La Capitale Financial Security

	MISSISSAUGA, OI		C		~		_												_	_						
GENERAL		SAFE DRIVER APPLICATION FOR INSURANCE											OC CODE													
Last Name (Proposed Insured)								First I	Name	9								Ini	tial		Occupation					
Primary Address Stre					et Numb	er			1		1			Street or Rural Ro			oute						Po	stal Co	de	
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City								Prov	vince	Age	Ger	nder	Heig	ght .			Ŵ	eight		ha			Birth	date:		
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	you have nam on to whom y																							Rev		
are married or civilly united,																			🗌 Irrevocable							
irrevocable unless you indicate				ent Beneficiary (Last Name) First Name Initial I									Re	latior	tionship Age Select Designation											
that you wish to be Revoce	n for the designat able.	ion														Revocable Irrevocable										
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Idoptificati	on Tuno log Dr	iver's	licon	C									Drovir		Cau	try	of Ia									
Ideniiicaii	on type (eg. Dr	iver s	Licen	nce, Passport): Province or Country of Issue:																						
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SECTION		SAF			ER PL			STI																		
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	eck Yes or No					-					-					-			-			-			Yes	No
	last 3 years,								•							•					•			•		
Is your current occupation as an ambulance, city bus, taxi, limo, or as a police officer?																										
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 Are you currently disabled or receiving disability benefits? Do you engage in competition, racing or speed contests? 																										
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J. Are y	ou now insure	ea or	are	ар	plication	onsp	send	aing	for	Sate D	river	r cov	veraç	geș	•••	•••	•••	• • •	• • • •	• • •	•••		•••	••••		
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│	DRIVER PLAN	1							\$				Pe	r Mont	h			\$						-		
administro organizati authorized the office of sending a Mississau	ANT: In mak tion and clair on or institution demployees of the Insurer a written reque ga ON L5W Company, 6	ns pu on the of La (ind ye st to t 0E5	at m Cap ou ha he fa 1 8(ses, iay itale ave ollo 202	which have i e Finar the rig wing a 268-28	will nforr icial htto ddre 335	con mati Sec revi ess: 1 (All	on c ority ewt Mar pro	any or re / Insu he p nage vince	inform cords c urance ersona er, La C es with	ation abou Com linfc apit the	n thơ npai ormo ale exce	at mo ou. Th ny (th ation Fina eptio	ny be nis info ne Insu conta ncial S on of C	obta orma urer) iinea Secu Quel	atior atior) will d in y urity bec)	d ab n wi hav rour Insi or I	out y re ac file a vran Man	/ou o helc cess nd if ce C age	ind's in s to th nece omp ; La	/our trict is fil essa any Cap	healt est cc e. You ry to h 715 5itale	th fro onfid or file have 0 De Fine	om any lence e will k e it corr errycr	y per and be ke recte est D	rson, only only of in d by Drive

APPLICATION #

La Capitale Financial Secur	ty Insurance Co	ompany (the Insurer)
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SECTION 3 BANKING INFORMATION SECTION
METHOD OF INITIAL PAYMENT: D By Cheque D By Money Order D By Visa* D By MasterCard* *Monthly charge to credit card is not available.
Cardholder's Name:
Credit Card Number:
Signed Authorization:
MODE OF PAYMENT FREQUENCY: PAD** Semi Annual ** If Pre-Authorized Debit is selected, please complete Section 4. AMOUNT PAID: \$
SECTION 4 PREAUTHORIZED DEBIT (PAD) AGREEMENT
I, the undersigned, hereby authorize La Capitale Financial Security Insurance Company to debit the fixed monthly amounts required for payment of the sums due to La Capitale Financial Security Insurance Company from the account indicated on the enclosed cheque or from the account identified below.
BANK ACCOUNT INFORMATION
Bank Name:
Please enclose a cheque specimen or complete: Transit Bank Account No.
TYPE OF PAD: Personal Use Business Use
 This agreement may be cancelled upon receipt by La Capitale Financial Security Insurance Company of ten (10) days written notice prior to the scheduled date of the next PAD. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain a sample PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, you may contact La Capitale Financial Security Insurance Company toll free at 1 800 268-2835 (English) or 1 800 363-8011 (French) or visit www.cdnpay.ca. You have waived your right to receive pre-notification of the amount of the PAD and agreed that you do not require advance notice of the amount of PADs before the debit is processed. PAYOR'S NAME: PAYOR'S ADDRESS (if other than proposed insured or policyholder):
Signed at day of 20
Signature of person paying premium:
ADVISOR STATEMENT: I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant and payor (if different from the applicant). I certify that I have seen the client in person and that I have seen the client's/payor's identification and compared the signature on the identification document with the applicant's/payor's signature on the application.
I ACKNOWLEDGE THAT THE ANSWERS GIVEN IN THIS APPLICATION ARE TRUE AND COMPLETE. AUTHORIZATION: I hereby authorize the Insurer or its reinsurers, for underwriting, administration and claims adjudication purposes only: a) to gather only that information necessary from any person or organization that has personal information relating to me or any family member to be insured, including other insurers, physicians, medical institutions, Provincial or Territorial WCB, WSIB or WHSCC, other Government organizations, the MIB, Inc., investigation and consumer reporting agencies, and all persons likely to have personal information relevant to the object of the file; b) to disclose to these same persons and organizations only the neces- sary personal information relating to me to allow them to collect the required information; c) to share such information as is necessary for the purposes described above with the advisor and agency of record of the policy issued in connection with this application; and (d) to make a brief report of my personal health information to MIB, Inc I understand and agree that: (a) the Insurer may provide access to my personal information to service providers located in jurisdictions outside Canada who provide the Insurer with, without limiting, information technology, data storage, claims adjudication and reinsurance services; and (b) I can obtain access to the Insurer's policy on personal information protection at www.lacapitaleFS.com under 'Privacy Policy'. A photocopy of this authorization shall be as valid as the origi- nal. This authorization is valid for the period required to achieve the purpose for which it was requested. I acknowledge receipt of notice regarding the MIB, Inc. I acknowledge that the Insurer may refuse to consider my application for insurance if I do not comply completely with this authorization.
Date: MM / DD / YY Signature of Proposed Insured:

La Capitale Financial Security Insurance Company (the Insurer)