM PAYMENT

### PREMIUM PAYMENT METHOD SELECTION

⚠ **In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, the financial security advisor/representative and the policyowner(s) must complete form *IND075 Identification of Politically Exposed Persons and Heads of International Organizations* for any lump sum deposit of $100,000 or more.**

◯ **Annual** Cheque must be made out to La Capitale Civil Service Insurer Inc.

◯ 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.

⚠ **Complete the Preauthorized Debit (PAD) agreement in Section 11.**

⚠ **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**

## 11 PREAUTHORIZED DEBIT (PAD) AGREEMENT

### 11.1 PREMIUM PAYOR'S INFORMATION

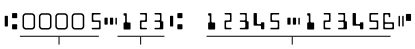
◯ Policyholder 1 ◯ Policyholder 2 ◯ Other: ◯ Mr. ◯ Ms.

First name (please print) _____ Last name (please print) _____

Address (No., street, apartment, city, province) _____ Postal code _____

Area code _____ Telephone _____ Date of birth: Year _____ Month _____ Day _____

### 11.2 BANK ACCOUNT INFORMATION: ◯ Cheque specimen attached ◯ Banking information provided below:



Branch number | Financial institution number | Account number

Branch number _____ Financial institution number _____ Account number _____

### 11.3 PAD TYPE: ◯ Personal ◯ Business

### 11.4 WITHDRAWAL DATE

The _____ of each month (between the 1st and 30th days of the month). If a date is not indicated, it will be selected by the Insurer.

### 11.5 WAIVER

**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.**

### 11.6 CANCELLATION

This agreement may be cancelled upon receipt by the Insurer of 10 days' written notice prior to the scheduled date of the next PAD. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement, contact your financial institution or visit www.cdnpay.ca.

### 11.7 RECOURSE AND REIMBURSEMENT

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information about your recourse rights, contact your financial institution or visit www.cdnpay.ca.

### 11.8 AUTHORIZATION

I authorize the Insurer or its mandatary to debit the fixed monthly amounts required for payment due to the Insurer from the account indicated on the enclosed cheque specimen or from the account identified above.

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

✗ _____

Premium payor's signature

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

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## 12 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 1 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 2 is under age 18 in Quebec or under age 16 outside Quebec

## 13 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.

The policyholder and proposed insured agree that if the recorded information is found to be inaccurate or incomplete, including but not limited to the information provided to support the application of non-smoker rates to the proposed insured in accordance with the contract applied for, the contract is null and void with regard to this proposed insured.

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 that occurs 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.

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

The policyholder and the proposed insured acknowledge having received and read the MIB, Inc. notice, the notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews and the protection of personal information notice.

The proposed insured authorizes the Insurer and its reinsurers to obtain and use any information held by a credit-rating agency for the purposes of pricing, underwriting, analyzing, conducting research and development, complying with regulations and contract provisions, developing its insurance product and financial services offering, preventing and detecting fraud, errors and misrepresentations. This authorization is valid for the length of time needed to achieve such purposes.

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 1 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 2 is under age 18 in Quebec or under age 16 outside Quebec

**ADVISOR'S SIGNATURE**

X _____

Advisor's signature

La Capitale

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

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Contract No.: Leave this blank

## 14 AUTHORIZATION

1. I authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, MIB, Inc., financial institutions, credit-rating agencies, insurance and reinsurance companies, personal information agents, investigation agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of pricing, underwriting, analyzing, conducting research and development, complying with regulations and contract provisions, developing its insurance product and financial services offering, preventing and detecting fraud, errors and misrepresentations. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including 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 is also valid with regard to 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 is 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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La Capitale

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

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## 15 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, 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;
- the 60th day following the effective date of the Certificate.

**15.1 – 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 15.1 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.

**15.2 – 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

## 15 CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE (cont.)

**15.3 – 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 15.3 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;
- $500,000 MINUS any other insurance 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 the proposed insured.

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

**ADVISOR'S SIGNATURE**

X _____

Advisor's signature

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## 16 NOTICES

**To be given to the policyholder and the proposed insured**

### 16.1 – MIB, Inc. notice

Certain information must be collected when an insurer receives an insurance application, and this information must be as complete as possible. This information can be of a medical or personal nature or can involve your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including La Capitale, work with an organization called MIB, Inc. (MIB).

The information about your insurability will be treated confidentially. However, La Capitale or its reinsurers may make a brief report to MIB, a non-profit organization that enables information to be exchanged among member insurance companies. When you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB will, upon request, supply such company with information in its files.

If you make a request, MIB will provide you with the information contained in your file. You can email MIB at Canadadisclosure@mib.com or call 866 692-6901. If you question the accuracy of the information recorded in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set out in the federal *Fair Credit Reporting Act*. The address of MIB's information bureau is 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734. It is possible that your information may be stored outside of Quebec and governed by the laws of foreign countries or states.

La Capitale, or its reinsurers, may also disclose the information in your file to any other insurance company to which you apply for life or health insurance or to which you submit a claim for benefits. Consumers may obtain information about MIB by consulting its website at www.mib.com.

### 16.2 – 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.

### 16.3 – Protection of personal information notice

Protecting your personal information is a priority for La Capitale. Your personal information is protected by high security measures in accordance with the laws and regulations applicable to the protection of personal information.

**Consent to the collection, disclosure, use and storage of your personal information**

La Capitale collects, discloses, uses and stores your personal information for purposes of pricing, underwriting, analyzing, conducting research and development, complying with regulations and contract provisions, developing its insurance product and financial services offering and preventing and detecting fraud, errors and misrepresentations for the length of time needed to achieve these purposes.

La Capitale, its affiliated companies and their distribution networks access, share with each other, use and store your personal information for the same purposes listed above. Accordingly, their employees, agents and service providers may have access to your personal information, if they require such access to carry out their duties or if such access is required by a contract.

**Purpose of the file, storage location and access to your personal information**

La Capitale collects, discloses, uses and stores your personal information for the purpose of managing your financial services, insurance, savings, annuities, credit or other related services.

Your personal information is stored at La Capitale's offices. It may be transferred and used securely in another country. If so, it is governed by the laws of that country.

If you would like to access your file or make a correction to it, make your request in writing to the address below.

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

La Capitale

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

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## 17 TELEPHONE INTERVIEW OR UNDERWRITING REQUIREMENTS ORDERS

**17.1** Is this a pre-screening exercise? ◯ Yes ◯ No **If so**, do not order a telephone interview or underwriting 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.

### 17.2. 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) |

### 17.3. UNDERWRITING REQUIREMENTS ORDER

Please indicate who is responsible for ordering requirements.

☐ **Requirements to be ordered by the Insurer**

☐ **Requirements ordered by the advisor**

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

Underwriting requirements ordered from: ☐ ExamOne ☐ Dynacare

☐ **Requirements ordered from another service provider**

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

Name of service provider: _____

| UNDERWRITING REQUIREMENTS | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| Vital signs | ☐ | ☐ |
| HIV urine | ☐ | ☐ |
| Blood profile | ☐ | ☐ |
| Inspection report | ☐ | ☐ |
| ECG at rest | ☐ | ☐ |
| Exercise ECG | ☐ | ☐ |

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## 18 ADVISOR'S REPORT

**18.1** Do the policyholders and the proposed insureds speak or read the application language? ◯ Yes ◯ No

**If not**, who explained the application content to the policyholders and the proposed insureds? _____

In your opinion, did they understand the explanations? ◯ Yes ◯ No Provide any applicable details: _____

**18.2** Did you complete this application in the presence of the policyholders and the proposed insureds? ◯ Yes ◯ No

**If not**, explain: _____

| | PROPOSED INSURED 1 | PROPOSED INSURED 2 |
|---|---|---|
| **18.3** How long have you known the proposed insureds? | ◯ Less than a year<br>◯ Between 1 and 5 years<br>◯ More than 5 years | ◯ Less than a year<br>◯ Between 1 and 5 years<br>◯ More than 5 years |
| **18.4** Are you related to the proposed insureds? | ◯ Yes ◯ No – **If so,** specify the relationship: _____ | ◯ Yes ◯ No – **If so,** specify the relationship: _____ |
| **18.5** Have you completed and given the Conditional Certificate of Temporary Insurance to the policyholder? | ◯ Yes ◯ No | ◯ Yes ◯ No |

### 18.6 ADVISOR'S INFORMATION

_____ Advisor's name | ⌊ ⌋ Advisor's code | _____ General Agent | ⌊ ⌋ General Agent's code

_____

Email address to be used by the Insurer to obtain any additional information

### 18.7 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 |
|---|---|---|---|---|
| _____ | ⌊ ⌋ | _____ % | _____ | ⌊ ⌋ |
| _____ | ⌊ ⌋ | _____ % | _____ | ⌊ ⌋ |
| _____ | ⌊ ⌋ | _____ % | _____ | ⌊ ⌋ |

### 18.8 SPECIAL INSTRUCTIONS

_____

_____

### 18.9 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 and my ties to these companies, 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, any potential conflicts of interest with regard to this sale and that the policyholder has the right to request supplementary information.

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 and that I have informed the policyholder of this in writing.

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**

X _____

Advisor's signature

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La Capitale